

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:

Dulaglutide

INITIATION

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 all of the following blood-glucose lowering agents for a period of at least 6 months, where clinically appropriate: empagliflozin, metformin and vildagliptin

and

☐ Funded dulaglutide is not to be prescribed in combination with funded empagliflozin / empagliflozin with metformin unless receiving funded empagliflozin / empagliflozin with metformin hydrochloride for the treatment of heart failure

I confirm that the above details are correct:

Signed: Date: