Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR WAIVER OF RULE BY SPECIAL AUTHORITY

Form SA1683
February 2026

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: .....

Azithromycin

Initial application — bronchiolitis obliterans syndrome, cystic fibrosis and atypical Mycobacterium infections
Applications only from a relevant specialist. Approvals valid without further renewal unless notified.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has received a lung transplant, stem cell transplant, or bone marrow transplant and requires treatment for bronchiolitis obliterans syndrome*

or

- ☐ Patient has received a lung transplant and requires prophylaxis for bronchiolitis obliterans syndrome*

or

- ☐ Patient has cystic fibrosis and has chronic infection with Pseudomonas aeruginosa or Pseudomonas-related gram negative organisms*

or

- ☐ Patient has an atypical Mycobacterium infection

Note: Indications marked with * are unapproved indications.

Initial application — non-cystic fibrosis bronchiectasis*
Applications only from a respiratory specialist or paediatrician. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ For prophylaxis of exacerbations of non-cystic fibrosis bronchiectasis*

and

- ☐ Patient is aged 18 and under

and

- ☐ Patient has had 3 or more exacerbations of their bronchiectasis, within a 12 month period

or

- ☐ Patient has had 3 acute admissions to hospital for treatment of infective respiratory exacerbations within a 12 month period

Note: Indications marked with * are unapproved indications.

Renewal — non-cystic fibrosis bronchiectasis*

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

Applications only from a respiratory specialist or paediatrician. Approvals valid for 12 months.
The patient must not have had more than 1 prior approval.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has completed 12 months of azithromycin treatment for non-cystic fibrosis bronchiectasis

and

- ☐ Following initial 12 months of treatment, the patient has not received any further azithromycin treatment for non-cystic fibrosis bronchiectasis for a further 12 months, unless considered clinically inappropriate to stop treatment

and

- ☐ The patient will not receive more than a total of 24 months' azithromycin cumulative treatment (see note)

Note: No further renewals will be subsidised. A maximum of 24 months of azithromycin treatment for non-cystic fibrosis bronchiectasis will be subsidised.
Indications marked with * are unapproved indications

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