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 blood-glucose lowering agents for a period of at least 6 months, where clinically appropriate: empagliflozin, metformin and vildagliptin

and

- ○ Funded dulaglutide is not to be prescribed in combination with funded empagliflozin / empagliflozin with metformin unless receiving funded empagliflozin / empagliflozin with metformin hydrochloride for the treatment of heart failure

I confirm that the above details are correct:

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