APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2732
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:	.....
.....	.....	.....
.....	.....	.....

Itraconazole

Initial application
Applications only from an infectious disease specialist, clinical microbiologist, clinical immunologist, dermatologist or any relevant practitioner on the recommendation of a infectious disease physician, clinical microbiologist, clinical immunologist or dermatologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ The patient has a congenital immune deficiency

or

- ☐ 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

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

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

Prerequisites(tick boxes where appropriate)

- ☐ The patient has a congenital immune deficiency

or

- ☐ 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: .....

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz