

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....	Address:	
.....		
Fax Number:		Fax Number:

Dulaglutide

Initial application

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- ☐ 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 funded blood glucose lowering agents for a period of least 6 months, where clinically appropriate: empagliflozin, metformin, and vildagliptin
- and
- ☐ Patient is Māori or any Pacific ethnicity*

or

☐ Patient has pre-existing cardiovascular disease or risk equivalent (see note a)*

or

☐ Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator*

or

☐ Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult*

or

☐ Patient has diabetic kidney disease (see note b)*

Note: * Criteria intended to describe patients at high risk of cardiovascular or renal complications of diabetes.

- a) Pre-existing cardiovascular disease or risk equivalent defined as: prior cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart failure or familial hypercholesterolaemia.
- b) Diabetic kidney disease defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three samples over a 3-6 month period) and/or eGFR less than 60 mL/min/1.73m² in the presence of diabetes, without alternative cause identified.
- c) Funded GLP-1a treatment is not to be given in combination with funded (empagliflozin /empagliflozin with metformin hydrochloride) unless receiving funded (empagliflozin or empagliflozin in combination with metformin hydrochloride) for the treatment of heart failure.

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz