Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2424
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:	.....
.....	.....	.....
.....	.....	.....

Trastuzumab emtansine

Initial application — early breast cancer
Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has early breast cancer expressing HER2 IHC3+ or ISH+

and

- ☐ Documentation of pathological invasive residual disease in the breast and/or axiliary lymph nodes following completion of surgery

and

- ☐ Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery

and

- ☐ Disease has not progressed during neoadjuvant therapy

and

- ☐ Patient has left ventricular ejection fraction of 45% or greater

and

- ☐ Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery

and

- ☐ Trastuzumab emtansine to be discontinued at disease progression

and

- ☐ Total adjuvant treatment duration must not exceed 42 weeks (14 cycles)

Initial application — metastatic breast cancer
Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

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

and

- ☐ Patient has previously received trastuzumab and chemotherapy, separately or in combination

and

- ☐ The patient has received prior therapy for metastatic disease*

or

- ☐ The patient developed disease recurrence during, or within six months of completing adjuvant therapy*

and

- ☐ Patient has a good performance status (ECOG 0-1)

and

- ☐ Patient does not have symptomatic brain metastases

or

- ☐ Patient has brain metastases and has received prior local CNS therapy

and

- ☐ Patient has not received prior funded trastuzumab emtansine or trastuzumab deruxtecan treatment

or

- ☐ Patient has discontinued trastuzumab deruxtecan due to intolerance

and

- ☐ The cancer did not progress while on trastuzumab deruxtecan

and

- ☐ Treatment to be discontinued at disease progression

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)

Reg No: .....

Name: .....

Address: .....

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PATIENT NHI: .....

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Surname: .....

Address: .....

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Trastuzumab emtansine *- continued*

Renewal — metastatic breast cancer

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

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

☐ The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab emtansine

and

☐ Treatment to be discontinued at disease progression

Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.

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