Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1988
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: .....

Galsulfase

Initial application
Applications only from a metabolic physician. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

☐ The patient has been diagnosed with mucopolysaccharidosis VI

and

☐ Diagnosis confirmed by demonstration of N-acetyl-galactosamine-4-sulfatase (arylsulfatase B) deficiency by either enzyme activity assay in leukocytes or skin fibroblasts

or

☐ Detection of two disease causing mutations and patient has a sibling who is known to have mucopolysaccharidosis VI

Renewal

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

Applications only from a metabolic physician. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

☐ The treatment remains appropriate for the patient and the patient is benefiting from treatment

and

☐ Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates

and

☐ Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by Enzyme Replacement Therapy (ERT)

and

☐ Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT

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