Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2384
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:	.....
.....	.....	.....
.....	.....	.....

Voriconazole

Initial application — invasive fungal infection
Applications only from a haematologist, infectious disease specialist or clinical microbiologist. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient is immunocompromised

and

- ☐ Applicant is part of a multidisciplinary team including an infectious disease specialist

and

- ☐ Patient has proven or probable invasive aspergillus infection

or

- ☐ Patient has possible invasive aspergillus infection

or

- ☐ Patient has fluconazole resistant candidiasis

or

- ☐ Patient has mould strain such as Fusarium spp. and Scedosporium spp

Renewal — invasive fungal infection

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

Applications only from a haematologist, infectious disease specialist or clinical microbiologist. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient is immunocompromised

and

- ☐ Applicant is part of a multidisciplinary team including an infectious disease specialist

and

- ☐ Patient continues to require treatment for proven or probable invasive aspergillus infection

or

- ☐ Patient continues to require treatment for possible invasive aspergillus infection

or

- ☐ Patient has fluconazole resistant candidiasis

or

- ☐ Patient has mould strain such as Fusarium spp. and Scedosporium spp

Initial application — Invasive fungal infection prophylaxis
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient is at risk of invasive fungal infection

and

- ☐ Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist

or

- ☐ Prescribing voriconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI)

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:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
.....	.....	.....

Voriconazole *- continued*

Renewal — Invasive fungal infection prophylaxis

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

☐ The patient is at risk of invasive fungal infection

and

☐ Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist

or

☐ Prescribing voriconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI)

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: ..... Date: .....