Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1930
November 2026

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

Carbohydrate (Moducal; Polycal)

Initial application — Cystic fibrosis or kidney disease
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.
Prerequisites(tick boxes where appropriate)

- ☐ Cystic fibrosis

or

- ☐ Chronic kidney disease

Initial application — Indications other than cystic fibrosis or renal failure
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.
Prerequisites(tick boxes where appropriate)

- ☐ Cancer in children

or

- ☐ Cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years

or

- ☐ Faltering growth in an infant/child

or

- ☐ Bronchopulmonary dysplasia

or

- ☐ Premature and post premature infant

or

- ☐ For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

Initial application — Inborn errors of metabolism
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick box where appropriate)

- ☐ The patient has inborn errors of metabolism

Renewal — Cystic fibrosis or renal failure

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian,relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.
Prerequisites(tick box, and write the data requested in the space provided where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted .....

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

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Carbohydrate (Moducal; Polycal) - *continued*

Renewal — Indications other than cystic fibrosis or renal failure

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

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Prerequisites(tick box, and write the data requested in the space provided where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

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