RS2063 - Adalimumab (Amgevita)

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Chambion and Sports, San Lines	

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER				PATIENT:	
Name:				Name:	
Ward:				NHI:	
Adal	imu	mab	(Amgevita)		
			ehcet's disease - severe tick boxes where appropriate)		
and		Prescri NZ Ho		cordance with a protocol or guideline that has been endorsed by the Health	
	and		The patient has severe Behcet's disease* that is significantly in	mpacting the patient's quality of life	
		or	O The patient has severe ocular, neurological, and/or vasc treatment(s) appropriate for the particular symptom(s)	ulitic symptoms and has not responded adequately to one or more	
			The patient has severe gastrointestinal, rheumatological to two or more treatments appropriate for the particular section.	and/or mucocutaneous symptoms and has not responded adequately symptom(s)	
Note	: Indi	ication	s marked with * are unapproved indications.		
INITIATION – Hidradenitis suppurativa Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Patient has hidradenitis suppurativa Hurley Stage II or Hurley Stage III lesions in distinct anatomic areas Patient has tried, but had an inadequate response to at least a 90 day trial of systemic antibiotics or patient has demonstrated intolerance to or has contraindications for systemic antibiotics Patient has 3 or more active lesions and The patient has a DLQI of 10 or more and the assessment is no more than 1 month old at time of application					
Re-a	CONTINUATION – Hidradenitis suppurativa Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and The patient has a reduction in active lesions (e.g. inflammatory nodules, abscesses, draining fistulae) of 25% or more from baseline The patient has a DLQI improvement of 4 or more from baseline				

PRES	CRIB	ER			PATIENT:
Name:	:				Name:
Ward:					NHI:
Adali	mur	nab	(An	ngev	ita) - continued
Re-as	sess	ment	requ	ired a	riasis - severe chronic fter 4 months where appropriate)
and	Hospital.				recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and	0	Patie	ent has had an initial Special Authority approval for etanercept for severe chronic plaque psoriasis
			or	O O	Patient has experienced intolerable side effects Patient has received insufficient benefit to meet the renewal criteria for etanercept for severe chronic plaque psoriasis
	or				
			or	OOO	Patient has "whole body" severe chronic plaque psoriasis with a (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis 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 Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10
		and	0	A PA	ent has tried, but had an inadequate response to, or has experienced intolerable side effects from, at least three of the wing (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin. SI assessment or (DLQI) assessment has been completed for at least the most recent prior treatment course but no er than 1 month following cessation of each prior treatment course and is no more than 1 month old at the time of cation.

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Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Amgevita) - continued	
CONTINUATION – Plaque psoriasis - severe chronic Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) O Patient had "whole body" severe chronic plaque psorias and O The patient has experienced a 75% or more reduct the pre-treatment baseline value or O The patient has a DLQI improvement of 5 or more or	is at the start of treatment ction in PASI score, or is sustained at this level, when compared with e, when compared with the pre-treatment baseline value or palm of a hand or sole of a foot at the start of treatment
slight or better, or sustained at this level, as comp	or more in the skin area affected, or sustained at this level, as
The patient has experienced a reduction of 75% of compared to the pre-treatment baseline value	or more in the skin area affected, or sustained at this level, as DLQI) improvement of 5 or more, as compared to baseline DLQI prior
INITIATION – pyoderma gangrenosum Prerequisites (tick boxes where appropriate) Or Prescribed by, or recommended by a dermatologist, or in accordance Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ
azathioprine, or methotrexate) and not received an adequate	luding a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, response
Note: Indications marked with * are unapproved indications.	

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	RESCRIBER PATIENT:					
Name	lame: Name:					
Ward	:		NHI:			
Adal	imu	mal	o (Amgevita) - continued			
INITI Re-a	ATIC sses equi:	Presson NZ H	Crohn's disease - adults (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital. Patient has severe active Crohn's disease Patient has a CDAI score of greater than or equal to 300 or HBI score of greater than or equal to 10 Patient has extensive small intestine disease affecting more than 50 cm of the small intestine Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection Patient has an ileostomy or colostomy and has intestinal inflammation Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators			
Re-a	sses equi:	smer sites	and corticosteroids DN – Crohn's disease - adults trequired after 2 years (tick boxes where appropriate)			
and			cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.			
	or or	OOO	CDAI score has reduced by 100 points from the CDAI score, or HBI score has reduced 3 points, from when the patient was initiated on adalimumab CDAI score is 150 or less, or HBI is 4 or less The patient has demonstrated an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed			
Re-a	sses equi:	smer sites Preso	Crohn's disease - children It required after 6 months (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.			
and	and	0	Paediatric patient has active Crohn's disease O Patient has a PCDAI score of greater than or equal to 30			
	and	or O	Patient has extensive small intestine disease Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids			

