



The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

29 September 2026

Pharmac | Te Pātaka Whaioranga
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By email: enquiry@pharmac.govt.nz

Tēnā koutou,

The Royal New Zealand College of General Practitioners (the College) thanks Pharmac for the opportunity to comment on the proposal to fund medicines for people with high blood pressure and bacterial infections.¹

The College is the professional body and postgraduate specialist education college for general practitioners and rural hospital doctors in Aotearoa New Zealand. We represent more than 6,000 specialist GPs and rural hospital doctors, comprising approximately 40 percent of New Zealand's specialist medical workforce. Our motto is Cum Scientia Caritas — with knowledge, compassion.

Our position

The College supports the proposal. Funding ceftolozane with tazobactam and widening access to captopril oral liquid for people experiencing episodes of high blood pressure during autonomic dysreflexia due to spinal cord injury would address unmet need for small groups of patients with serious conditions. The proposed changes for bedaquiline and linezolid would formalise access that is currently provided on a case-by-case basis through NPPA making access more transparent and timely.¹ We particularly welcome the reduction in NPPA applications, as case-by-case access places the burden of securing treatment on individual clinicians and hospitals and contributes to variation in access.¹ Our comments focus on equitable access, patient safety, and practical support for the general practitioners and rural hospital doctors who will share in the care of people receiving these medicines.

Te Tiriti o Waitangi and equity

The College is committed to honouring Te Tiriti o Waitangi, upholding Māori health rights and advancing Māori health equity. Pharmac's responsibilities under the Pae Ora (Healthy Futures) Act 2022² should be reflected in the design, implementation and monitoring of access to these medicines. The Waitangi Tribunal's Hauora report identified longstanding failures to meet Te Tiriti obligations in primary health care.³ Equity is particularly relevant to this proposal. Access to low-volume, specialist-controlled medicines may be influenced by where people live and their access to specialist services.⁴ The Anti-infectives Advisory Committee has identified the potential for inequities in multi-drug resistant infection for Māori and Pacific Peoples.⁵ Bronchiectasis, an important underlying condition in pulmonary non-tuberculous mycobacterial (NTM) infection, also disproportionately affects Māori and Pacific Peoples.⁶ We ask Pharmac to:

- monitor uptake and Special Authority outcomes for these medicines by ethnicity, rurality and deprivation, publish the findings, and commit to action where inequities are identified;
- co-design implementation, communications, and culturally safe patient and whānau information with Māori, including Māori health providers and communities, and with disabled people in relation to captopril; and

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- ensure access processes do not disadvantage people outside main centres, particularly where specialist input is less readily available.

Ceftolozane with tazobactam for multi-drug-resistant bacterial organism infections

The College supports funding ceftolozane with tazobactam, and the proposed restriction to clinical microbiologist or infectious disease specialist prescribing. In June 2024 the Anti-infectives Advisory Committee concluded that ceftolozane-tazobactam would address an unmet need for multi-drug-resistant *Pseudomonas aeruginosa* infection where ceftazidime-avibactam or other funded antibiotics are not appropriate.⁵ Furthermore, international guidance also identifies ceftolozane-tazobactam as a preferred treatment option for these infections, with recent comparative evidence reporting higher clinical cure rates than ceftazidime-avibactam and similar mortality.^{7,8}

Protecting the effectiveness of ceftolozane-tazobactam through appropriate antimicrobial stewardship is important, as resistance can emerge during treatment, particularly with prolonged courses.⁹ The Committee also noted that current case-by-case access places responsibility on individual prescribers and hospitals, creating potential for variation and inequity in access across the country. Supply lead times of up to four weeks may also delay treatment when clinically indicated.⁵ We recommend that Pharmac:

