

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:

Zoledronic acid inj 4 mg per 5 ml, vial

Initial application — bone metastases

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

Prerequisites(tick boxes where appropriate)

Patient has hypercalcaemia of malignancy

or

Patient has bone metastases or involvement
and
 Patient has severe bone pain resistant to standard first-line treatments

or

Patient has bone metastases or involvement
and
 Patient is at risk of skeletal-related events pathological fracture, spinal cord compression, radiation to bone or surgery to bone

Initial application — early breast cancer*

Applications from any relevant practitioner. Approvals valid for 3 years.

Prerequisites(tick boxes where appropriate)

Treatment to be used as adjuvant therapy for early breast cancer

and

Patient has been amenorrhoeic for 12 months or greater, either naturally or induced, with endocrine levels consistent with a postmenopausal state

and

Treatment to be administered at a minimum interval of 6-monthly for a maximum of 3 years

Note: Indications marked with * are unapproved indications.

Initial application — symptomatic hypercalcaemia*

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

Prerequisites(tick box where appropriate)

The patient has symptomatic hypercalcaemia

Note: Indications marked with * are unapproved indications.

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

Signed: Date:

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