Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA1609**
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: ..... |

## Progesterone

**Initial application**
Applications only from an obstetrician or gynaecologist. Approvals valid for 12 months.
**Prerequisites**(tick boxes where appropriate)

☐ For the prevention of pre-term labour*

**and**

☐ The patient has a short cervix on ultrasound (defined as < 25 mm at 16 to 28 weeks)

**or**

☐ The patient has a history of pre-term birth at less than 28 weeks

**Renewal**

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

Applications only from an obstetrician or gynaecologist. Approvals valid for 12 months.
**Prerequisites**(tick boxes where appropriate)

☐ For the prevention of pre-term labour*

**and**

☐ Treatment is required for second or subsequent pregnancy

**and**

☐ The patient has a short cervix on ultrasound (defined as < 25 mm at 16 to 28 weeks)

**or**

☐ The patient has a history of pre-term birth at less than 28 weeks

Note: 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: .....

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