Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA2733**
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: ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

## Bedaquiline

**Initial application — multi-drug resistant tuberculosis**
Applications from any relevant practitioner. Approvals valid for 6 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ The person has multi-drug resistant tuberculosis (MDR-TB)

**and**

- ☐ Ministry of Health's Tuberculosis Clinical Network has reviewed the individual case and recommends bedaquiline as part of the treatment regimen

**Initial application — Non-tuberculosis mycobacteria**
Applications from any relevant practitioner. Approvals valid for 12 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ The person has non-tuberculosis mycobacteria (NTM) infection

**and**

- ☐ Ministry of Health's Tuberculosis Clinical Network has reviewed the individual case and recommends bedaquiline as part of the treatment regimen

**Renewal — Non-tuberculosis mycobacteria**

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

Applications from any relevant practitioner. Approvals valid for 12 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ The person has non-tuberculosis mycobacteria (NTM) infection

**and**

- ☐ Ministry of Health's Tuberculosis Clinical Network has reviewed the individual case and continues to recommend bedaquiline as part of the treatment regimen

**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**