Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2024
September 2026

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

Acitretin

Initial application
Applications from any relevant practitioner. Approvals valid for 1 year.
Prerequisites(tick boxes where appropriate)

☐ Applicant is a vocationally registered dermatologist, vocationally registered general practitioner, or nurse practitioner working in a relevant scope of practice

and

☐ Applicant has an up to date knowledge of the safety issues around acitretin and is competent to prescribe acitretin

and

☐ Patient is of child bearing potential and the possibility of pregnancy has been excluded prior to commencement of treatment and patient has been counselled and understands the risk of teratogenicity if acitretin is used during pregnancy and that they must not become pregnant during treatment and for a period of three years after the completion of treatment

or

☐ Patient is not of child bearing potential

Renewal

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

Applications from any relevant practitioner. Approvals valid for 1 year.
Prerequisites(tick boxes where appropriate)

☐ Patient is of child bearing potential and the possibility of pregnancy has been excluded prior to commencement of treatment and patient has been counselled and understands the risk of teratogenicity if acitretin is used during pregnancy and that they must not become pregnant during treatment and for a period of three years after the completion of treatment

or

☐ Patient is not of child bearing potential

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