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:   |
| Upadacitinib   |  |
| Hospital.  The patient has had an initial Special Authority approval for an and  The patient has experienced intolerable side effects from the patient has received insufficient benefit from at least not meet the renewal criteria for rheumatoid arthritis and  The patient is seronegative for both anti-cyclic citrullination  The patient has been started on rituximab for rhe and  The patient has experienced intolerable side or  At four months following the initial course of do not meet the renewal criteria for rheumannian. | dalimumab and/or etanercept for rheumatoid arthritis  m adalimumab and/or etanercept et a three-month trial of adalimumab and/or etanercept such that they do  ted peptide (CCP) antibodies and rheumatoid factor  umatoid arthritis in a Health NZ Hospital e effects from rituximab f rituximab the patient has received insufficient benefit such that they |
| CONTINUATION – Rheumatoid Arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)   |  |
| O Prescribed by, or recommended by a rheumatologist, or in accordar Hospital.  | nce with a protocol or guideline that has been endorsed by the Health NZ   |
| significant response to treatment in the opinion of the physicial or   | ast a continuing 30% improvement in active joint count from baseline and   |
|  |  |