

**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: .....

### Moxifloxacin

#### Initial application — Tuberculosis

Applications only from a respiratory specialist or infectious disease specialist. Approvals valid for 1 year.

**Prerequisites**(tick boxes where appropriate)

Active tuberculosis\*  
**and**  
 Documented resistance to one or more first-line medications  
**or**  
 Suspected resistance to one or more first-line medications (tuberculosis assumed to be contracted in an area with known resistance), as part of regimen containing other second-line agents  
**or**  
 Impaired visual acuity (considered to preclude ethambutol use)  
**or**  
 Significant pre-existing liver disease or hepatotoxicity from tuberculosis medications  
**or**  
 Significant documented intolerance and/or side effects following a reasonable trial of first-line medications

**or**  
 Mycobacterium avium-intracellulare complex not responding to other therapy or where such therapy is contraindicated.\*  
**or**  
 Patient is under five years of age and has had close contact with a confirmed multi-drug resistant tuberculosis case

Note: Indications marked with \* are unapproved indications.

#### Renewal

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

Applications only from a respiratory specialist or infectious disease specialist. Approvals valid for 1 year.

**Prerequisites**(tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

#### Initial application — Mycoplasma genitalium

Applications only from a sexual health specialist or Practitioner on the recommendation of a sexual health specialist. Approvals valid for 1 month.

**Prerequisites**(tick boxes where appropriate)

Has nucleic acid amplification test (NAAT) confirmed Mycoplasma genitalium\* and is symptomatic  
**and**  
 Has tried and failed to clear infection using azithromycin  
**or**  
 Has laboratory confirmed azithromycin resistance  
**and**  
 Treatment is only for 7 days

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](mailto:customerservice@health.govt.nz)

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.....	.....	.....
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**Moxifloxacin** - *continued*

**Initial application — Penetrating eye injury**

Applications only from an ophthalmologist. Approvals valid for 1 month.

**Prerequisites**(tick box where appropriate)

The patient requires prophylaxis following a penetrating eye injury and treatment is for 5 days only

Note: 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: .....

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