## SA2400 - Adalimumab (Amgevita)

Arthritis - oligoarticular course juvenile idiopathic - Initial application	9
Arthritis - oligoarticular course juvenile idiopathic - Renewal	
Arthritis - polyarticular course juvenile idiopathic - Initial application	
Arthritis - polyarticular course juvenile idiopathic - Renewal	10
Arthritis - psoriatic - Initial application	11
Arthritis - psoriatic - Renewal	11
Arthritis - rheumatoid - Initial application	
Arthritis - rheumatoid - Renewal	12
Behcet's disease - severe - Initial application	2
Crohn's disease - adults - Initial application	5
Crohn's disease - adults - Renewal	5
Crohn's disease - children - Initial application	
Crohn's disease - children - Renewal	6
Crohn's disease - fistulising - Initial application	6
Crohn's disease - fistulising - Renewal	
Hidradenitis suppurativa - Initial application	
Hidradenitis suppurativa - Renewal	
Ocular inflammation - chronic - Initial application	7
Ocular inflammation - chronic - Renewal	7
Ocular inflammation - severe - Initial application	
Ocular inflammation - severe - Renewal	8
Plaque psoriasis - severe chronic - Initial application	3
Plaque psoriasis - severe chronic - Renewal	4
Still's disease - adult-onset (AOSD) - Initial application	13
Ankylosing spondylitis - Initial application	
Ankylosing spondylitis - Renewal	
Inflammatory bowel arthritis – axial - Initial application	
Inflammatory bowel arthritis – axial - Renewal	15
Inflammatory bowel arthritis – peripheral - Initial application	15
Inflammatory bowel arthritis – peripheral - Renewal	15
Pyoderma gangrenosum - Initial application	
Ulcerative colitis - Initial application	
Ulcerative colitis - Renewal	
Undifferentiated spondyloarthritis - Initial application	
Undifferentiated spondyloarthritis - Renewal	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 2 Form SA2400 December 2024

APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	lo:	First Names:	First Names:
Name	·	Surname:	Surname:
Addre	ss:	DOB:	Address:
		Address:	
Fax N	umber:		Fax Number:
Adal	imumab (Amgevita)		
App Prer	The patient has severe Behcet's diand  The patient has severe Behcet's diand  The patient has severe ocula treatment(s) appropriate for The patient has severe gasti	rointestinal, rheumatological, and/or mucocutaneous opropriate for the particular symptom(s)	not responded adequately to one or more
App	Il application — Hidradenitis suppurativa lications only from a dermatologist. Approvals equisites(tick boxes where appropriate)	valid for 4 months.	
	Patient has hidradenitis suppurativ	a Hurley Stage II or Hurley Stage III lesions in distinc	et anatomic areas
	Patient has tried, but had an inade has contraindications for systemic and	quate response to at least a 90 day trial of systemic a antibiotics	antibiotics or has demonstrated intolerance to or
	Patient has 3 or more active lesion	s	
	The patient has a DLQI of 10 or m	ore and the assessment is no more than 1 month old	at time of application
Rene	ewal — Hidradenitis suppurativa		
Appli	ent approval Number (if known): cations from any relevant practitioner. Approvequisites(tick boxes where appropriate)		
	The patient has a reduction in activand  The patient has a DLQI improvement	ve lesions (e.g. inflammatory nodules, abscesses, drent of 4 or more from baseline	aining fistulae) of 25% or more from baseline

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 3 Form SA2400 December 2024

APPLICA	<b>VT</b> (star	np o	r sticker acceptable)	PATIENT NHI:	REFERRER Reg No:		
Reg No:				First Names:	First Names:		
Name:				Surname:	Surname:		
Address: .				DOB:	Address:		
				Address:			
Fax Numb	er:		ngevita) - continued		Fax Number:		
Application	ons only	/ froi	Plaque psoriasis - severe m a dermatologist or any rele exes where appropriate)	chronic vant practitioner on the recommendation of a dermat	ologist. Approvals valid for 4 months.		
	and	or	Patient has experienc	pecial Authority approval for etanercept for severe chronic plaque psoriasis  ced intolerable side effects  insufficient benefit to meet the renewal criteria for etanercept for severe chronic plaque psoriasis			
or  Patient has severe chron have been present for at least 6 mc  Patient has severe chron have been present for at least 6 mc  Patient has severe chron				dy" severe chronic plaque psoriasis with a PASI score months from the time of initial diagnosis ronic plaque psoriasis of the face, or palm of a hand or at least 6 months from the time of initial diagnosis ronic localised genital or flexural plaque psoriasis whereometric from the time of initial diagnosis, and with a Dermatol	or sole of a foot, where the plaque or plaques ere the plaques or lesions have been present		
	and		following (at maximum tolers A PASI assessment or DLQ	n inadequate response to, or has experienced intolera ated doses unless contraindicated): phototherapy, me I assessment has been completed for at least the mo ation of each prior treatment course and is no more the	ethotrexate, ciclosporin, or acitretin st recent prior treatment course but no longer		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 4 Form SA2400 December 2024

APPLIC	ANT (	stamp c	r stick	ker acceptable)	PATIENT NHI:		REFERRER Reg No:			
Reg No:					. First Names:		First Names:			
Name:					. Surname:		Surname:			
Address	:				. DOB:		Address:			
					. Address:					
Fax Nun	nber:			ita) - continued			Fax Number:			
Renew	al — I	Plaque	osoria	asis - severe chronic						
				rant practitioner. App here appropriate)	rovals valid for 2 years.					
o	or	or or		The patient has exp the pre-treatment base. The patient has a D ent had severe chronic. The patient has exp slight or better, or si	DLQI improvement of 5 or more, when compared with the pre-treatment baseline value or plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment overienced reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaustained at this level, as compared to the treatment course baseline values overienced reduction of 75% or more in the skin area affected, or sustained at this level, as contained a					
a		or	Patie	The patient has exp	baseline value atology Quality of Life Index (DL	more in the skin area at	ffected, or sustained at this level, as compared or more, as compared to baseline DLQI prior to			
Applica	ations	only fro s(tick bo	m a do exes w	here appropriate)	als valid without further renewal	unless notified.				
а	nd	Patie	nt has				e pharmaceuticals (e.g. prednisone, ciclosporin,			
Note: I	ndicat	ions ma	rked v	vith * are unapproved	indications.					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 5 Form SA2400 December 2024

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:	First Names:	First Names:	
Name:	Surname:	Surname:	
Address:	DOB:	Address:	
	Address:		
Fax Number:		Fax Number:	
Adalimumab (Amgevita) - continued			
Initial application — Crohn's disease - adults Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)	vals valid for 6 months.		
Patient has active Crohn's disease			
or	greater than or equal to 300, or HBI score of greater intestine disease affecting more than 50 cm of the sm		
Patient has evidence of showing or	rt gut syndrome or would be at risk of short gut syndr	ome with further bowel resection	
Patient has an ileostomy or	colostomy and has intestinal inflammation		
and Patient has tried but had an inaded and corticosteroids	quate response to, or has experienced intolerable sid	e effects from, prior therapy with immunomodulators	
Renewal — Crohn's disease - adults			
Current approval Number (if known):			
Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)			
CDAI score has reduced by 100 poor	oints from the CDAI score, or HBI score has reduced	by 3 points, from when the patient was initiated	
CDAI score is 150 or less, or HBI i	s 4 or less		
The patient has demonstrated an a	adequate response to treatment, but CDAI score and	or HBI score cannot be assessed	
Initial application — Crohn's disease - children Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)			
Paediatric patient has active Crohr	n's disease		
Patient has a PCDAI score of	of greater than or equal to 30		
Patient has extensive small	intestine disease		
Patient has tried but had an inaded and corticosteroids	quate response to, or has experienced intolerable sid	e effects from, prior therapy with immunomodulators	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 6 Form SA2400 December 2024

APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:							
Reg N	lo:	First Names:	First Names:							
Name	:	Surname:	Surname:							
Addre	ss:	DOB:	Address:							
		Address:								
	umber:		Fax Number:							
Adal	imumab (Amgevita) - continued									
Rene	ewal — Crohn's disease - children									
Appli	Current approval Number (if known):									
Appl	al application — Crohn's disease - fistulising ications from any relevant practitioner. Appropriates (tick boxes where appropriate)	vals valid for 6 months.								
	Patient has confirmed Crohn's disc	ease								
	Patient has one or more con	nplex externally draining enterocutaneous fistula(e)								
	Patient has one or more rec	tovaginal fistula(e)								
	Patient has complex peri-an	al fistula								
	A Baseline Fistula Assessment ha	s been completed and is no more than 1 month old a	at the time of application							
Rene	ewal — Crohn's disease - fistulising									
Appli	Current approval Number (if known):									
	The number of open draining fistul	ae have decreased from baseline by at least 50%								
		n in drainage of all fistula(e) from baseline as demon n and patient-reported pain	nstrated by a reduction in the Fistula Assessment							

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 7 Form SA2400 December 2024

APPL	ICAN	<b>IT</b> (sta	amp o	r sticker acceptable)	PATIENT NHI:	REFERRER Reg No:				
Reg N	lo:				First Names:	First Names:				
Name	:				Surname:	Surname:				
Addre	ss:				DOB:	Address:				
					Address:					
Fax N	umbe	er:				Fax Number:				
Adali	imu	mab	(Am	gevita) - continued						
Appl	icatio	ons fro	m any	Ocular inflammation - chro relevant practitioner. Approxes where appropriate)						
	or		The p	atient has had an initial Spec	cial Authority approval for infliximab for chronic ocular	inflammation				
	or	and		Patient has severe uveitis un	ncontrolled with treatment of steroids and other immu	ncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision loss				
		and		Patient is 18 years or	older and treatment with at least two other immunome	odulatory agents has proven ineffective				
			or	Patient is under 18 ve	ars and treatment with methotrexate has proven ineffective or is not tolerated at a therapeutic dose					
			or		ars and treatment with steroids or methotrexate has pr	.				
					lisease requires control to prevent irreversible vision k					
				monorato						
Rene	wal -	— Ос	ular iı	nflammation - chronic						
Curre	ant ar	oprove	al Nium	nber (if known):						
				relevant practitioner. Appro-						
Prere	equis	sites(t	ick bo	xes where appropriate)						
			The p	atient has had a good clinica	al response following 12 weeks' initial treatment					
	or		Follov	ving each 2 year treatment p	period, the patient has had a sustained reduction in in	flammation (Standardisation of Uveitis				
				nclature (SUN) criteria < ½+ d macular oedema)	anterior chamber or vitreous cells, absence of active	vitreous or retinal lesions, or resolution of uveitic				
	or				period, the patient has a sustained steroid sparing effe	ct, allowing reduction in prednisone to < 10mg				
			daily,	or steroid drops less than tw	ice daily if under 18 years old					
Appl	icatio	ons fro	m any	Ocular inflammation - sev relevant practitioner. Approxes where appropriate)						
	0.5		Patier	nt has had an initial Special A	Authority approval for infliximab for severe ocular inflat	mmation				
	or	and		Patient has severe, vision-th	nreatening ocular inflammation requiring rapid control					
		ant		Treatment with high-d ineffective at controlling	lose steroids (intravenous methylprednisolone) followeng symptoms	ed by high dose oral steroids has proven				
			or		w inflammatory symptoms while receiving high dose s	teroids				
			or		8 years and treatment with high dose oral steroids ar					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 8 Form SA2400 December 2024