- establish national supply arrangements that enable prompt and equitable access to ceftolozane-tazobactam across the country, including for patients receiving care in smaller and rural hospitals, consistent with the Committee's recommendation;⁵
- include a Pharmaceutical Schedule listing note that microbiology laboratories report susceptibility to ceftolozane-tazobactam on request, consistent with the approach recommended for other reserve antibiotics;¹⁰ and
- monitor utilisation and resistance patterns and regularly review the access criteria with the Anti-infectives Advisory Committee as resistance patterns and clinical practice evolve.⁵

Bedaquiline and linezolid for non-tuberculous mycobacterial (NTM) infection

The College supports formalising existing access to bedaquiline and linezolid for NTM infection. Requiring review by the Tuberculosis Clinical Network provides appropriate specialist oversight,¹ particularly given the limited evidence for these medicines in NTM infection and the complexity and duration of treatment.¹¹ Case-by-case specialist decision-making therefore remains appropriate.¹²

Both medicines require careful safety monitoring: bedaquiline for QT prolongation and liver function, and linezolid for haematological, neurological and visual adverse effects, as well as interactions with commonly prescribed antidepressants.^{12,13} NTM treatment often continues beyond 12 months.¹² Where GPs and rural hospital doctors are expected to renew approvals, prescribe or undertake monitoring in the community, responsibilities for ongoing care and responding to abnormal results need to be clearly defined and supported. We recommend that Pharmac:

- publish clear renewal criteria that enable efficient renewal by the treating clinician, including the patient's GP, where this is consistent with the specialist treatment plan;
- set out monitoring requirements in the Special Authority or prescriber information, developed with the Tuberculosis Clinical Network, including what monitoring is required and its frequency, and clearly define responsibilities between specialist and primary care teams for arranging, monitoring, reviewing results and acting on abnormalities; and
- work with Health New Zealand to support timely access to required monitoring in the community, including in rural areas.

Captopril oral liquid for autonomic dysreflexia after spinal cord injury

The College supports funding captopril oral liquid for autonomic dysreflexia following spinal cord injury. Autonomic dysreflexia is a medical emergency,¹⁴ and captopril provides a practical, evidence-supported alternative when glyceryl trinitrate (GTN) cannot be used.¹⁵ Funded access would enable some people to manage episodes safely at home and avoid emergency presentations,¹ with general practice playing a central role supporting prescribing and ongoing management. We recommend that Pharmac:

- widen the proposed criteria beyond contraindication to include people for whom GTN is not tolerated or cannot be practically self-administered, including because of limited hand function, and correct “glyceryl nitrate” to “glyceryl trinitrate” in the criteria;
- ensure dispensing arrangements, including pack size and shelf life, enable people to maintain a usable supply at home; and
- provide clear implementation information for patients, whānau and clinicians on the safe use of captopril for autonomic dysreflexia, including its place following initial non-pharmacological management, blood pressure monitoring following treatment, and relevant ACE inhibitor precautions.¹⁴

Supporting safe use in practice

College members will provide much of the ongoing care for patients receiving these medications. To support safe use and minimise unnecessary administrative burden, we recommend that Pharmac provide concise prescriber information for each change at listing, distributed through its usual implementation channels and the education providers and clinical platforms it works with. Special Authority applications and renewals should be kept as simple as possible, with responsibilities between specialist and primary care teams clearly defined where care is shared.

Summary of recommendations

The College recommends that Pharmac:

- monitor equitable access and outcomes, including by ethnicity, rurality and deprivation, publish the findings and act where inequities are identified; co-design implementation and patient and whānau information with Māori, including Māori health providers and communities, and with disabled people in relation to captopril;
- lists ceftolozane with tazobactam with the proposed restriction, supported by national supply arrangements, a susceptibility-reporting note and regular review;
- formalise access to bedaquiline and linezolid with Tuberculosis Clinical Network review, publish clear renewal criteria and explicit monitoring and shared-care responsibilities;
- widens the captopril criteria beyond GTN contraindication to include people who cannot use GTN because it is not tolerated or cannot be practically self-administered, and ensure dispensing supports home use; and
- provides concise implementation information for clinicians, patients and whānau, and keep Special Authority processes as simple as possible.

Nāku noa, nā



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