

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

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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.

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