

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: .....

**Denosumab**

**INITIATION – Osteoporosis**

**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

**INITIATION – Hypercalcaemia**

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has hypercalcaemia of malignancy  
and  
☐ Patient has severe renal impairment

I confirm that the above details are correct:

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