APPLICANT (stamp or sticker acceptable)							PATIENT NHI:					REFERRER Reg No:													
Reg N	o:								Fire	st Na	ames	s:											First Names:		
Name	:								Sur	rnam	ıe:											;	Surname:		
Addre	ss:								DO	)B:													Address:		
									Add	dres	s:														
Fax N	umbei	r:																					ax Number:		
Adali	mun	nab (	٩m	gevit	a) -	contir	nued																		
Rene	wal –	– Ocul	ar iı	nflamn	natio	n - se	vere																		_
Curre	nt an	proval <b>i</b>	Num	nher (if	know	m).																			
		s from		,		,																			
		i <b>tes</b> (ticl	-									•													
	[	Tr	ne p	atient l	—— າas h	ad a c	ood c	linica	l res	pons	se fc	ollow	vina (	3 ini	tial c	doses	 }								1
	or [	_											_					rod	luot	ion	in i	o fl	ammatian (Standardication of Llyait	io	
	L	No	ome	nclatu	re (Sl	JN) cr	iteria ·																ammation (Standardisation of Uveit itreous or retinal lesions, or resoluti		
	or	`		d macı																					
	L			ving ea or ster													sterc	oid s	spa	ring	eff	ec	, allowing reduction in prednisone t	.o < 10mg	
									_																=
		l <b>icatior</b> ns only							ls va	ılid fo	or 6	mon	nths.												
		i <b>tes</b> (ticl				_																			
		Г	_	Datie		ll -		-10-	1		la a ata							ć	1						ī
		and		Patien	nas	nad a	ın ınıtı	аі Бр	eciai	Auti	norit	у ар	oprov	/ai ic	or et	aner	сері	ior	ank	cylos	sing	j S	pondylitis		
			٥r		The p	atien	t has e	xper	ience	ed in	itole	rable	e sid	e ef	fects	5									
			or		The p	atien	t has r	eceiv	∕ed ir	nsuff	icier	nt be	enefit	t to ı	mee	t the	rene	ewal	l cri	teria	a fo	r a	nkylosing spondylitis		
	or	L																							
	٥.	Γ		Patien	t has	a con	ıfirmec	l diad	nosi	is of	ank	vlos	ina s	spon	ndylit	is for	mor	re th	nan	six	mo	nt	ns		
		and	_	Patien					•			•	J		•										
		and	_												-				1101	ГОУ	168	ı			
		and_	_	Patien	t has	bilate	ral sad	croilii	tis de	emor	nstra	ated	by ra	adio	logy	ima	ging								
		L		Patien a regu											ith tv	vo or	mor	re N	ISA	IDs	, wł	nile	patient was undergoing at least 3	months of	
		and																							
																							ntal planes as determined by the fo		
			or				ual to 1																		
					Patie gend		limita	tion	of ch	est e	эхра	ınsio	on by	at l	east	2.5	cm b	belo	w t	he a	ave	raç	e normal values corrected for age	and	
		and_																							
				A BAS															erc	ise 1	trial	, b	ut prior to ceasing any previous pha	armacologica	al
				ucauii	ont a	114 15	110	i C ti le	AII I			iu al			- 01 6	appii	Jano	,, ,							П

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 9 Form SA2400 December 2024

