Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1403
February 2026

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: .....

Riluzole

Initial application
Applications only from a neurologist or respiratory specialist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has amyotrophic lateral sclerosis with disease duration of 5 years or less

and

- ☐ The patient has at least 60 percent of predicted forced vital capacity within 2 months prior to the initial application

and

- ☐ The patient has not undergone a tracheostomy

and

- ☐ The patient has not experienced respiratory failure

and

  - ☐ The patient is ambulatory

  or

  - ☐ The patient is able to use upper limbs

  or

  - ☐ The patient is able to swallow

Renewal

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

Applications from any relevant practitioner. Approvals valid for 18 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has not undergone a tracheostomy

and

- ☐ The patient has not experienced respiratory failure

and

  - ☐ The patient is ambulatory

  or

  - ☐ The patient is able to use upper limbs

  or

  - ☐ The patient is able to swallow

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