Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2204
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: .....

Fat (Calogen; Liquigen; MCT oil (Nutricia))

Initial application — Inborn errors of metabolism
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick box where appropriate)

☐ The patient has an inborn error of metabolism

Initial application — Indications other than inborn errors of metabolism
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.
Prerequisites(tick boxes where appropriate)

☐ Faltering growth in an infant/child
or
☐ Bronchopulmonary dysplasia
or
☐ Fat malabsorption
or
☐ Lymphangiectasia
or
☐ Short bowel syndrome
or
☐ Infants with necrotising enterocolitis
or
☐ Biliary atresia
or
☐ For use in a ketogenic diet
or
☐ Chyle leak
or
☐ Ascites
or
☐ For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

Renewal — Indications other than inborn errors of metabolism

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.
Prerequisites(tick box, and write the data requested in the space provided where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment
and
General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted .....

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