Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA1998**
August 2025

| **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: ..... |

## Hyoscine (Scopolamine)

**Initial application**
Applications from any relevant practitioner. Approvals valid for 1 year.
**Prerequisites**(tick boxes where appropriate)

- ☐ Control of intractable nausea, vomiting, or inability to swallow saliva in the treatment of malignancy or chronic disease where the patient cannot tolerate or does not adequately respond to oral anti-nausea agents

**or**

- ☐ Control of clozapine-induced hypersalivation where trials of at least two other alternative treatments have proven ineffective

**Renewal**

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

Applications from any relevant practitioner. Approvals valid for 1 year.
**Prerequisites**(tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from 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**