Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2088
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: .....

Vigabatrin

Initial application
Applications from any relevant practitioner. Approvals valid for 15 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has infantile spasms
- **or**
- ☐ Patient has epilepsy
- **and**
- ☐ Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents
- **or**
- ☐ Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents
- **or**
- ☐ Patient has tuberous sclerosis complex
- **and**
- ☐ Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter)
- **or**
- ☐ It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields.

Renewal

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life
- **and**
- ☐ Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin
- **or**
- ☐ It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields.

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