

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

Empagliflozin; Empagliflozin with metformin hydrochloride

Initial application — heart failure reduced ejection fraction

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

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

Initial application — Type 2 Diabetes

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 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 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