

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....
Fax Number:	Fax Number:

Cabergoline

Initial application

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Hyperprolactinemia
or	
<input type="checkbox"/>	Acromegaly*
or	
<input type="checkbox"/>	Inhibition of lactation

Renewal — for patients who have previously been funded under Special Authority form SA1031

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick box where appropriate)

<input type="checkbox"/>	The patient has previously held a valid Special Authority which has expired and the treatment remains appropriate and the patient is benefiting from treatment
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Note: Indication marked with * is an unapproved indication.

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