Enquiries to Ministry of Health 0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Benzbromarone		
Renewal		
Current approval Number (if known):		
Applications from any relevant practitioner. Approvals valid for 2 years.		
Prerequisites(tick boxes where appropriate)		
The treatment remains appropriate and the patient is benefitting from the treatment		
There is no evidence of liver toxicity and patient is continuing to receive regular (at least every three months) liver function tests		

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