Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2690
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:	.....
.....	.....	.....
.....	.....	.....

Dulaglutide

Initial application
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick boxes where appropriate)

☐ Patient has type 2 diabetes

and

☐ Target HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of all of the following blood-glucose lowering agents for a period of at least 6 months, where clinically appropriate: empagliflozin, metformin and vildagliptin

and

☐ Funded dulaglutide is not to be prescribed in combination with funded empagliflozin/ empagliflozin with metformin unless receiving funded empagliflozin / empagliflozin with metformin hydrochloride for the treatment of heart failure

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