Enquiries to Ministry of Health 0800 855 066

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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PPLICANT (stamp or sticker acceptable)		PATIENT NHI:	REFERRER Reg No:
No:		First Names:	First Names:
e:		Surname:	Surname:
ess:		DOB:	Address:
		Address:	
lexamfeta	amine dimesilate		
requisites(t	ly from a paediatrician, psychiatrist the recommendation of a paediatric tick boxes where appropriate)	t, medical practitioner on the recommendation of a polician or psychiatrist (in writing). Approvals valid with	out further renewal unless notified.
or	Patient is currently on treatment w	ith lisdexamfetamine dimesilate and met all remaini	ng criteria prior to commencing treatment
and	Diagnosed according to DSI  d  Applicant is a paediate  or  Applicant is a medical	M-V or ICD 11 criteria	
and	k		
		rently subsidised formulation of atomoxetine or metl sufficient benefit or has experienced intolerable side	
		rently subsidised formulation of dexamfetamine sulf icant administration and/or treatment adherence diff	
		oncern regarding the risk of diversion or abuse of im	mediate release dexamfetamine sulfate
		rently subsidised formulation of methylphenidate hy of been effective due to significant administration and	
	There is significant co	oncern regarding the risk of diversion or abuse of im	mediate release methylphenidate hydrochloride
	or		
	Patient would ha	ave been prescribed a subsidised formulation of menable to access due to supply issues with methylphe	

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