

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: .....

**Zoledronic acid Inj 4 mg per 5 ml, vial**

**INITIATION – bone metastases**

**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)

**INITIATION – early breast cancer\***

**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.

**INITIATION – symptomatic hypercalcaemia\***

**Prerequisites** (tick box where appropriate)

- Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  
and  
 Patient has symptomatic hypercalcaemia

Note: Indications marked with \* are unapproved indications.

I confirm that the above details are correct:

Signed: ..... Date: .....