

**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: .....

**Denosumab**

**Initial application — Osteoporosis**

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

**Prerequisites**(tick boxes where appropriate)

The patient has established osteoporosis

**and**

History of one significant osteoporotic fracture demonstrated radiologically, with a documented T-Score less than or equal to -2.5, that incorporates BMD measured using dual-energy x-ray absorptiometry (DEXA)

**or**

History of one significant osteoporotic fracture, demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of logistical, technical or pathophysiological reasons

**or**

History of two significant osteoporotic fractures demonstrated radiologically

**or**

Documented T-Score less than or equal to -3.0

**or**

A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm that incorporates BMD measured using DEXA

**and**

Bisphosphonates are contraindicated because the patient's creatinine clearance or eGFR is less than 35 mL/min

**or**

The patient has experienced at least two symptomatic new fractures or a BMD loss greater than 2% per year, after at least 12 months' continuous therapy with a funded antiresorptive agent

**or**

Bisphosphonates result in intolerable side effects

**or**

Intravenous bisphosphonates cannot be administered due to logistical or technical reasons

**Initial application — Hypercalcaemia**

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

**Prerequisites**(tick boxes where appropriate)

Patient has hypercalcaemia of malignancy

**and**

Patient has severe renal impairment

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](mailto:customerservice@health.govt.nz)