Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1359
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: .....

Fluconazole oral liquid

Initial application — Systemic candidiasis
Applications from any relevant practitioner. Approvals valid for 6 weeks.
Prerequisites(tick boxes where appropriate)

- ☐ Patient requires prophylaxis for, or treatment of systemic candidiasis
- **and**
- ☐ Patient is unable to swallow capsules

Initial application — Immunocompromised
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient is immunocompromised
- **and**
- ☐ Patient is at moderate to high risk of invasive fungal infection
- **and**
- ☐ Patient is unable to swallow capsules

Renewal — Systemic candidiasis
Current approval Number (if known):.....
Applications from any relevant practitioner. Approvals valid for 6 weeks.
Prerequisites(tick boxes where appropriate)

- ☐ Patient requires prophylaxis for, or treatment of systemic candidiasis
- **and**
- ☐ Patient is unable to swallow capsules

Renewal — Immunocompromised
Current approval Number (if known):.....
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient remains immunocompromised
- **and**
- ☐ Patient remains at moderate to high risk of invasive fungal infection
- **and**
- ☐ Patient is unable to swallow capsules

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