RS2063 - Adalimumab (Amgevita)

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Chambion and Sports, San Lines	

PRES	CRIBER	PATIENT:			
Name:		Name:			
Ward:		NHI:			
Adali	mumab (Amgevita)				
	ATION – Behcet's disease - severe equisites (tick boxes where appropriate)				
and	Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	ecordance with a protocol or guideline that has been endorsed by the Health			
	O The patient has severe Behcet's disease* that is significantly in and	mpacting the patient's quality of life			
	The patient has severe ocular, neurological, and/or vasor treatment(s) appropriate for the particular symptom(s)	culitic symptoms and has not responded adequately to one or more			
		and/or mucocutaneous symptoms and has not responded adequately symptom(s)			
Note:	Indications marked with * are unapproved indications.				
Re-as	Hospital. O Patient has hidradenitis suppurativa Hurley Stage II or Hurley and	a 90 day trial of systemic antibiotics or patient has demonstrated			
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					
	O The patient has a reduction in active lesions (e.g. inflammator and O The patient has a DLQI improvement of 4 or more from baseling	ry nodules, abscesses, draining fistulae) of 25% or more from baseline			

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

ESCRI	BER			PA	TIENT:
me:				Na	me:
ırd:				NF	II:
lalimu	ımab	(An	ngev	r ita) - continued	
e-asses	ssment	requ	ired a	riasis - severe chronic fter 4 months where appropriate)	
	Presci Hospit		by, or	recommended by a dermatologist, or in accordance wi	th a protocol or guideline that has been endorsed by the Health NZ
	and	O	Patie	ent has had an initial Special Authority approval for etan	ercept for severe chronic plaque psoriasis
		or	0	Patient has experienced intolerable side effects	
			0	Patient has received insufficient benefit to meet the re	newal criteria for etanercept for severe chronic plaque psoriasis
or				4	
			0	Patient has "whole body" severe chronic plaque psoria been present for at least 6 months from the time of ini	asis with a (PASI) score of greater than 10, where lesions have tial diagnosis
		or	0	Patient has severe chronic plaque psoriasis of the fac- have been present for at least 6 months from the time	e, or palm of a hand or sole of a foot, where the plaque or plaques of initial diagnosis
		or	0	Patient has severe chronic localised genital or flexural	plaque psoriasis where the plaques or lesions have been present and with a Dermatology Life Quality Index (DLQI) score greater
	and	0			experienced intolerable side effects from, at least three of the ed): phototherapy, methotrexate, ciclosporin, or acitretin
		0	longe		eted for at least the most recent prior treatment course but no nent course and is no more than 1 month old at the time of

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.

PRE	PRESCRIBER PATIENT:					
Name: Name:				Name:		
Ward	Ward: NHI:					
Ada	limur	nab	(An	ngev	ita) - continued	
Re-a	assess	ment ı	equi	ired at	psoriasis - severe chronic tter 2 years where appropriate)	
		(and	С	Patie	nt had "whole body" severe chronic plaque psoriasis at the start of treatment	
			or	0	The patient has experienced a 75% or more reduction in PASI score, or is sustained at this level, when compared with the pre-treatment baseline value	
			UI.	0	The patient has a DLQI improvement of 5 or more, when compared with the pre-treatment baseline value	
	or					
		and	C	Patie	nt had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment	
			or	0	The patient has experienced a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values	
				0	The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value	
	or					
		and	C	Patie	nt had severe chronic localised genital or flexural plaque psoriasis at the start of treatment	
			or	0	The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value	
			Ů.	0	Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing adalimumab	
				_	angrenosum 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.				recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
and	O Patient has pyoderma gangrenosum*				pyoderma gangrenosum*	
	(received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, e, or methotrexate) and not received an adequate response	
Note	e: Indic	cations	ma	rked v	vith * are unapproved indications.	

