Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2740
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:	.....
.....	.....	.....
.....	.....	.....

Venetoclax

Initial application — previously untreated chronic lymphocytic leukaemia in combination with obinutuzumab
Applications from any relevant practitioner. Approvals valid for 15 months.
Prerequisites(tick boxes where appropriate)

☐ Individual is currently on treatment with venetoclax and obinutuzumab and met all of the following criteria prior to commencing treatment

or

☐ Individual has previously untreated chronic lymphocytic leukaemia

and

☐ Venetoclax is to be administered with obinutuzumab

and

☐ Venetoclax is to be used to a maximum dose of 400 mg and for a total of 12 (28 day) cycles

Initial application — previously untreated chronic lymphocytic leukaemia in combination with ibrutinib
Applications from any relevant practitioner. Approvals valid for 15 months.
Prerequisites(tick boxes where appropriate)

☐ Individual has previously untreated chronic lymphocytic leukaemia

and

☐ Venetoclax is to be administered in combination with ibrutinib

and

☐ Venetoclax is to be used to a maximum dose of 400 mg and for a total of 12 (28 day) cycles

Initial application — relapsed/refractory chronic lymphocytic leukaemia
Applications from any relevant practitioner. Approvals valid for 8 months.
Prerequisites(tick boxes where appropriate)

☐ Individual has chronic lymphocytic leukaemia requiring treatment

and

☐ Individual has received at least one prior therapy for chronic lymphocytic leukaemia

and

☐ The individual's disease has relapsed

and

☐ Venetoclax to be used in combination with six 28-day cycles of rituximab commencing after the 5-week dose titration schedule with venetoclax

and

☐ Individual has an ECOG performance status of 0-2

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

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.....	Address:	.....
.....	.....	.....
.....	.....	.....

Venetoclax *- continued*

Renewal — relapsed/refractory chronic lymphocytic leukaemia

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Treatment remains clinically appropriate and the individual is benefitting from and tolerating treatment

and

- ☐ Venetoclax is to be discontinued after a maximum of 24 months of treatment following the titration schedule unless earlier discontinuation is required due to disease progression or unacceptable toxicity

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)*. Indications marked with * are Unapproved indications.

Initial application — previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation*

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Individual has previously untreated chronic lymphocytic leukaemia

and

- ☐ There is documentation confirming that individual has 17p deletion by FISH testing or TP53 mutation by sequencing

and

- ☐ Individual has an ECOG performance status of 0-2

Renewal — previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation*

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick box where appropriate)

- ☐ The treatment remains clinically appropriate and the patient is benefitting from and tolerating treatment

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL)* and B-cell prolymphocytic leukaemia (B-PLL)*. Indications marked with * are Unapproved indications

Initial application — previously untreated acute myeloid leukaemia

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ The individual is currently on treatment with venetoclax and met all remaining special authority criteria prior to commencing treatment

or

- ☐ Individual has previously untreated acute myeloid leukaemia (see note a), according to World Health Organization (WHO) Classification

and

- ☐ Venetoclax not to be used in combination with standard intensive remission induction chemotherapy

and

- ☐ Venetoclax to be used in combination with azacitidine or low dose cytarabine

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

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.....	Address:	.....
.....	.....	.....
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Venetoclax *- continued*

Renewal — previously untreated acute myeloid leukaemia

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick box where appropriate)

☐ There is no evidence of disease progression

Note:

a) 'Acute myeloid leukaemia' includes myeloid sarcoma*

b) Indications marked with * are Unapproved indications

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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