APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2692
September 2026

APPLICANT (stamp or sticker acceptable)	**PATIENT** NHI:	**REFERRER** Reg No: .....
Reg No:	First Names:	First Names: .....
Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
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Empagliflozin; Empagliflozin with metformin hydrochloride

Initial application — heart failure reduced ejection fraction
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
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

Initial application — Type 2 Diabetes
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick boxes where appropriate)

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

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

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz