Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1149
October 2021

APPLICANT (stamp or sticker acceptable)	**PATIENT** NHI:	**REFERRER** Reg No: .....
Reg No:	First Names:	First Names: .....
Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

Dexamfetamine Sulfate

Initial application — ADHD in patients 5 or over
Applications only from a paediatrician, psychiatrist or medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing). Approvals valid for 24 months.
Prerequisites(tick boxes where appropriate)

- ☐ ADHD (Attention Deficit and Hyperactivity Disorder) patients aged 5 years or over

and

- ☐ Diagnosed according to DSM-IV or ICD 10 criteria

and

- ☐ Applicant is a paediatrician or psychiatrist

or

- ☐ Applicant is a medical practitioner and confirms that a paediatrician or psychiatrist has been consulted within the last 2 years and has recommended treatment for the patient in writing

Initial application — ADHD in patients under 5
Applications only from a paediatrician or psychiatrist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ ADHD (Attention Deficit and Hyperactivity Disorder) patients under 5 years of age

and

- ☐ Diagnosed according to DSM-IV or ICD 10 criteria

Initial application — Narcolepsy
Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.
Prerequisites(tick box where appropriate)

- ☐ The patient suffers from narcolepsy

Renewal — ADHD in patients 5 or over

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

Applications only from a paediatrician, psychiatrist or medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing). Approvals valid for 24 months.
Prerequisites(tick boxes where appropriate)

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

and

- ☐ Applicant is a paediatrician or psychiatrist

or

- ☐ Applicant is a medical practitioner and confirms that a paediatrician or psychiatrist has been consulted within the last 2 years and has recommended treatment for the patient in writing

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

Signed: ..... Date: .....
Post application to Ministry of Health, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz

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.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

Dexamfetamine Sulfate *- continued*

Renewal — ADHD in patients under 5

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

Applications only from a paediatrician or psychiatrist. Approvals valid for 12 months.
Prerequisites(tick box where appropriate)

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

Renewal — Narcolepsy

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

Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.
Prerequisites(tick box where appropriate)

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

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

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