APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2586
August 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: .....

Olanzapine depot injection

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

☐ The patient has had an initial Special Authority approval for paliperidone depot injection or risperidone depot injection

or

☐ The patient has schizophrenia or other psychotic disorder

and

☐ The patient has tried but failed to comply with treatment using oral atypical antipsychotic agents

and

☐ The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months

and

☐ The patient has trialled other funded depot antipsychotics (aripiprazole, risperidone, and paliperidone) unless it is considered clinically inappropriate to use these

and

☐ The patient continues to have difficulties with adherence on oral antipsychotic treatments

and

☐ Prescribing clinician has relevant Clinical Director (Mental Health and Addiction services) approval

Renewal

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

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

☐ The initiation of olanzapine depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection

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