

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: .....

**Sacubitril with valsartan**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

Patient has heart failure

and

Patient is in NYHA/WHO functional class II

or

Patient is in NYHA/WHO functional class III

or

Patient is in NYHA/WHO functional class IV

and

Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 35%

or

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

and

Patient is receiving concomitant optimal standard chronic heart failure treatments

I confirm that the above details are correct:

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