Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA2204**
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: ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

## Fat (Calogen; Liquigen; MCT oil (Nutricia))

**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 an inborn error of metabolism

**Initial application — Indications other than inborn errors of metabolism**
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.
**Prerequisites**(tick boxes where appropriate)

☐ Faltering growth in an infant/child
**or**
☐ Bronchopulmonary dysplasia
**or**
☐ Fat malabsorption
**or**
☐ Lymphangiectasia
**or**
☐ Short bowel syndrome
**or**
☐ Infants with necrotising enterocolitis
**or**
☐ Biliary atresia
**or**
☐ For use in a ketogenic diet
**or**
☐ Chyle leak
**or**
☐ Ascites
**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.

**Renewal — Indications other than inborn errors of metabolism**

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 1 year.
**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**