APPL	ICAN	(stamp or sticker acceptable)	PATIENT NHI:	. REFERRER Reg No:				
Reg N	lo:		First Names:	First Names:				
Name	:		Surname:	Surname:				
Addre	ss:		DOB:	Address:				
			Address:					
Fax N	umbei			Fax Number:				
Adal	imun	nab (Amgevita) - continued						
Rene	ewal –	- ankylosing spondylitis						
Curre	ent apı	proval Number (if known):						
		s from any relevant practitioner. Appro						
Prer	equisi —	tes(tick box where appropriate)						
L		reatment has resulted in an improvement ASDAI of 50%, whichever is less	ent in BASDAI of 4 or more points from pre-treatment	baseline on a 10 point scale, or an improvement in				
1141								
App	lication	•	matologist. Approvals valid for 6 months.					
Prer	equisi	tes(tick boxes where appropriate)						
		The patient has had an initi	al Special Authority approval for etanercept for oligoar	rticular course juvenile idiopathic arthritis (JIA)				
		and						
		or Patient has experienc	ced intolerable side effects					
		Patient has received	insufficient benefit to meet the renewal criteria for oligoarticular course JIA					
	or							
		To be used as an adjunct to and	methotrexate therapy or monotherapy where use of r	methotrexate is limited by toxicity or intolerance				
		Patient has had oligoarticul	ar course JIA for 6 months duration or longer					
		At least 2, active joint	s with limited range of motion, pain or tandernoss after	or a 2 month trial of mothetrovate (at the				
		maximum tolerated d	s with limited range of motion, pain or tenderness afteose)	er a 3-monur mai or memorrexate (at me				
		Moderate or high dise	ease activity (cJADAS10 score greater than 1.5) with praximum tolerated dose)	poor prognostic features after a 3-month trial of				
		methotrexate (at the r	maximum tolerated dose)					
Rene	ewal –	- Arthritis - oligoarticular course juv	renile idiopathic					
Curre	ent app	proval Number (if known):						
		s from any relevant practitioner. Appro tes(tick boxes where appropriate)	vals valid for 2 years.					
1.0.	- r							
		Following initial treatment, the pat assessment from baseline	ient has at least a 50% decrease in active joint count	and an improvement in physician's global				
	or [	$\neg$	e patient demonstrates at least a continuing 30% impr	rovement in active joint count and continued				
	improvement in physician's global assessment from baseline							

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 10 Form SA2400 December 2024

APPL	.ICAN	T (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg N	No:		First Names:	First Names:	
Name	):		Surname:	Surname:	
Addre	ess:		DOB:	Address:	
			Address:		
Fax N	lumbe	r:		Fax Number:	
Adal	imur	mab (Amgevita) - continued			
App	licatio	Patient has had an initial Sp  and  Patient has had an initial Sp  Patient has experience or  Patient has received in  To be used as an adjunct to  and  Patient has had polyarticular and  At least 5 active joints methotrexate (at the month)  Moderate or high dise tolerated dose)	urse juvenile idiopathic matologist. Approvals valid for 6 months.  ecial Authority approval for etanercept for polyarticula ed intolerable side effects nsufficient benefit to meet the renewal criteria for poly methotrexate therapy or monotherapy where use of r r course JIA for 6 months duration or longer and at least 3 joints with limited range of motion, paraximum tolerated dose) ase activity (cJADAS10 score of at least 2.5) after a c- cJADAS10 score between 1.1 and 2.5) after a 6-mon	methotrexate is limited by toxicity or intolerance ain or tenderness after a 3-month trial of 3-month trial of methotrexate (at the maximum	
Ren	ewal -	Arthritis - polyarticular course juve	nile idiopathic		
		proval Number (if known):			
		ns from any relevant practitioner. Approvites (tick boxes where appropriate)	als valid for 2 years.		
. 101	or	Following initial treatment, the pati- assessment from baseline	ent has at least a 50% decrease in active joint count patient demonstrates at least a continuing 30% imprassessment from baseline		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 11 Form SA2400 December 2024

