APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2385
December 2026

APPLICANT (stamp or sticker acceptable)

Reg No: .....

Name: .....

Address: .....

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PATIENT NHI: .....

First Names: .....

Surname: .....

DOB: .....

Address: .....

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REFERRER Reg No: .....

First Names: .....

Surname: .....

Address: .....

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Dasatinib

Initial application
Applications only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis or accelerated phase

or

- ☐ The patient has a diagnosis of Philadelphia chromosome-positive acute lymphoid leukaemia (Ph+ ALL)

or

- ☐ The patient has a diagnosis of CML in chronic phase

and

  - ☐ Patient has documented treatment failure* with imatinib

  or

  - ☐ Patient has experienced treatment-limiting toxicity with imatinib precluding further treatment with imatinib

  or

  - ☐ Patient has high-risk chronic-phase CML defined by the Sokal or EURO scoring system

Renewal

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

Applications only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Lack of treatment failure while on dasatinib*

and

- ☐ Dasatinib treatment remains appropriate and the patient is benefiting from treatment

Note: *treatment failure for CML as defined by Leukaemia Net Guidelines.

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