APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2555
November 2026

APPLICANT (stamp or sticker acceptable)

Reg No: .....

Name: .....

Address: .....

.....

.....

.....

PATIENT NHI: .....

First Names: .....

Surname: .....

DOB: .....

Address: .....

.....

.....

.....

REFERRER Reg No: .....

First Names: .....

Surname: .....

Address: .....

.....

.....

.....

Febuxostat

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

☐ Patient has been diagnosed with gout

and

☐ The patient has a serum urate level greater than 0.36 mmol/l despite treatment with allopurinol at doses of at least 600 mg/day and addition of probenecid at doses of up to 2 g per day or maximum tolerated dose

or

☐ The patient has experienced intolerable side effects from allopurinol such that treatment discontinuation is required and serum urate remains greater than 0.36 mmol/l despite use of probenecid at doses of up to 2 g per day or maximum tolerated dose

or

☐ The patient has renal impairment such that probenecid is contraindicated or likely to be ineffective and serum urate remains greater than 0.36 mmol/l despite optimal treatment with allopurinol

or

☐ The patient has previously had an initial Special Authority approval for benzbromarone for treatment of gout.

Initial application — Tumour lysis syndrome
Applications only from a haematologist or oncologist. Approvals valid for 6 weeks.
Prerequisites(tick boxes where appropriate)

☐ Patient is scheduled to receive cancer therapy carrying an intermediate or high risk of tumour lysis syndrome

and

☐ Patient has a documented history of allopurinol intolerance

Renewal — Tumour lysis syndrome

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

Applications only from a haematologist or oncologist. Approvals valid for 6 weeks.
Prerequisites(tick box where appropriate)

☐ The treatment remains appropriate and the patient is benefitting from treatment

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