Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA1685**
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: ..... |

## Lamivudine

**Initial application**
Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.
**Prerequisites**(tick box where appropriate)

☐ Used for the treatment or prevention of hepatitis B

**Renewal**
Current approval Number (if known):.....
Applications from any relevant practitioner. Approvals valid for 2 years.
**Prerequisites**(tick box where appropriate)

☐ Used for the treatment or prevention of hepatitis B

**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**