

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: .....