APPLICA	ANT	(stam	ро	sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:					First Names:	First Names:
Name: .					Surname:	Surname:
Address:					DOB:	Address:
					Address:	
Fax Num	ber:					Fax Number:
Adalim	um	ab (	٩m	gevita) - continued		
Applica	uisit	s only	fror	The patient has experi	ecial Authority approval for etanercept or secukinumal enced intolerable side effects ed insufficient benefit from to meet the renewal criter atic arthritis for six months duration or longer ponded to at least three months of methotrexate at a ponded to at least three months of sulfasalazine or lessymptoms of poorly controlled and active disease in deither shoulder or hip el greater than 15 mg/L measured no more than one leater than 25 mm per hour assured as patient is currently receiving prednisone the	maximum tolerated dose (unless contraindicated) efflunomide at maximum tolerated doses (unless at least 15 swollen joints at least four joints from the following: wrist,
Renewa	al —	Arth	itis	- psoriatic		
Applicat	tions	from es(ticles) Fore re	any k bo ollov spo	nse in the opinion of the phys	rals valid for 2 years.  ent has at least a 50% decrease in swollen joint counsician  ntinuing 30% improvement in swollen joint count from	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 12 Form SA2400 December 2024

APPL	ICAN	<b>T</b> (stan	np c	or sticke	er acceptable)	PATIENT NHI:	REFERRER Reg No:			
Reg N	lo:					First Names:	First Names:			
Name	:					Surname:	Surname:			
Address:						DOB:	Address:			
						Address:				
Fax N	umbei	r:					Fax Number:			
Adal	imun	nab (	An	ngevit	(a) - continued					
App	lication	ns only	fro	m a rhe		al Special Authority approval for etanercept for rheum-	atoid arthritis			
				Ш	The patient has receive	red insufficient benefit from etanercept to meet the re	newal criteria for rheumatoid arthritis			
	or	and and and	or	month Treatn intoler Patien Sulpha	nent is to be used as a ance  It has tried and not result has persistent patient has persistent	arthritis (either confirmed by radiology imaging, or the an adjunct to methotrexate therapy or monotherapy with a ponded to at least three months of methotrexate at a sponded to at least three months of methotrexate in conted doses (unless contraindicated)  not responded to at least three months of methotrexate and responded to at least three months of methotrexate and responded to at least three months of therapy at the single with methotrexate and responded to at least three months of therapy at the single with methotrexate and responded to a single property and active disease in a symptoms of poorly controlled and active disease in a symptoms of poorly controlled and active disease in a symptom of poorly cont	here use of methotrexate is limited by toxicity or maximum tolerated dose (unless contraindicated) ombination with sulfasalazine and hydroxychloroquin te in combination with the maximum tolerated the maximum tolerated dose of leflunomide at least 15 swollen joints			
Curre	ent app	proval s from ites(tic	Nur any k bo	mber (if y releva oxes wh	nt practitioner. Approvere appropriate)		from baseline and a clinically significant			
	or [									
	[					patient demonstrates at least a continuing 30% impreatment in the opinion of the physician	ovement in active joint count from baseline and a			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 13 Form SA2400 December 2024

APPLICANT (stamp or sticker acceptable)			PATIENT NHI:	REFERRER Reg No:					
Reg No:			First Names:	First Names:					
Name:			Surname:	Surname:					
Addre	ss:		DOB:	Address:					
			Address:						
Fax Number:				Fax Number:					
Adal	Adalimumab (Amgevita) - continued								
Initial application — Still's disease - adult-onset (AOSD) Applications only from a rheumatologist. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)									
		The patient has had an initia	al Special Authority approval for etanercept and/or too	ilizumab for AOSD					
		Patient has experienced intolerable side effects from etanercept and/or tocilizumab  or							
		Patient has received in	nsufficient benefit from at least a three-month trial of	etanercept and/or tocilizumab					
	or	Patient diagnosed with AOS	D according to the Yamaguchi criteria						
		and Patient has tried and not res methotrexate	ponded to at least 6 months of glucocorticosteroids a	at a dose of at least 0.5 mg/kg, NSAIDs and					
		and Patient has persistent symptoms of disabling poorly controlled and active disease							
Initial application — ulcerative colitis Applications from any relevant practitioner. Approvals valid for 3 months.  Prerequisites(tick boxes where appropriate)									
	and	Patient has active ulcerative colitis							
		Patient's SCCAI score is gre	eater than or equal to 4						
		Patient's PUCAI score is greater than or equal to 20							
	and and	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from prior therapy with immunomodulators and systemic corticosteroids							
		Surgery (or further surgery) is considered to be clinically inappropriate							
Renewal — ulcerative colitis									
Appli	Current approval Number (if known):								
		The SCCAI score has reduced by	2 points or more from the SCCAI score when the pat	ient was initiated on biologic therapy					
	or 	The PUCAI score has reduced by	10 points or more from the PUCAI score when the pa	tient was initiation on biologic therapy					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 14 Form SA2400 December 2024

