

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:

Empagliflozin; Empagliflozin with metformin hydrochloride

INITIATION – heart failure reduced ejection fraction

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

INITIATION – Type 2 Diabetes

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 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 that the above details are correct:

Signed: Date: