Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA2380**
November 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: ..... |

## Insulin Pump Consumables

**Initial application — type 1 diabetes**
Applications from any relevant practitioner. Approvals valid for 2 years.
**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has type 1 diabetes

**or**

- ☐ The patient has permanent neonatal diabetes or specific monogenic diabetes subtypes with insulin deficiency, considered by the treating endocrinologist as likely to benefit

**or**

- ☐ The patient has Type 3c diabetes considered by the treating endocrinologist as likely to benefit (Type 3c diabetes includes insulin deficiency due to pancreatectomy, insulin deficiency secondary to cystic fibrosis or pancreatitis)

**or**

- ☐ The patient has atypical inherited forms of diabetes

**and**

☐ Patient has been evaluated by a diabetes multidisciplinary team for their suitability for insulin pump therapy

**and**

☐ In the opinion of the treating relevant practitioner the patient would benefit from an Automated Insulin Delivery (AID) system

**Renewal — type 1 diabetes**

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

Applications from any relevant practitioner. Approvals valid for 2 years.
**Prerequisites**(tick box where appropriate)

☐ The patient is continuing to derive benefit according to the treatment plan agreed at induction

**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**