Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2734
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:	.....
.....	.....	.....
.....	.....	.....

Linezolid

Initial application — multi-drug resistant tuberculosis
Applications from any relevant practitioner. Approvals valid for 18 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 linezolid 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 linezolid 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 linezolid 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