Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA1331**
December 2026

| **APPLICANT** (stamp or sticker acceptable) | **PATIENT** NHI: ..... | **REFERRER** Reg No: ..... |
|---|---|---|
| Reg No: ..... | First Names: ..... | First Names: ..... |
| Name: ..... | Surname: ..... | Surname: ..... |
| Address: ..... | DOB: ..... | Address: ..... |
| ..... | Address: ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

## Sulfadiazine

**Initial application**
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
**Prerequisites**(tick boxes where appropriate)

- ☐ For the treatment of toxoplasmosis in patients with HIV for a period of 3 months

**or**

- ☐ For pregnant patients for the term of the pregnancy

**or**

- ☐ For infants with congenital toxoplasmosis until 12 months of age

**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**