Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA1691**
June 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: ..... |

## Methylnaltrexone bromide

**Initial application — Opioid induced constipation**
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
**Prerequisites**(tick boxes where appropriate)

☐ The patient is receiving palliative care

**and**

**or**

☐ Oral and rectal treatments for opioid induced constipation are ineffective

☐ Oral and rectal treatments for opioid induced constipation are unable to be tolerated

**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**