Enquiries to Ministry of Health 0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 1 Form SA1666 July 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:
Melatonin		
Initial application Applications only from a psychiatrist, paediatrician, neurologist, respiratory specialist or medical practitioner on the recommendation of a psychiatrist, paediatrician, neurologist or respiratory specialist. Approvals valid for 12 months. Prerequisites(tick boxes where appropriate)		
Patient has been diagnosed with persistent and distressing insomnia secondary to a neurodevelopmental disorder (including, but not limited to, autism spectrum disorder or attention deficit hyperactivity disorder)* Behavioural and environmental approaches have been tried and were unsuccessful, or are inappropriate and Funded modified-release melatonin is to be given at doses no greater than 10 mg per day Patient is aged 18 years or under*		
Renewal		
Current approval Number (if known):		
Patient is aged 18 years or under*		
and Patient has demonstrated clinically meaningful benefit from funded modified-release melatonin (clinician determined)		
Patient has had a trial of funded modified-release melatonin discontinuation within the past 12 months and has had a recurrence of persistent and distressing insomnia		
	n is to be given at doses no greater than 10 mg per d	ay

Note: Indications marked with * are unapproved indications.