ALBERTA BLUE CROSS®

Please complete all required sections to allow your request to be processed.

DENOSUMAB / ZOLEDRONIC ACID FOR OSTEOPOROSIS
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL

DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE:

- ☐ Alberta Blue Cross
- ☐ Alberta Human Services
- ☐ Other

IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL

STREET ADDRESS

CITY , PROVINCE

POSTAL CODE

PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION

- ☐ CPSA
- ☐ CARNA
- ☐ ACP
- ☐ ACO
- ☐ ADA+C
- ☐ Other

REGISTRATION NO.

PHONE:

FAX:

FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Indicate which drug is requested (check ONE box): ☐ **Denosumab 60 mg/syr** ☐ **Zoledronic Acid 0.05 mg/ml**

Indicate diagnosis and associated risk factors:

☐ **POSTMENOPAUSAL OSTEOPOROSIS**

→ **Please indicate which of the following pertain to this patient (check ALL that apply):**

- ☐ prior fragility fracture
- ☐ bone mineral density (BMD) T-Score of less than or equal to -2.5

☐ **MALE OSTEOPOROSIS**

→ **Please indicate which of the following pertain to this patient (check ALL that apply):**

- ☐ high 10-year risk (i.e., greater than 20%) of experiencing a major osteoporotic fracture
- ☐ moderate 10-year fracture risk (10-20%)
- ☐ prior fragility fracture

☐ **Other (specify):**

Please indicate which of the following pertain to this patient (check ALL that apply):

Denosumab requests only

- ☐ bisphosphonates are contraindicated due to drug-induced hypersensitivity (i.e., immunologically mediated).
- ☐ bisphosphonates are contraindicated due to severe renal impairment (i.e. creatinine clearance < 35 mL/min)

Denosumab and Zoledronic Acid requests

- ☐ abnormality of the esophagus which delays esophageal emptying
- ☐ severe gastrointestinal intolerance* with previous use of the following bisphosphonates. If so, must specify the nature and severity of adverse effects:
  - ☐ alendronate: _____
  - ☐ risedronate: _____

  *Note: severe gastrointestinal intolerance is defined as manifested by weight loss or vomiting directly attributable to the oral bisphosphonate
- ☐ unsatisfactory response (defined as a fragility fracture despite adhering to oral alendronate or risedronate treatment fully for 1 year and evidence of a decline in BMD below pre-treatment baseline level)

Additional information relating to request:

PRESCRIBER'S SIGNATURE	DATE

Please forward this request to:

- **Alberta Blue Cross, Clinical Drug Services**
  10009-108 Street NW, Edmonton, Alberta T5J 3C5
- **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.