Enquiries to Ministry of Health 0800 855 066

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 1 Form SA2395

		January 2023
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:
Aripiprazole		
or The patient has schized and The patient has received and The patient has been 30 days or more in last or Patient has been unable to access have been started on olanzapine of Note: The Olanzapine depot injection Special Authorized and the patient has been unable to access have been started on olanzapine depot injection Special Authorized and the patient has been unable to access have been started on olanzapine depot injection Special Authorized and the patient has schized and the patient has schized and the patient has schized and the patient has received and the patient has received and the patient has received and the patient has been unable to access have been started on olanzapine depot injection Special Authorized and the patient has been unable to access have been started on olanzapine depot injection Special Authorized and the patient has been unable to access have been started on olanzapine depot injection Special Authorized and the patient has been unable to access have been started and the patient has been unable to access have been started and the patient has been unable to access have been started and the patient has been unable to access have been started and the patient has been unable to access have the patient have b	I Special Authority approval for risperidone depot injustice of the properties of th	out has been unable to adhere nsive outpatient or home-based treatment for olanzapine depot injection, or otherwise would ssues with olanzapine depot injection ole Special Authority application are as follows:
All of the following:		
The patient has schizophrenia; and		
The patient has not been able to adhere with treatment using oral atypical antipsychotic agents; and		
<ul> <li>The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months.</li> </ul>		

I confirm the above details are correct and that in signing this form I understand I may be audited.