Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2118
December 2026

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

Abiraterone acetate

Initial application
Applications only from a medical oncologist, radiation oncologist, urologist or medical practitioner on the recommendation of a medical oncologist, radiation oncologist or urologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has prostate cancer
- **and** ☐ Patient has metastases
- **and** ☐ Patient's disease is castration resistant
- **and**
  - ☐ Patient is symptomatic
  - **and** ☐ Patient has disease progression (rising serum PSA) after second line anti-androgen therapy
  - **and** ☐ Patient has ECOG performance score of 0-1
  - **and** ☐ Patient has not had prior treatment with taxane chemotherapy

  or

  - ☐ Patient's disease has progressed following prior chemotherapy containing a taxane
  - **and** ☐ Patient has ECOG performance score of 0-2
  - **and** ☐ Patient has not had prior treatment with abiraterone

Renewal — abiraterone acetate

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

Applications only from a medical oncologist, radiation oncologist, urologist or medical practitioner on the recommendation of a medical oncologist, radiation oncologist or urologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Significant decrease in serum PSA from baseline
- **and** ☐ No evidence of clinical disease progression
- **and** ☐ No initiation of taxane chemotherapy with abiraterone
- **and** ☐ The treatment remains appropriate and the patient is benefiting 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

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

Abiraterone acetate *- continued*

Renewal — pandemic circumstances

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ The patient is clinically benefiting from treatment and continued treatment remains appropriate

and

- ☐ Abiraterone acetate to be discontinued at progression

and

- ☐ No initiation of taxane chemotherapy with abiraterone

and

- ☐ The regular Special Authority renewal requirements cannot be met due to COVID-19 constraints on the health sector

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