APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2084
April 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: .....

Secukinumab

Initial application — severe chronic plaque psoriasis – second-line biologic
Applications only from a dermatologist. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has had an initial Special Authority approval for adalimumab or etanercept, or has trialled infliximab in a Te Whatu Ora Hospital, for severe chronic plaque psoriasis

and

- ☐ The patient has experienced intolerable side effects from adalimumab, etanercept or infliximab

or

- ☐ The patient has received insufficient benefit from adalimumab, etanercept or infliximab

and

- ☐ A Psoriasis Area and Severity Index (PASI) assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course

and

- ☐ The most recent PASI or DQLI assessment is no more than 1 month old at the time of application

Initial application — severe chronic plaque psoriasis – first-line biologic
Applications only from a dermatologist. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis

or

- ☐ Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis

and

- ☐ Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin

and

- ☐ A PASI assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course

and

- ☐ The most recent PASI or DQLI assessment is no more than 1 month old at the time of application

Note: A treatment course is defined as a minimum of 12 weeks of treatment. "Inadequate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face, hand or foot, at least 2 of the 3 PASI symptom sub scores for erythema, thickness and scaling are rated as severe or very severe, and the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.

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

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Secukinumab *- continued*

Renewal — severe chronic plaque psoriasis – first and second-line biologic

Current approval Number (if known):.....

Applications only from a dermatologist or medical practitioner on the recommendation of a dermatologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient's PASI score has reduced by 75% or more (PASI 75) as compared to baseline PASI prior to commencing secukinumab

or

- ☐ Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing secukinumab

and

- ☐ Secukinumab to be administered at a maximum dose of 300 mg monthly

Initial application — ankylosing spondylitis – second-line biologic

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

- ☐ The patient has had an initial Special Authority approval for adalimumab and/or etanercept for ankylosing spondylitis

and

- ☐ The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept

or

- ☐ Following 12 weeks of adalimumab and/or etanercept treatment, the patient did not meet the renewal criteria for adalimumab and/or etanercept for ankylosing spondylitis

Renewal — ankylosing spondylitis – second-line biologic

Current approval Number (if known):.....

Applications only from a rheumatologist or medical practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Following 12 weeks initial treatment of secukinumab treatment, BASDAI has improved by 4 or more points from pre-secukinumab baseline on a 10 point scale, or by 50%, whichever is less

and

- ☐ Physician considers that the patient has benefitted from treatment and that continued treatment is appropriate

and

- ☐ Secukinumab to be administered at doses no greater than 150 mg monthly

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Secukinumab *- continued*

Initial application — psoriatic arthritis
Applications only from a rheumatologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has had an initial Special Authority approval for adalimumab, etanercept or infliximab for psoriatic arthritis

and

  - ☐ Patient has experienced intolerable side effects from adalimumab, etanercept or infliximab

  or

  - ☐ Patient has received insufficient benefit from adalimumab, etanercept or infliximab to meet the renewal criteria for adalimumab, etanercept or infliximab for psoriatic arthritis

or

- ☐ Patient has had severe active psoriatic arthritis for six months duration or longer

and

- ☐ Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose

and

- ☐ Patient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day or leflunomide at a dose of up to 20 mg daily (or maximum tolerated doses)

and

  - ☐ Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints

  or

  - ☐ Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip

and

  - ☐ Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application

  or

  - ☐ Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour

  or

  - ☐ ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months

Renewal — psoriatic arthritis

Current approval Number (if known):.....

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

or

- ☐ The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior secukinumab treatment in the opinion of the treating physician

and

- ☐ Secukinumab to be administered at doses no greater than 300 mg monthly

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