Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Sacubitril with valsartan

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ Patient has heart failure

and

- ○ Patient is in NYHA/WHO functional class II

or

- ○ Patient is in NYHA/WHO functional class III

or

- ○ Patient is in NYHA/WHO functional class IV

and

- ○ Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 35%

or

- ○ An ECHO is not reasonably practical, and in the opinion of the treating practitioner the patient would benefit from treatment

and

- ○ Patient is receiving concomitant optimal standard chronic heart failure treatments

I confirm that the above details are correct:

Signed: ..... Date: .....