Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2523
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:	.....
.....	.....	.....
.....	.....	.....

Melatonin

Initial application
Applications only from a psychiatrist, paediatrician, neurologist, respiratory specialist or any relevant practitioner on the recommendation of a psychiatrist, paediatrician, neurologist or respiratory specialist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has been diagnosed with persistent and distressing insomnia secondary to a neurodevelopmental disorder (including, but not limited to, autism spectrum disorder or attention deficit hyperactivity disorder)*

and

- ☐ Behavioural and environmental approaches have been tried and were unsuccessful, or are inappropriate

and

- ☐ Funded modified-release melatonin is to be given at doses no greater than 10 mg per day

and

- ☐ Patient is aged 18 years or under*

Renewal

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

Applications only from a psychiatrist, paediatrician, neurologist, respiratory specialist or any relevant practitioner on the recommendation of a psychiatrist, paediatrician, neurologist or respiratory specialist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient is aged 18 years or under*

and

- ☐ Patient has demonstrated clinically meaningful benefit from funded modified-release melatonin (clinician determined)

and

- ☐ Patient has had a trial of funded modified-release melatonin discontinuation within the past 12 months and has had a recurrence of persistent and distressing insomnia

and

- ☐ Funded modified-release melatonin is to be given at doses no greater than 10 mg per day

Note: Indications marked with * are unapproved indications.

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