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: .....

Empagliflozin; Empagliflozin with metformin hydrochloride

INITIATION – heart failure reduced ejection fraction

Prerequisites (tick boxes where appropriate)

- ○ Patient has heart failure

and

- ○ Patient is in NYHA functional class II or III or IV

and

- ○ Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 40%

or

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

and

- ○ Patient is receiving concomitant optimal standard funded chronic heart failure treatment

INITIATION – Type 2 Diabetes

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 at least one blood-glucose lowering agent (e.g. metformin, vildagliptin, or insulin) for at least 3 months

or

- ○ Patient has previously had an initial approval for a GLP-1 agonist and is changing funded treatment to an SGLT2i

and

- ○ Funded empagliflozin or empagliflozin with metformin hydrochloride is not to be prescribed in combination with a funded GLP-1 agonist unless for the treatment of heart failure

I confirm that the above details are correct:

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