

**APPLICATION FOR
WAIVER OF RULE
BY SPECIAL AUTHORITY**

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:

Cabergoline

Initial application

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

Prerequisites(tick boxes where appropriate)

- ☐ Hyperprolactinemia
- or
- ☐ Acromegaly*
- or
- ☐ 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)

- ☐ The patient has previously held a valid Special Authority which has expired and the treatment remains appropriate and the patient is benefiting from treatment

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