HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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: .....

Dulaglutide

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ For continuation use

or

- ○ Patient has type 2 diabetes

and

- ○ Target HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of all of the following funded blood glucose lowering agents for a period of least 6 months, where clinically appropriate: empagliflozin, metformin, and vildagliptin

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)*

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/1.73m2 in the presence of diabetes, without alternative cause identified.

c) Funded GLP-1a treatment is not to be given in combination with (empagliflozin / empagliflozin with metformin hydrochloride) unless receiving (empagliflozin or empagliflozin in combination with metformin hydrochloride) for the treatment of heart failure.

I confirm that the above details are correct:

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