Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2686
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:	.....
.....	.....	.....
.....	.....	.....

Temozolomide

Initial application — gliomas
Applications only from a relevant specialist. Approvals valid for 12 months.
Prerequisites(tick box where appropriate)

☐ The patient has a glioma

Renewal — gliomas

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

Applications only from a relevant specialist. Approvals valid for 12 months.
Prerequisites(tick box where appropriate)

☐ Treatment remains appropriate and patient is benefitting from treatment

Initial application — neuroendocrine tumours
Applications only from a relevant specialist. Approvals valid for 9 months.
Prerequisites(tick boxes where appropriate)

☐ Patient has been diagnosed with metastatic or unresectable well-differentiated neuroendocrine tumour
and
☐ Temozolomide is to be given in combination with capecitabine
and
☐ Temozolomide is to be used in 28 day treatment cycles for a maximum of 5 days treatment per cycle at a maximum dose of 200 mg/m^2 per day
and
☐ Temozolomide to be discontinued at disease progression

Renewal — neuroendocrine tumours

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

Applications only from a relevant specialist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

☐ No evidence of disease progression
and
☐ The treatment remains appropriate and the patient is benefitting from treatment

Initial application — ewing's sarcoma
Applications only from a relevant specialist. Approvals valid for 9 months.
Prerequisites(tick box where appropriate)

☐ The patient has relapsed/refractory Ewing's sarcoma

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: .....

.....

.....

.....

Temozolomide *- continued*

Renewal — ewing's sarcoma

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

Applications only from a relevant specialist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

☐ No evidence of disease progression

and

☐ The treatment remains appropriate and the patient is benefitting from treatment

Initial application — Neuroblastoma

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites(tick box where appropriate)

☐ The patient has neuroblastoma

Renewal — Neuroblastoma

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites(tick box where appropriate)

☐ There is no evidence of disease progression

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

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

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