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PRES	CRIBER		PATIENT:	
Name	e:		Name:	
Ward	:		NHI:	
Adal	imuma	b (Amgevita) - continued		
Re-a	ssessme	ON – Crohn's disease - children nt required after 2 years s (tick boxes where appropriate)		
(and) Pres		ccordance with a protocol or guideline that has been endorsed by the Health	
unu	or O	PCDAI score has reduced by 10 points from the PCDAI score	when the patient was initiated on adalimumab	
	or O	PCDAI score is 15 or less		
	O	The patient has demonstrated an adequate response to treatr	ment but PCDAI score cannot be assessed	
INITIATION – Crohn's disease - fistulising Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by to NZ Hospital. Patient has confirmed Crohn's disease and Patient has one or more complex externally draining enterocutaneous fistula(e) or Patient has one or more rectovaginal fistula(e)				
	and	Patient has complex peri-anal fistula A Baseline Fistula Assessment has been completed and is no	o more than 1 month old at the time of application	
CONTINUATION – Crohn's disease - fistulising Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Hean NZ Hospital.				
and	or O	The number of open draining fistulae have decreased from bathere has been a marked reduction in drainage of all fistula(e score, together with less induration and patient-reported pain	e) from baseline as demonstrated by a reduction in the Fistula Assessment	

PRESCRIBER	ESCRIBER PATIENT:				
Name:	ame: Name:				
Ward:	NHI:				
Adalimumab (Am	gevita) - continued				
Re-assessment require Prerequisites (tick book of tick b	exes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health				
and or or	O Patient is 18 years or older and treatment with at least two other immunomodulatory agents has proven ineffective O Patient is under 18 years and treatment with methotrexate has proven ineffective or is not tolerated at a therapeutic dose O Patient is under 8 years and treatment with steroids or methotrexate has proven ineffective or is not tolerated at a therapeutic dose; or disease requires control to prevent irreversible vision loss prior to achieving a therapeutic dose of methotrexate				
Re-assessment require Prerequisites (tick bo	oxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health				
or The part of Follow Nomer uveitic or Follow	atient has had a good clinical response following 12 weeks' initial treatment ring each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis inclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of cystoid macular oedema) ring each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg or steroid drops less than twice daily if under 18 years old				

PRES	RESCRIBER PATIENT:			ATIENT:
Name	e:	: Name:		
Ward	:			IHI:
Ada	limu	ımab	o (Amgevita) - continued	
INIT Re-a	IATIC	ON - Cosmen	Ocular inflammation - severe nt required after 4 months (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accolospital. Patient has had an initial Special Authority approval for infliximate Patient has severe, vision-threatening ocular inflammation Treatment with high-dose steroids (intravenous methineffective at controlling symptoms Patient developed new inflammatory symptoms while or	requiring rapid control lylprednisolone) followed by high dose oral steroids has proven
Re-a	asses equi	Presco NZ Ho	DN – Ocular inflammation - severe nt required after 2 years (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accolospital. The patient has had a good clinical response following 3 initial definitions of the patient has had a since the patient has had a since the patient has had as since the patient had been since	

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCR	IBER		PATIENT:		
Name:			Name:		
Ward:	Vard: NHI:				
Adalim	umab	(Ar	ngevita) - continued		
Re-asse	ssmen iisites	t requ (tick b cribed	besing spondylitis ired after 6 months index appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
		O	Patient has had an initial Special Authority approval for etanercept for ankylosing spondylitis		
	and		O The patient has experienced intolerable side effects		
		or	O The patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis		
or	and	0	Patient has a confirmed diagnosis of ankylosing spondylitis for more than six months		
	and		Patient has low back pain and stiffness that is relieved by exercise but not by rest Patient has bilateral sacroillitis demonstrated by radiology imaging		
	and	0	Patient has not responded adequately to treatment with two or more NSAIDs, while patient was undergoing at least 3 months of a regular exercise regimen for ankylosing spondylitis		
		or	O Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following BASMI measures: a modified Schober's test of less than or equal to 4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right) O Patient has limitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and		
	and	O	A BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological treatment and is no more than 1 month old at the time of application		
Re-asse	ssmen	t requ	nkylosing spondylitis ired after 2 years ox where appropriate)		
O	Preso NZ H		by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.		
and			tions where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point a improvement in BASDAI of 50%, whichever is less		
confirm	that the	aho	re details are correct.		

