APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2367
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:	.....
.....	.....	.....
.....	.....	.....

Insulin pump with algorithm

Initial application — type 1 diabetes
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has type 1 diabetes

or

- ☐ The patient has permanent neonatal diabetes or specific monogenic diabetes subtypes with insulin deficiency, considered by the treating endocrinologist as likely to benefit

or

- ☐ The patient has Type 3c diabetes considered by the treating endocrinologist as likely to benefit (Type 3c diabetes includes insulin deficiency due to pancreatectomy, insulin deficiency secondary to cystic fibrosis or pancreatitis)

or

- ☐ The patient has atypical inherited forms of diabetes

and

☐ Patient has been evaluated by a diabetes multidisciplinary team for their suitability for insulin pump therapy

and

☐ In the opinion of the treating relevant practitioner the patient would benefit from an Automated Insulin Delivery (AID) system

Renewal — type 1 diabetes

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

Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick box where appropriate)

☐ The patient is continuing to derive benefit according to the treatment plan agreed at induction

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