I confirm that the above details are correct:

Signed: Date:

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PRES	CRII	BER	PATIENT:
Name	:		
Ward:			NHI:
Adal	imu	mal	b (Amgevita) - continued
Re-a	ssess equis	smer sites Prese	Crohn's disease - adults nt 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 Hospital.
	and	0	Patient has severe active Crohn's disease
		or or	O Patient has extensive small intestine disease affecting more than 50 cm of the small intestine
		or	
	and	0	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids
Re-a	ssess equis	smer sites Prese	ON – Crohn's disease - adults nt required after 2 years (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 Hospital. 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
			Crohn's disease - children nt required after 6 months
Prer	equis	sites Prese	(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 dospital.
and	and	O	Paediatric patient has active Crohn's disease
		or	O Patient has a PCDAI score of greater than or equal to 30 O Patient has extensive small intestine disease
	and		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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PRESCRIBER	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Adalimumab (Amgevita) - continued					
CONTINUATION – Crohn's disease - children Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital. and	ccordance with a protocol or guideline that has been endorsed by the Health				
O PCDAI score has reduced by 10 points from the PCDAI score or O PCDAI score is 15 or less or	when the patient was initiated on adalimumab				
O The patient has demonstrated an adequate response to treat	ment but PCDAI score cannot be assessed				
NZ Hospital. Patient has confirmed Crohn's disease and Patient has one or more complex externally draining en or Patient has one or more rectovaginal fistula(e) or Patient has complex peri-anal fistula and A Baseline Fistula Assessment has been completed and is no					
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 Healt NZ Hospital. and					
O The number of open draining fistulae have decreased from ba	e) from baseline as demonstrated by a reduction in the Fistula Assessment				

PRES	CRI	BER	PATIENT:	
Name	ame: Name:			
Ward:	:		NHI:	
Adal	imu	ımab	(Amgevita) - continued	
Re-a	sses equi	sment sites (t Prescr NZ Ho	cular inflammation - chronic required after 4 months 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 spital. The patient has had an initial Special Authority approval for infliximab for chronic ocular inflammation	
		and	Patient has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision loss Patient is 18 years or older and treatment with at least two other immunomodulatory agents has proven ineffective or Patient is under 18 years and treatment with methotrexate has proven ineffective or is not tolerated at a therapeutic dose 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-a	sses equi	sment sites (t	N – Ocular inflammation - chronic 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 applial.	
u IV	or or	0 !	The patient has had a good clinical response following 12 weeks' initial treatment Following each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)	
			Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old	

PRESCRIBER			F	ATIENT:
Name	me: Name:			lame:
Ward	:		N	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 as	

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.

PRESC	RIBE	ĒR		PATIENT:
Name:				
Ward:				NHI:
Adalir	num	nab (An	ngevita) - continued
Re-ass	sessn	nent r	equi	red after 6 months oxes where appropriate)
and		rescrik ospita		by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and)	Patient has had an initial Special Authority approval for etanercept for ankylosing spondylitis
			or	O The patient has experienced intolerable side effects
				O The patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis
		and (and and and and and and and	O O O O O O O O O O O O O O O O O O O	Patient has a confirmed diagnosis of ankylosing spondylitis for more than six months Patient has low back pain and stiffness that is relieved by exercise but not by rest Patient has bilateral sacroiliitis demonstrated by radiology imaging 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 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 gender 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-ass	essn quisit Pr N2	nent retes (tid rescrik Z Hos or app	equi ck b bed pita	nkylosing spondylitis red after 2 years ox where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health l. icions where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point improvement in BASDAI of 50%, whichever is less

I confirm that the above details are correct:

Signed: Date:

PRES	SCRI	BER	PATIENT:
Name	e:		Name:
Ward	:		NHI:
Adal	limu	ımab (A	ngevita) - continued
Re-a	equi:	sment red sites (tick Prescribe	tis - oligoarticular course juvenile idiopathic ired after 6 months loxes where appropriate) by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed th NZ Hospital.
	or	and and and	The patient has had an initial Special Authority approval for etanercept for oligoarticular course juvenile idiopathic arthritis (JIA) O Patient has experienced intolerable side effects O Patient has received insufficient benefit to meet the renewal criteria for oligoarticular course JIA To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance Patient has had oligoarticular course JIA for 6 months duration or longer
			At least 2 active 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 greater than 1.5) with poor prognostic features after a 3-month trial of methotrexate (at the maximum tolerated dose)
Re-a	sses	sment red	arthritis - oligoarticular course juvenile idiopathic ired after 2 years oxes where appropriate)
and		Prescribe NZ Hosp	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.
-	or	On On	wing initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global ssment from baseline subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued overnent in physician's global assessment from baseline

