Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA2042**
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: ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

## 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**