Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1199
January 2025

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Propylthiouracil

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

☐ The patient has hyperthyroidism
and
☐ The patient is intolerant of carbimazole or carbimazole is contraindicated

Renewal

Current approval Number (if known):..

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

☐ The treatment remains appropriate and the patient is benefitting from the treatment

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