Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2325
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:	.....
.....	.....	.....
.....	.....	.....

Niraparib

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

- ☐ Patient has advanced high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer

and

- ☐ Patient has received at least one line** of treatment with platinum-based chemotherapy

and

- ☐ Patient has experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy

and

- ☐ Patient has not previously received funded treatment with a PARP inhibitor

and

- ☐ Treatment will be commenced within 12 weeks of the patient's last dose of the preceding platinum-based regimen

or

- ☐ Patient commenced treatment with niraparib prior to 1 May 2024

and

- ☐ Treatment to be administered as maintenance treatment

and

- ☐ Treatment not to be administered in combination with other chemotherapy

Renewal

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

Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ No evidence of progressive disease

and

- ☐ Treatment to be administered as maintenance treatment

and

- ☐ Treatment not to be administered in combination with other chemotherapy

and

- ☐ Treatment with niraparib to cease after a total duration of 36 months from commencement

or

- ☐ Treatment with niraparib is being used in the second-line or later maintenance setting

Note: * "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component.
**A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments

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