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:					
Reg No:	First Names:	First Names:					
Name:	Surname:	Surname:					
Address:	DOB:	Address:					
	Address:						
Fax Number:		Fax Number:					
Adalimumab (Amgevita) - continued							
Initial application — undifferentiated spondyloarthritis Applications only from a rheumatologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)							
	Patient has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip						
Patient has tried and not responded tolerated doses (unless contraindica	to at least three months of each of methotrexate, suated)	ulfasalazine and leflunomide, at maximum					
or	ater than 15 mg/L measured no more than one month prior to the date of this application						
Patient has an ESR greater th	than 25 mm per hour measured no more than one month prior to the date of this application						
ESR and CRP not measured done so for more than three n	as patient is currently receiving prednisone therapy nonths	at a dose of greater than 5 mg per day and has					
Note: Indications marked with * are unapproved ind	ications						
Renewal — undifferentiated spondyloarthritis							
Current approval Number (if known):							
Prerequisites(tick boxes where appropriate)							
response to treatment in the opinion	ient has at least a 50% decrease in active joint count from baseline and a clinically significant on of the physician						
The patient demonstrates at least a in the opinion of the treating physicial	continuing 30% improvement in active joint count from	om baseline and a clinically significant response					
Initial application — inflammatory bowel arthritis	a ovial						
Applications only from a rheumatologist. Approvals  Prerequisites(tick boxes where appropriate)							
Patient has a diagnosis of active uld	erative colitis or active Crohn's disease						
Patient has axial inflammatory pain	for six months or more						
Patient is unable to take NSAIDs							
and							
Patient has unequivocal sacroiliitis o	demonstrated by radiological imaging or MRI						
Patient has unequivocal sacroiliitis of	demonstrated by radiological imaging or MRI ely to prior treatment consisting of at least 3 months	of an exercise regime supervised by a					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 15 Form SA2400 December 2024

APPLICANT (stamp or sticker acceptable)		PATIENT NHI:	REFERRER Reg No:				
Reg N	lo:	First Names:	First Names:				
Name	:	Surname:	Surname:				
Address:		DOB:	Address:				
		Address:					
Fax N	umber:		Fax Number:				
Adal	imumab (Amgevita) - continued						
Renewal — inflammatory bowel arthritis – axial							
Curre	ent approval Number (if known):						
	cations from any relevant practitioner. Approv	als valid for 2 years.					
Prer	equisites(tick box where appropriate)						
Treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less							
App	Patient has active arthritis in at lead sternoclavicular  and Patient has tried and not experience (unless contraindicated)  and Patient has tried and not experience contraindicated)  and Patient has a CRP level great or Patient has an ESR greater to	Icerative colitis or active Crohn's disease st four joints from the following: hip, knee, ankle, subsed a response to at least three months of methotrexacted a response to at least three months of sulfasalazing the subsection of the sulfasalazing that the subsection of the subsection	ne at a maximum tolerated dose ne at a maximum tolerated dose (unless n prior to the date of this application onth prior to the date of this application				
Rene	ewal — inflammatory bowel arthritis – perip	pheral					
	ent approval Number (if known):						
Applications from any relevant practitioner. Approvals valid for 2 years.  Prerequisites(tick boxes where appropriate)							
	Following initial treatment, patient I treatment in the opinion of the physics	nas at least a 50% decrease in active joint count from sician continuing 30% improvement in active joint count from					