Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA2345**
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: ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

## Palbociclib (Ibrance)

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

- ☐ Patient has unresectable locally advanced or metastatic breast cancer
- **and** ☐ There is documentation confirming disease is hormone-receptor positive and HER2-negative
- **and** ☐ Patient has an ECOG performance score of 0-2
- **and**
  - ☐ Disease has relapsed or progressed during prior endocrine therapy
  - **or**
    - ☐ Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state
    - **and** ☐ Patient has not received prior systemic treatment for metastatic disease
- **and** ☐ Treatment must be used in combination with an endocrine partner
- **and** ☐ Patient has not received prior funded treatment with a CDK4/6 inhibitor

**or**

- ☐ Patient has an active Special Authority approval for ribociclib
- **and** ☐ Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation
- **and** ☐ Treatment must be used in combination with an endocrine partner
- **and** ☐ There is no evidence of progressive disease since initiation of ribociclib

**Renewal**

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

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

- ☐ Treatment must be used in combination with an endocrine partner
- **and** ☐ There is no evidence of progressive disease since initiation of palbociclib

**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**