Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2406
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:	.....
.....	.....	.....
.....	.....	.....

Fosfomycin

Initial application
Applications from any relevant practitioner. Approvals valid for 2 months.
Prerequisites(tick boxes where appropriate)

☐ Patient has an acute, symptomatic, bacteriologically-proven uncomplicated urinary tract infection (UTI)/cystitis with Escherichia Coli

and

☐ Microbiological testing confirms the pathogen is resistant to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin, amoxicillin with clavulanic acid, and norfloxacin

or

☐ The patient has a contraindication or intolerance to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin, amoxicillin with clavulanic acid, and norfloxacin that the pathogen is susceptible to

Renewal

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

Applications from any relevant practitioner. Approvals valid for 2 months.
Prerequisites(tick boxes where appropriate)

☐ Patient has an acute, symptomatic, bacteriologically-proven uncomplicated urinary tract infection (UTI)/cystitis with Escherichia Coli

and

☐ Microbiological testing confirms the pathogen is resistant to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin, amoxicillin with clavulanic acid, and norfloxacin

or

☐ The patient has a contraindication or intolerance to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin, amoxicillin with clavulanic acid, and norfloxacin that the pathogen is susceptible to

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