

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

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 - *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:

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz