Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2276
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:	.....
.....	.....	.....
.....	.....	.....

Pertuzumab

Initial application — metastatic breast cancer
Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)

and

- ☐ Patient is chemotherapy treatment naïve

or

- ☐ Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer

and

- ☐ The patient has good performance status (ECOG grade 0-1)

and

- ☐ Pertuzumab to be administered in combination with trastuzumab

and

- ☐ Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg every 3 weeks

and

- ☐ Pertuzumab to be discontinued at disease progression

Renewal — metastatic breast cancer

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

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

- ☐ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)

and

- ☐ The cancer has not progressed at any time point during the previous 12 months whilst on pertuzumab and trastuzumab

or

- ☐ Patient has previously discontinued treatment with pertuzumab and trastuzumab for reasons other than severe toxicity or disease progression

and

- ☐ Patient has signs of disease progression

and

- ☐ Disease has not progressed during previous treatment with pertuzumab and trastuzumab

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