Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1331
December 2025

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: .....

Sulfadiazine

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

- ☐ For the treatment of toxoplasmosis in patients with HIV for a period of 3 months

or

- ☐ For pregnant patients for the term of the pregnancy

or

- ☐ For infants with congenital toxoplasmosis until 12 months of age

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