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

PRES	SCRIE	BER			PATIENT:
Name	э:				
Ward	:				NHI:
Ada	limu	mab	(An	nge	evita) - continued
Re-a	equis	sment sites (t Prescri	requ ick b bed	ired oxe by,	polyarticular course juvenile idiopathic after 6 months s where appropriate) or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed IZ Hospital.
		and	0	Pat	tient has had an initial Special Authority approval for etanercept for polyarticular course juvenile idiopathic arthritis (JIA)
			or	C	Patient has experienced intolerable side effects Patient has received insufficient benefit to meet the renewal criteria for polyarticular course JIA
	or	and	O or or		be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance tient has had polyarticular course JIA for 6 months duration or longer At 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
Re-a	sses	sment	requ	ired	ritis - polyarticular course juvenile idiopathic after 2 years s where appropriate)
and		Prescri NZ Hos			or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
	or	0 0	isses On si	ubse	g initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global ent from baseline equent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued ment in physician's global assessment from baseline

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

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PRES	SCRIB	ER		PATIENT:	
Name	e:			Name:	
Ward	:			NHI:	
Adal	imur	mab	(An	gevita) - continued	
Re-a	ssess equis	ment ites (t	requi ick b bed	s - psoriatic ed after 6 months xes where appropriate) y, or recommended by a rheumatologist, or in accordance with a protocol or o	guideline that has been endorsed by the Health NZ
		and	С	Patient has had an initial Special Authority approval for etanercept or secuking	umab for psoriatic arthritis
			or	O Patient has experienced intolerable side effects	
			<u> </u>	O Patient has received insufficient benefit to meet the renewal criteria for patient has received insufficient benefit to meet the renewal criteria for patient has received insufficient benefit to meet the renewal criteria for patient has received insufficient benefit to meet the renewal criteria for patient has received insufficient benefit to meet the renewal criteria for patient benefit to meet the renewal criteria for pat	osoriatic arthritis
	or				
		and	C C	Patient has had active psoriatic arthritis for six months duration or longer Patient has tried and not responded to at least three months of methotrexate a	
		and	J	Patient has tried and not responded to at least three months of sulfasalazine ounless contraindicated)	or leflunomide at maximum tolerated doses
			or	Patient has persistent symptoms of poorly controlled and active disease	-
				Patient has persistent symptoms of poorly controlled and active disease elbow, knee, ankle, and either shoulder or hip	e in at least four joints from the following: wrist,
		and		O Patient has CRP level greater than 15 mg/L measured no more than on	e month prior to the date of this application
			or	O Patient has an elevated ESR greater than 25 mm per hour	
			Ů.	ESR and CRP not measured as patient is currently receiving prednison and has done so for more than three months	e therapy at a dose of greater than 5 mg per day
Re-a	ssess	ment	requi	thritis - psoriatic ed after 2 years xes where appropriate)	
and		Prescri NZ Hos		y, or recommended by any relevant practitioner, or in accordance with a proto	col or guideline that has been endorsed by the Health
	or			ing initial treatment, the patient has at least a 50% decrease in swollen joint o se in the opinion of the physician	ount from baseline and a clinically significant
	(demonstrates at least a continuing 30% improvement in swollen joint count opinion of the treating physician	from baseline and a clinically significant response

I confirm that the above details are correct:

Signed: Date:

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RIBER		PATIENT:	
		Name:	
		NHI:	
umal	o (An	Amgevita) - continued	
ION – A essmer uisites	Arthrit It requ (tick b	thritis - rheumatoid equired after 6 months ck boxes where appropriate)	that has been endorsed by the Health NZ
an	O	The patient has had an initial Special Authority approval for etanercept for rheumatoid a	arthritis
	or	O The patient has experienced intolerable side effects	
		O The patient has received insufficient benefit from etanercept to meet the renewal	criteria for rheumatoid arthritis
an	O d O	Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patie antibody positive) for six months duration or longer Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use or intolerance.	
	O	Patient has tried and not responded to at least three months of methotrexate at a maxim	num tolerated dose (unless contraindicated)
an	d	Patient has tried and not responded to at least three months of methotrexate in combina sulphate at maximum tolerated doses (unless contraindicated)	ation with sulfasalazine and hydroxychloroquir
	or	O Patient has tried and not responded to at least three months of methotrexate in codose of ciclosporin	ombination with the maximum tolerated
		Patient has tried and not responded to at least three months of therapy at the man alone or in combination with methotrexate	ximum tolerated dose of leflunomide
an		O Patient has persistent symptoms of poorly controlled and active disease in at leas	st 15 swollen joints
	or	O Patient has persistent symptoms of poorly controlled and active disease in at leas elbow, knee, ankle, and either shoulder or hip	st four joints from the following: wrist,
essmer	t requ	equired after 2 years	
			deline that has been endorsed by the Health
			paseline and a clinically significant
0			ent in active joint count from baseline and
	an aisites	and	Name: NHI: NHI NHI

