Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2524
March 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: .....

Rivastigmine patches

Initial application
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has been diagnosed with dementia

and

- ☐ The patient is contraindicated to or has experienced intolerable side effects from donepezil tablets

Renewal

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

Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ The treatment remains appropriate

and

- ☐ The patient has demonstrated a significant and sustained benefit from treatment

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