Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1987
December 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: .....

Betaine

Initial application
Applications only from a metabolic physician. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

☐ The patient has a confirmed diagnosis of homocystinuria

and

☐ A cystathionine beta-synthase (CBS) deficiency

or

☐ A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency

or

☐ A disorder of intracellular cobalamin metabolism

and

☐ An appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation

Renewal

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

Applications only from a metabolic physician. Approvals valid for 12 months.
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 Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz