## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 1 Form SA2092 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:
Amino acid formula (Alfamino Junior; Elecare	; Neocate)	
Extensively hydrolysed formu intolerance or allergy or mala	s protein formula or dairy products  been trialled in an inpatient setting and is clinically in the	inappropriate due to documented severe

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Name:				Surname:	Surname:
Address:				DOB:	Address:
				Address:	
Fax Numb	er:				Fax Number:
Amino a	cid f	ormu	la (Alfamino Junior; Elecare	e; Neocate) - continued	
Application paediatric	ons onle gastro sites(t	y from pentercondick box	Applicant is a dietitian and consulted within the last 12 in the l	astroenterologist, paediatric immunologist or dietitian on the recommendation of a paediatrician, logist. Approvals valid for 6 months.  paediatric gastroenterologist or paediatric immunologist  profirms that a paediatrician, paediatric gastroenterologist or paediatric immunologist has been months and has recommended treatment for the patient  w's milk protein formula or dairy products	
Severe Immune deficiency		Severe Immune deficiency			
			Extensively hydrolysed form	ula has been trialled in an inpatient setting and is clin	ically inappropriate
Extensively hydrolysed		severe intolerance or	d formula has been reasonably trialled for 2-4 weeks and is inappropriate due to documented allergy or malabsorption		
			or	a valid Special Authority approval for extensively hyd	rolysed formula: approval number

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Name:	Surname:	Surname:
Address:	DOB:	Address:
Fax Number:	amino Junior; Elecare; Neocate) - continued	Fax Number:
` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `	known):t practitioner. Approvals valid for 6 months.	
or Patient immune	to a cow's milk protein, soy or extensively hydrolysed infant to require an amino acid infant formula  val  ncluding eosinophilic oesophagitis, ultra-short gut and severe to a cow's milk protein, soy, or extensively hydrolysed infant	

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APPLICANT (stamp or sticker acceptable)		T (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	o:		First Names:	First Names:
Name:	:		Surname:	Surname:
Addres	ss:		DOB:	Address:
			Address:	
Fax N	umbei	r:		Fax Number:
Amin	o ac	cid formula (Alfamino Junion	r; Elecare; Neocate) - continued	
Curre Applio paedi	ent apposition	ns only from a paediatrician, pag	ediatric gastroenterologist, paediatric imr immunologist. Approvals valid for 6 mor	munologist or dietitian on the recommendation of a paediatrician, nths.
	and	or Applicant is a dietiti	iatrician, paediatric gastroenterologist or an and confirms that a paediatrician, pae a last 12 months and has recommended	ediatric gastroenterologist or paediatric immunologist has been
		or	ficiency sed formula has been trialled in an inpati ydrolysed formula has been reasonably to ance or allergy or malabsorption	ient setting and is clinically inappropriate trialled for 2-4 weeks and is inappropriate due to documented val for extensively hydrolysed formula: approval number
Appli	cation	ns only from a dietitian, relevant ites(tick boxes where appropria  Patient has a valid Specia  Extensively hydrolysed for	ate)  Al Authority approval for extensively hydro	plysed formula (SA1557)  Pro SYNEO 1 and 2) is unable to be supplied at this time
		criteria is short term funding to		e extensively hydrolysed formula powder funded under Special Authority