APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2042
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:	.....
.....	.....	.....
.....	.....	.....

Arginine

Initial application
Applications only from a metabolic physician. Approvals valid for 6 months.
Prerequisites(tick box where appropriate)

☐ Patient has a suspected inborn error of metabolism that may respond to arginine supplementation

Renewal

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

Applications only from a metabolic physician. Approvals valid for 24 months.
Prerequisites(tick boxes where appropriate)

☐ The patient has a confirmed diagnosis of an inborn error of metabolism that responds to arginine supplementation

and

☐ The treatment remains appropriate and the patient is benefiting 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