Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2731
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:	.....
.....	.....	.....
.....	.....	.....

Fluconazole oral liquid

Initial application — Systemic candidiasis
Applications from any relevant practitioner. Approvals valid for 6 weeks.
Prerequisites(tick boxes where appropriate)

- ☐ Patient requires prophylaxis for, or treatment of systemic candidiasis

and

- ☐ Patient is unable to swallow capsules

Renewal — Systemic candidiasis

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

Applications from any relevant practitioner. Approvals valid for 6 weeks.
Prerequisites(tick boxes where appropriate)

- ☐ Patient requires prophylaxis for, or treatment of systemic candidiasis

and

- ☐ Patient is unable to swallow capsules

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

- ☐ Patient is immunocompromised

and

- ☐ Patient is at moderate to high risk of invasive fungal infection

and

- ☐ Patient is unable to swallow capsules

Renewal — Immunocompromised

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

Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient remains immunocompromised

and

- ☐ Patient remains at moderate to high risk of invasive fungal infection

and

- ☐ Patient is unable to swallow capsules

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: .....
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Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
.....	.....	.....

Fluconazole oral liquid *- continued*

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

- ☐ The patient has tinea capitis or extensive cutaneous dermatophyte infection not sensitive to terbinafine confirmed on mycological culture, or by an equivalent validated molecular method

or

- ☐ The patient has tinea capitis or extensive cutaneous dermatophyte infection confirmed with ectothrix hair invasion on microscopy

or

- ☐ The patient has tinea capitis or extensive cutaneous dermatophyte infection which has not responded to 3 months of oral terbinafine

and

☐ The patient is unable to swallow capsules

Renewal — cutaneous dermatophyte infection

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

Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has tinea capitis or extensive cutaneous dermatophyte infection not sensitive to terbinafine confirmed on mycological culture, or by an equivalent validated molecular method

or

- ☐ The patient has tinea capitis or extensive cutaneous dermatophyte infection confirmed with ectothrix hair invasion on microscopy

or

- ☐ The patient has tinea capitis or extensive cutaneous dermatophyte infection which has not responded to 3 months of oral terbinafine

and

☐ The patient is unable to swallow capsules

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

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