

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

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

PATIENT INFORMATION				COVERAGE TYPE	
PATIENT LAST NAME	FIRST NAME	INITIAL		<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> Other	
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER				
STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER	

PRESCRIBER INFORMATION					
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION		
STREET ADDRESS			<input type="checkbox"/> CPSA	<input type="checkbox"/> ACO	REGISTRATION NUMBER
			<input type="checkbox"/> CARNA	<input type="checkbox"/> ADA+C	
CITY, PROVINCE			<input type="checkbox"/> ACP	<input type="checkbox"/> Other	
			PHONE	FAX	
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

Drug requested (check ONE box) Denosumab 60 mg/syr → complete Section I Zoledronic Acid 0.05 mg/ml → complete Section II

Section I DENOSUMAB requests	Section II ZOLEDRONIC ACID requests
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Indicate diagnosis and associated risk factors		Indicate diagnosis and associated risk factors	
<input type="checkbox"/> POSTMENOPAUSAL OSTEOPOROSIS → Indicate which of the following pertain to this patient (check ALL that apply) <input type="checkbox"/> prior fragility fracture <input type="checkbox"/> bone mineral density (BMD) T-Score of less than or equal to -2.5	<input type="checkbox"/> MALE OSTEOPOROSIS → Indicate which of the following pertain to this patient (check ALL that apply) <input type="checkbox"/> high 10-year risk (i.e. greater than 20%) of experiencing a major osteoporotic fracture <input type="checkbox"/> moderate 10-year fracture risk (10 to 20%) <input type="checkbox"/> prior fragility fracture	<input type="checkbox"/> OSTEOPOROSIS → Indicate which of the following pertain to this patient (check ALL that apply) <input type="checkbox"/> high 10-year risk (i.e. greater than 20%) of experiencing a major osteoporotic fracture <input type="checkbox"/> moderate 10-year fracture risk (i.e. 10 to 20%) <input type="checkbox"/> prior fragility fracture	

Other (specify):	Other (specify):
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Indicate which of the following pertain to this patient (check ALL that apply)	Indicate which of the following pertain to this patient (check ALL that apply)
<input type="checkbox"/> abnormality of the esophagus which delays esophageal emptying <input type="checkbox"/> unsatisfactory response (defined as a fragility fracture despite adhering to oral alendronate or risedronate treatment fully for one year and evidence of a decline in BMD below pre-treatment baseline level) <input type="checkbox"/> intolerance with previous use of bisphosphonates defined as manifested by weight loss or vomiting directly attributable to the bisphosphonate → Check which bisphosphonates apply <input type="checkbox"/> alendronate <input type="checkbox"/> risedronate <input type="checkbox"/> bisphosphonates are contraindicated due to drug-induced hypersensitivity (i.e. immunologically mediated) <input type="checkbox"/> bisphosphonates are contraindicated due to severe renal impairment (i.e. creatinine clearance less than 35 mL/min)	<input type="checkbox"/> abnormality of the esophagus which delays esophageal emptying <input type="checkbox"/> 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) <input type="checkbox"/> persistent severe gastrointestinal intolerance with previous use of the following bisphosphonates → Check which bisphosphonate(s) apply <input type="checkbox"/> alendronate <input type="checkbox"/> risedronate

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

