Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2170
August 2026

APPLICANT (stamp or sticker acceptable)	**PATIENT** NHI:	**REFERRER** Reg No: .....
Reg No:	First Names:	First Names: .....
Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
.....	.....	.....

Cinacalcet

Initial application — parathyroid carcinoma or calciphylaxis
Applications only from a nephrologist or endocrinologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has been diagnosed with a parathyroid carcinoma (see Note)
- **and**
- ☐ The patient has persistent hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) despite previous first-line treatments including sodium thiosulfate (where appropriate) and bisphosphonates
- **and**
- ☐ The patient is symptomatic

or

- ☐ The patient has been diagnosed with calciphylaxis (calcific uraemic arteriolopathy)
- **and**
- ☐ The patient has symptomatic (e.g. painful skin ulcers) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L)
- **and**
- ☐ The patient's condition has not responded to previous first-line treatments including bisphosphonates and sodium thiosulfate

Renewal — parathyroid carcinoma or calciphylaxis

Current approval Number (if known):.....

Applications only from a nephrologist or endocrinologist. Approvals valid without further renewal unless notified.
Prerequisites(tick boxes where appropriate)

- ☐ The patient's serum calcium level has fallen to < 3mmol/L
- **and**
- ☐ The patient has experienced clinically significant symptom improvement

Note: This does not include parathyroid adenomas unless these have become malignant.

Initial application — primary hyperparathyroidism
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has primary hyperparathyroidism
- **and**
- ☐ Patient has hypercalcaemia of more than 3 mmol/L with or without symptoms
- **or**
- ☐ Patient has hypercalcaemia of more than 2.85 mmol/L with symptoms
- **and**
- ☐ Surgery is not feasible or has failed
- **and**
- ☐ Patient has other comorbidities, severe bone pain, or calciphylaxis

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: ..... Date: .....

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz

APPLICANT (stamp or sticker acceptable)	**PATIENT** NHI:	**REFERRER** Reg No: .....
Reg No:	First Names:	First Names: .....
Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
.....	.....	.....

Cinacalcet *- continued*

Initial application — secondary or tertiary hyperparathyroidism
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has tertiary hyperparathyroidism and markedly elevated parathyroid hormone (PTH) with hypercalcaemia
  or
- ☐ Patient has symptomatic secondary hyperparathyroidism and elevated PTH

and

- ☐ Patient is on renal replacement therapy

and

- ☐ Residual parathyroid tissue has not been localised despite repeat unsuccessful parathyroid explorations
  or
- ☐ Parathyroid tissue is surgically inaccessible
  or
- ☐ Parathyroid surgery is not feasible

Renewal — secondary or tertiary hyperparathyroidism

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has had a kidney transplant, and following a treatment free interval of at least 12 weeks a clinically acceptable parathyroid hormone (PTH) level to support ongoing cessation of treatment has not been reached
  or
- ☐ The patient has not received a kidney transplant and trial of withdrawal of cinacalcet is clinically inappropriate

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: ..... Date: .....
Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz