

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT</b> NHI: .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
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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)