APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2683
December 2026

APPLICANT (stamp or sticker acceptable)

Reg No: .....

Name: .....

Address: .....

.....

.....

.....

PATIENT NHI: .....

First Names: .....

Surname: .....

DOB: .....

Address: .....

.....

.....

.....

REFERRER Reg No: .....

First Names: .....

Surname: .....

Address: .....

.....

.....

.....

Ticagrelor

Initial application — acute coronary syndrome
Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has recently (within the last 60 days) been diagnosed with an ST-elevation or a non-ST-elevation acute coronary syndrome

and

- ☐ Fibrinolytic therapy has not been given in the last 24 hours and is not planned

Renewal — subsequent acute coronary syndrome

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

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

- ☐ Patient has recently (within the last 60 days) been diagnosed with an ST-elevation or a non-ST-elevation acute coronary syndrome

and

- ☐ Fibrinolytic therapy has not been given in the last 24 hours and is not planned

Initial application — thrombosis prevention neurological stenting
Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has had a neurological stenting procedure* in the last 60 days

or

- ☐ Patient is about to have a neurological stenting procedure performed*

and

- ☐ Patient has demonstrated clopidogrel resistance using the P2Y12 (VerifyNow) assay or another appropriate platelet function assay and requires antiplatelet treatment with ticagrelor

or

- ☐ Clopidogrel resistance has been demonstrated by the occurrence of a new cerebral ischemic event

or

- ☐ Clopidogrel resistance has been demonstrated by the occurrence of transient ischemic attack symptoms referable to the stent

Renewal — thrombosis prevention neurological stenting

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

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

- ☐ Patient is continuing to benefit from treatment

and

- ☐ Treatment continues to be clinically appropriate

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: .....

.....

.....

.....

PATIENT NHI: .....

First Names: .....

Surname: .....

DOB: .....

Address: .....

.....

.....

.....

REFERRER Reg No: .....

First Names: .....

Surname: .....

Address: .....

.....

.....

.....

Ticagrelor *- continued*

Initial application — Percutaneous coronary intervention with stent deployment
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has undergone percutaneous coronary intervention
- **and**
- ☐ Patient has had a stent deployed in the previous 4 weeks
- **and**
- ☐ Patient is clopidogrel-allergic**

Renewal — Percutaneous coronary intervention with stent deployment
Current approval Number (if known):.....
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has undergone percutaneous coronary intervention
- **and**
- ☐ Patient has had a stent deployed in the previous 4 weeks
- **and**
- ☐ Patient is clopidogrel-allergic**

Initial application — Stent thrombosis
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick box where appropriate)

- ☐ Patient has experienced cardiac stent thrombosis whilst on clopidogrel

Initial application — acute minor stroke or high-risk transient ischemic attack (TIA)*
Applications from any relevant practitioner. Approvals valid for 1 month.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has been diagnosed with a minor stroke (NIHSS† score 3 or less), high-risk TIA (ABCD2 score 4 or more) or Crescendo TIA
- **and**
  - ☐ Patient is expected to be a poor metaboliser of clopidogrel, with documented clinical rationale
  - **or**
  - ☐ Patient is allergic to clopidogrel**
- **and**
- ☐ Ticagrelor to be prescribed for a maximum of 21 days following minor stroke or TIA

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)	**PATIENT** NHI:	**REFERRER** Reg No: .....
Reg No:	First Names:	First Names: .....
Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
.....	.....	.....

Ticagrelor *- continued*

Renewal — subsequent minor stroke or TIA, or Crescendo TIA

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

Applications from any relevant practitioner. Approvals valid for 1 month.

Prerequisites(tick box where appropriate)

☐ Patient has been diagnosed with a minor stroke (NIHSS score 3 or less) or high-risk transient ischemic attack (ABCD2 score 4 or more) or Crescendo TIA

Note: indications marked with * are unapproved indications.
Note: Note:** Clopidogrel allergy is defined as a history of anaphylaxis, urticaria, generalised rash or asthma (in non-asthmatic patients) developing soon after clopidogrel is started and is considered unlikely to be caused by any other treatment.
Note: Note:NIHSS† National Institutes of Health Stroke Scale.

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: ..... Date: .....