Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2511
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: .....

Ivermectin

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

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

or

- ☐ The person has a confirmed diagnosis of scabies or is a close contact of a scabies case

and

- ☐ The person is unable to complete topical therapy

or

- ☐ Previous treatment with topical therapy has been tried and not cleared the infestation

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

- ☐ Filariasis

or

- ☐ Cutaneous larva migrans (creeping eruption)

or

- ☐ Strongyloidiasis

or

- ☐ The individual has a travel or residence history that requires presumptive parasite treatment

Renewal — Scabies

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

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

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

or

- ☐ The person has a confirmed diagnosis of scabies or is a close contact of a scabies case

and

- ☐ The person is unable to complete topical therapy

or

- ☐ Previous treatment with topical therapy has been tried and not cleared the infestation

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

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 — Other parasitic infections

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

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

Prerequisites(tick boxes where appropriate)

- ☐ Filariasis

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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