PRES	SCRII	PATIENT:	
Name	ne:Name:		
Ward	:	NHI:	
Ada	limu	numab (Amgevita) - continued	
INIT Re-a	IATIC usses equi:	TION – Arthritis - oligoarticular course juvenile idiopathic sessment required after 6 months quisites (tick boxes where appropriate) Prescribed by, or recommended by a named specialist or rheumatologist, or in ac by the Health NZ Hospital. The patient has had an initial Special Authority approval for etanerce and Patient has experienced intolerable side effects or Patient has received insufficient benefit to meet the renewal cri	ot for oligoarticular course juvenile idiopathic arthritis (JIA)
	or	To be used as an adjunct to methotrexate therapy or monotherapy with and Patient has had oligoarticular course JIA for 6 months duration or long and At least 2 active joints with limited range of motion, pain or tender maximum tolerated dose) Or Moderate or high disease activity (cJADAS10 score greater that of methotrexate (at the maximum tolerated dose)	ger derness after a 3-month trial of methotrexate (at the
CONTINUATION – Arthritis - oligoarticular course juvenile idiopathic Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Healt NZ Hospital.			h a protocol or guideline that has been endorsed by the Health
and	or	e joint count and an improvement in physician's globaling 30% improvement in active joint count and continued	

I confirm that the above details are correct:	
Signed:	Date:

PRES	SCRII	BER		PATIENT:			
Name	ə:						
Ward	:			NHI:			
Ada	Adalimumab (Amgevita) - continued						
Re-a	equis	sment sites (Presc	requ tick b ribed	tis - polyarticular course juvenile idiopathic lired after 6 months looxes where appropriate) by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed lith NZ Hospital.			
		and	0	Patient has had an initial Special Authority approval for etanercept for polyarticular course juvenile idiopathic arthritis (JIA)			
			or	O Patient has experienced intolerable side effects O Patient has received insufficient benefit to meet the renewal criteria for polyarticular course JIA			
	or	and	\circ	To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance Patient has had polyarticular course JIA for 6 months duration or longer Ohat least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose) Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose) Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate			
CONTINUATION – Arthritis - polyarticular course juvenile idiopathic Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) Orescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endors NZ Hospital.							
Following initial treatment, the patient has at least a 50% decrease in active joint count and an impassessment from baseline			asse: On s	ubsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued			
-							

I confirm that the above details are correct:		
Signed:	Date:	

PRESCRIBER			:R		PATIENT:	
Name:						
Ward:			NHI:			
Adalir	nun	nab	(An	ıgev	ita) - continued	
Re-ass	sessn quisi t Pr	nent i tes (ti	requick b	red a	soriatic riter 6 months where appropriate) recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
		and	С	Patie	nt has had an initial Special Authority approval for etanercept or secukinumab for psoriatic arthritis	
			or	O O	Patient has experienced intolerable side effects Patient has received insufficient benefit to meet the renewal criteria for psoriatic arthritis	
ď	or		_			
		and and and)))	Patie Patie	Int has had active psoriatic arthritis for six months duration or longer Int has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated) Int has tried and not responded to at least three months of sulfasalazine or leflunomide at maximum tolerated doses see contraindicated)	
			or	0	Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints 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	or or	O O O	Patient has CRP level greater than 15 mg/L measured no more than one month prior to the date of this application Patient has an elevated ESR greater than 25 mm per hour 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	
Re-ass	sessn quisi t	nent i tes (ti	requi	red a	recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health	
and		Z Hos			recommended by any relevant practitioner, or in accordance with a protocor or guideline that has been endorsed by the rhealth	
	response in the opinion of the physician or				nonstrates at least a continuing 30% improvement in swollen joint count from baseline and a clinically significant response	

I confirm that the above details are correct:

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PRESC	CRIBE	R		PATIENT:	PATIENT:		
Name:							
Ward: NHI:							
Adaliı	mum	nab ((Arr	gevita) - continued			
Re-ass	sessn quisit) Pr	nent r es (ti	equi ck bo bed l	s - rheumatoid ed after 6 months ees where appropriate) y, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ			
		and		he patient has had an initial Special Authority approval for etanercept for rheumatoid arthritis			
			or	The patient has experienced intolerable side effects			
				The patient has received insufficient benefit from etanercept to meet the renewal criteria for rheumatoid arthritis			
	or						
		and (\sim	Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) intibody positive) for six months duration or longer reatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity intolerance			
and				Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated	i)		
			Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquiphate at maximum tolerated doses (unless contraindicated)	luine			
			or	Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin			
			<u>.</u>	Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate			
		and		Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen 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			
					<u>၂</u>		
Re-ass	sessn	nent r	equi	hritis - rheumatoid ed after 2 years			
Prerec	quisit	es (ti	ck b	xes where appropriate)			
and		escril Z Hos		y, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Healt	th		
	or (ng initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant se to treatment in the opinion of the physician			
				sequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and ally significant response to treatment in the opinion of the physician			