I confirm that the above details are correct:

Signed: Date:

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	CRI	BER	PATIENT:
Name	e:		
Ward	·		NHI:
Adal	imu	ımab (Ar	ngevita) - continued
	equi	sites (tick b	disease - adult-onset (AOSD) boxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		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
	or		O Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab
	Or	and o	Patient diagnosed with AOSD according to the Yamaguchi criteria 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 Patient has persistent symptoms of disabling poorly controlled and active disease
	equi	Prescribed NZ Hospita	uired after 6 months poxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al. ent has active ulcerative colitis
	and	or O	Patient's SCCAI score is greater than or equal to 4 Patient's PUCAI score is greater than or equal to 20
	and	and:	ent has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators systemic corticosteroids ery (or further surgery) is considered to be clinically inappropriate
Re-a	sses equi	sment requ	ulcerative colitis uired after 2 years coxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.
unu	or	\circ	SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on biologic therapy 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:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	CRI	BER	PATIENT:				
Name	e:						
Ward	:		NHI:				
Adal	imu	ımak	(Amgevita) - continued				
Re-a	sses equi:	smen sites	ndifferentiated spondyloarthiritis required after 6 months tick boxes where appropriate)				
and		Preso	ibed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorse al.	d by the Health NZ			
	anc		Patient has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the follow wrist, elbow, knee, ankle, and either shoulder or hip				
	and	O 1	Patient has tried and not responded to at least three months of each of methotrexate, sulphasalazine and leflunomic tolerated doses (unless contraindicated)	de, at maximum			
		or	O Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this app	lication			
		or	O Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this	application			
			ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 has done so for more than three months	mg per day and			
Note	: Ind	licatio	s marked with * are unapproved indications.				
Re-a	sses equi:	smen sites Preso	N – undifferentiated spondyloarthiritis required after 2 years tick boxes where appropriate) ibed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been espital.				
	or	0	Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically 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				
			response in the opinion of the treating physician				
Re-a	sses	smen	flammatory bowel arthritis – axial required after 6 months tick boxes where appropriate)				
and		Preso Hosp	ibed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorse al.	d by the Health NZ			
	anc	\circ	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				
	anc		Patient is unable to take NSAIDs				
	and		Patient has unequivocal sacroiliitis demonstrated by radiological imaging or MRI				
	and) 1	Patient has not responded adequately to prior treatment consisting of at least 3 months of an exercise regime supe ohysiotherapist	rvised by a			
		0	A BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous treatment	s pharmacological			

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	CRIBER PATIENT:
	: Name:
	NHI:
	imumab (Amgevita) - continued
	TINUATION – inflammatory bowel arthritis – axial ssessment required after 2 years
	equisites (tick box where appropriate)
sed by the Health	Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by NZ Hospital.
ale, or an	Where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or improvement in BASDAI of 50%, whichever is less
	ATION – inflammatory bowel arthritis – peripheral ssessment required after 6 months
	equisites (tick boxes where appropriate)
the Health NZ	Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the He Hospital.
	O Patient has a diagnosis of active ulcerative colitis or active Crohn's disease and
w, shoulder,	Patient has active arthritis in at least four joints from the following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, show sternoclavicular
n tolerated	O Patient has tried and not experienced a response to at least three months of methotrexate, or azathioprine at a maximum tolera dose (unless contraindicated) and
se (unless	Patient has tried and not experienced a response to at least three months of sulphasalazine at a maximum tolerated dose (unle contraindicated) and
on	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
	O Patient has an ESR greater than 25 mm per hour or
er day and	ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day has done so for more than three months
	TINUATION – inflammatory bowel arthritis – peripheral ssessment required after 2 years equisites (tick boxes where appropriate)
sed by the Health	Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by NZ Hospital.
nificant	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
ating physician	O Patient demonstrates at least a continuing 30% improvement in active joint count from baseline in the opinion of the treating ph
	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