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.

PRESCRIBE	R	PATIENT:
Name:		Name:
Nard:		NHI:
Empagliflo	ozin; Empagliflozin with metformin hydrochlor	ide
INITIATION Prerequisite	es (tick boxes where appropriate)	
or C	For continuation use  Patient has previously had an initial approval for a GLP-1 a	ngonist
or	O Patient has type 2 diabetes	
8	or risk assessment calculator*  O Patient has a high lifetime cardiovascular risk of young adult*  O Patient has diabetic kidney disease (see note)	disease risk of 15% or greater according to a validated cardiovascular due to being diagnosed with type 2 diabetes during childhood or as a b)*
a) Pre-existi coronary		or renal complications of diabetes.  cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous emic attack, ischaemic stroke, peripheral vascular disease), congestive heart
	kidney disease defined as: persistent albuminuria (albumin:cr over a 3-6 month period) and/or eGFR less than 60 mL/min/1	eatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three .73m2 in the presence of diabetes, without alternative cause.

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