Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1376
December 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 and Fat (Duocal Super Soluble Powder)

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

- ☐ Infant or child aged four years or under
- **and**
- ☐ Cystic fibrosis

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

- ☐ Infant or child aged four years or under
- **and**
  - ☐ Cancer in children
  - **or**
  - ☐ Faltering growth
  - **or**
  - ☐ Bronchopulmonary dysplasia
  - **or**
  - ☐ Premature and post premature infants

Renewal — Cystic fibrosis

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 .....

Renewal — Indications other than cystic fibrosis

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