I confirm that the above details are correct:

PRESCRIBER			PATIENT:
Name	e:		
Ward	:		NHI:
Adal	imu	ımab (Amgevita) - continued
	equi	sites (tic	's disease - adult-onset (AOSD) k boxes where appropriate) ed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and		Hospital	
		and	The patient has had an initial Special Authority approval for etanercept and/or tocilizumab for (AOSD)
			O Patient has experienced intolerable side effects from etanercept and/or tocilizumab Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab
			Patient has received insulincient benefit from at least a timee-month that of etanercept and/or tocilizumab
	or	and	Patient diagnosed with AOSD according to the Yamaguchi criteria
		and	Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, NSAIDs and methotrexate
		and	Patient has persistent symptoms of disabling poorly controlled and active disease
and		Prescrib NZ Hosp	ed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ital.
	and	_	tient has active ulcerative colitis
		or	Patient's SCCAI score is greater than or equal to 4
			Patient's PUCAI score is greater than or equal to 20
	and	O Pa	tient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators d systemic corticosteroids
	and	\sim	rgery (or further surgery) is considered to be clinically inappropriate
Re-a	sses	sment re	- ulcerative colitis quired after 2 years k boxes where appropriate)
and	C	Prescrib NZ Hosp	ed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ital.
	or	O Th	e SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on biologic therapy
		O Th	e PUCAI score has reduced by 10 points or more from the PUCAI score when the patient was initiated on biologic therapy
-			

I confirm that the above details are correct:

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	CRII	BER	PATIENT:				
Name	:						
Ward			NHI:				
Adal	imu	mal	(Amgevita) - continued				
Re-a	sses	smer	ndifferentiated spondyloarthiritis required after 6 months tick boxes where appropriate)				
and		Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					
	and		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				
	and	0	Patient has tried and not responded to at least three months of each of methotrexate, sulphasalazine and leflunomide, at maximum tolerated doses (unless contraindicated)				
		or	O Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application				
		or	Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this application				
			O 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				
Note	: Ind	icatio	ns marked with * are unapproved indications.				
	equis	sites Preso	required after 2 years tick boxes where appropriate) ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital. Following 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 The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response in the opinion of the treating physician				
INITIATION – inflammatory bowel arthritis – axial Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)							
and		Preso Hosp	ribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal.				
unu	and		Patient has a diagnosis of active ulcerative colitis or active Crohn's disease				
	and	0	Patient has axial inflammatory pain for six months or more Patient is unable to take NSAIDs				
	and	0	Patient has unequivocal sacroiliitis demonstrated by radiological imaging or MRI				
	and	\circ	Patient has not responded adequately to prior treatment consisting of at least 3 months of an exercise regime supervised by a physiotherapist				
	4110	O	A BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological treatment				

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PRESCRIBER		PATIENT:				
Name:		Name:				
Ward:		NHI:				
Adalimumab (Am	ngevita) - continued					
Re-assessment requi	nflammatory bowel arthritis – axial ired after 2 years ox where appropriate)					
\circ	by, or recommended by any relevant practitioner, or in a	ccordance with a protocol or guideline that has been endorsed by the Health				
	tment has resulted in an improvement in BASDAI of 4 or nt in BASDAI of 50%, whichever is less	r more points from pre-treatment baseline on a 10 point scale, or an				
Re-assessment requi	oxes where appropriate)	nce with a protocol or guideline that has been endorsed by the Health NZ				
and Patier sterno and Patier dose and Patier	oclavicular Int has tried and not experienced a response to at least the (unless contraindicated) Int has tried and not experienced a response to at least the laindicated)	ving: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, hree months of methotrexate, or azathioprine at a maximum tolerated hree months of sulphasalazine at a maximum tolerated dose (unless				
or O	Patient has an ESR greater than 25 mm per hour	d no more than one month prior to the date of this application elving prednisone therapy at a dose of greater than 5 mg per day and				
CONTINUATION – inflammatory bowel arthritis – peripheral Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)						
Prescribed NZ Hospital		ccordance with a protocol or guideline that has been endorsed by the Health				
or respo	onse to treatment in the opinion of the physician	rease in active joint count from baseline and a clinically significant in active joint count from baseline in the opinion of the treating physician				