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	PATIENT:
Name:	Name:
Ward:	NHI:
Sacubitril with valsartan	
INITIATION Prerequisites (tick boxes where appropriate)	
Patient has heart failure	
O Patient is in NYHA/WHO functional class II	
O Patient is in NYHA/WHO functional class III	
O Patient is in NYHA/WHO functional class IV	
and	
O Patient has a documented left ventricular ejection fracti	on (LVEF) of less than or equal to 35%
	n of the treating practitioner the patient would benefit from treatment
Patient is receiving concomitant optimal standard chronic hea	art failure treatments

C:	D-1	
Signed.	Date:	
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