Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1740
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:	.....
.....	.....	.....
.....	.....	.....

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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.....	Address:	.....
.....	.....	.....
.....	.....	.....

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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