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N&WICS - TA160 - Etidronate - Primary prevention of fragility fractures in postmenopausal women with osteoporosis

Before providing patient identifiable data on this form, please confirm that the patient (or in the case of a minor or vulnerable adult with the parent/legal guardian/carer) has given appropriate explicit consent for sensitive personal information on this form to be passed to the CCG and/or CSU for processing this funding request and validating subsequent invoices. Consent given: ☐

If there is more than one NICE-approved treatment available, a discussion between the responsible clinician and the patient has taken place about the advantages and disadvantages of the treatments available. This has taken into consideration therapeutic need and whether or not the patient is likely to adhere to treatment. The most appropriate, least expensive, will be chosen (taking into account administration costs, dosage and price per dose) unless an order of preference is stated in the TAs. ☐

Patient NHS No:	**Trust:**	**Practice Name:**
Patient Hospital No:	**Consultant Making Request:**	**Practice Postcode:**
Patient's Initials and DoB:		**Practice Code:**
Notification Email Address: (@NHS.net account ONLY)		**Contact name & number:**
Start date of requested treatment:	**Provider:** ☐ Private ☐ NHS **Supplier:** ☐ Homecare ☐ Hospital	**Sub-Type:** (if applicable) N/A

By completing this form, you confirm that you intend to use the requested medicinal product described below as agreed in the local commissioning statement. Any requests which fall outside of this use will require an individual funding request (IFR).

For support regarding IFRs, please contact: norfolkicd@nhs.net

For support regarding the criteria listed below, please contact: norfolknontariff@nhs.net

The following form references TA1.

Please indicate whether patient meets the following NICE criteria:	**Please tick**
1. This recommendation has been replaced by the recommendations in the NICE technology appraisal guidance on bisphosphonates for treating osteoporosis.	☐ Yes ☐ No
2. This recommendation has been replaced by the recommendations in the NICE technology appraisal guidance on bisphosphonates for treating osteoporosis.	☐ Yes ☐ No
3. The recommendation for strontium ranelate has been withdrawn because strontium ranelate is no longer marketed in the UK.	☐ Yes ☐ No
4. Raloxifene is not recommended as a treatment option for the primary prevention of osteoporotic fragility fractures in postmenopausal women.	☐ Yes ☐ No
5. For the purposes of this guidance, independent clinical risk factors for fracture are parental history of hip fracture, alcohol intake of 4 or more units per day, and rheumatoid arthritis.	☐ Yes ☐ No
6. This recommendation has been replaced by the recommendations in the NICE technology appraisal guidance on bisphosphonates for treating osteoporosis.	☐ Yes ☐ No
7. For the purposes of this guidance, intolerance of alendronate or risedronate is defined as persistent upper gastrointestinal disturbance that is sufficiently severe to warrant discontinuation of treatment, and that occurs even though the instructions for administration have been followed correctly.	☐ Yes ☐ No
8. For the purposes of this guidance, primary prevention refers to opportunistic identification, during visits to a healthcare professional for any reason, of postmenopausal women who are at risk of osteoporotic fragility fractures and who could benefit from drug treatment. It does not imply a dedicated screening programme.	☐ Yes ☐ No
9. Women who are currently receiving treatment, but for whom treatment would not have been recommended according to sections 1.1 to 1.4, should have the option to continue treatment until they and their clinicians consider it appropriate to stop.	☐ Yes ☐ No

• [1] T-score relates to the measurement of bone mineral density (BMD) using central (hip and/or spine) DXA scanning, and is expressed as the number of standard deviations (SD) from peak BMD.	
I confirm that the patient meets the criteria for treatment Name of person completing: Designation of person completing:	 Contact Details: Date:
Trust Authorising Pharmacist Name: Date:	