APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2305
May 2024

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: .....

Methylphenidate Hydrochloride Extended Release (Concerta; Ritalin LA)

Initial application — ADHD
Applications only from a paediatrician, psychiatrist, medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing) or nurse 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)

and

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

and

- ☐ Applicant is a paediatrician or psychiatrist

or

- ☐ Applicant is a medical practitioner or nurse 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

and

- ☐ Patient is taking a currently subsidised formulation of methylphenidate hydrochloride (immediate-release or sustained-release) which has not been effective due to significant administration and/or difficulties with adherence

or

- ☐ There is significant concern regarding the risk of diversion or abuse of immediate-release methylphenidate hydrochloride

Renewal — ADHD

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

Applications only from a paediatrician, psychiatrist, medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing) or nurse 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 or nurse 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