

**APPLICATION FOR  
WAIVER OF RULE  
BY SPECIAL AUTHORITY**

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT</b> NHI: .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Cabergoline**

**Initial application**

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

**Prerequisites**(tick boxes where appropriate)

- ☐ Hyperprolactinemia
- or
- ☐ Acromegaly\*
- or
- ☐ Inhibition of lactation

**Renewal — for patients who have previously been funded under Special Authority form SA1031**

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

**Prerequisites**(tick box where appropriate)

- ☐ The patient has previously held a valid Special Authority which has expired and the treatment remains appropriate and the patient is benefiting from treatment

Note: Indication marked with \* is an unapproved indication.

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](mailto:customerservice@health.govt.nz)