Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1225
November 2021

APPLICANT (stamp or sticker acceptable)	**PATIENT** NHI:	**REFERRER** Reg No: .....
Reg No:	First Names:	First Names: .....
Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

Ivermectin

Initial application — Scabies
Applications from any relevant practitioner. Approvals valid for 1 month.
Prerequisites(tick boxes where appropriate)

- ☐ Applying clinician has discussed the diagnosis of scabies with a dermatologist, infectious disease physician or clinical microbiologist

and

- ☐ The patient is in the community

and

- ☐ Patient has a severe scabies hyperinfestation (Crusted/ Norwegian scabies)

or

- ☐ The community patient is physically or mentally unable to comply with the application instructions of topical therapy

or

- ☐ The patient has previously tried and failed to clear infestation using topical therapy

or

- ☐ The Patient is a resident in an institution

and

- ☐ All residents of the institution with scabies or at risk of carriage are to be treated for scabies concurrently

and

- ☐ Patient has a severe scabies hyperinfestation (Crusted/ Norwegian scabies)

or

- ☐ The patient is physically or mentally unable to comply with the application instructions of topical therapy

or

- ☐ Previous topical therapy has been tried and failed to clear the infestation

Note: Ivermectin is no more effective than topical therapy for treatment of standard scabies infestation.

Initial application — Other parasitic infections
Applications only from an infectious disease specialist, clinical microbiologist or dermatologist. Approvals valid for 1 month.
Prerequisites(tick boxes where appropriate)

- ☐ Filaricides

or

- ☐ Cutaneous larva migrans (creeping eruption)

or

- ☐ Strongyloidiasis

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: ..... Date: .....
Post application to Ministry of Health, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz

APPLICANT (stamp or sticker acceptable)	**PATIENT** NHI:	**REFERRER** Reg No: .....
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Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

Ivermectin *- continued*

Renewal — Scabies

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

Applications from any relevant practitioner. Approvals valid for 1 month.

Prerequisites(tick boxes where appropriate)

☐ Applying clinician has discussed the diagnosis of scabies with a dermatologist, infectious disease physician or clinical microbiologist

and

☐ The patient is in the community

and

☐ Patient has a severe scabies hyperinfestation (Crusted/ Norwegian scabies)

or

☐ The community patient is physically or mentally unable to comply with the application instructions of topical therapy

or

☐ The patient has previously tried and failed to clear infestation using topical therapy

or

☐ The Patient is a resident in an institution

and

☐ All residents of the institution with scabies or at risk of carriage are to be treated for scabies concurrently

and

☐ Patient has a severe scabies hyperinfestation (Crusted/ Norwegian scabies)

or

☐ The patient is physically or mentally unable to comply with the application instructions of topical therapy

or

☐ Previous topical therapy has been tried and failed to clear the infestation

Note: Ivermectin is no more effective than topical therapy for treatment of standard scabies infestation.

Renewal — Other parasitic infections

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

Applications only from an infectious disease specialist, clinical microbiologist or dermatologist. Approvals valid for 1 month.

Prerequisites(tick boxes where appropriate)

☐ Filaricides

or

☐ Cutaneous larva migrans (creeping eruption)

or

☐ Strongyloidiasis

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: ..... Date: .....

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