

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER** Reg No: .....

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

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Fax Number: .....      Fax Number: .....

**Empagliflozin; Empagliflozin with metformin hydrochloride**

**Initial application**

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

**Prerequisites**(tick boxes where appropriate)

Patient has previously received an initial approval for a GLP-1 agonist

or

Patient has type 2 diabetes

and

Patient is Māori or any Pacific ethnicity\*

or

Patient has pre-existing cardiovascular disease or risk equivalent (see note a)\*

or

Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator\*

or

Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult\*

or

Patient has diabetic kidney disease (see note b)\*

and

Target HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of at least one blood-glucose lowering agent (e.g. metformin, vildagliptin, or insulin) for at least 3 months

Note: \* Criteria intended to describe patients at high risk of cardiovascular or renal complications of diabetes.

- a) Pre-existing cardiovascular disease or risk equivalent defined as: prior cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart failure or familial hypercholesterolaemia.
- b) Diabetic kidney disease defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three samples over a 3-6 month period) and/or eGFR less than 60 mL/min/1.73m<sup>2</sup> in the presence of diabetes, without alternative cause.

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

Signed: .....      Date: .....

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)