

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

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 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 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