RS2063 - Adalimumab (Amgevita)

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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.

PRES	ESCRIBER PATIENT:				
Name	ame: Name:				
Ward	:	NHI:			
Adal	imuma	ab (Amgevita)			
		- Behcet's disease - severe s (tick boxes where appropriate)			
(and	O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the He NZ Hospital.				
una	and _	The patient has severe Behcet's disease* that is significantly impact	ng the patient's quality of life		
	ď		ymptoms and has not responded adequately to one or more r mucocutaneous symptoms and has not responded adequately		
		to two or more treatments appropriate for the particular symptom			
Note	: Indicat	ions marked with * are unapproved indications.			
Re-a	ssessme equisite Pre	- Hidradenitis suppurativa ent required after 4 months s (tick boxes where appropriate) scribed by, or recommended by a dermatologist, or in accordance with spital.	a protocol or guideline that has been endorsed by the Health NZ		
	and and	Patient has hidradenitis suppurativa Hurley Stage II or Hurley Stage Patient has tried, but had an inadequate response to at least a 90 d 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	e than 1 month old at time of application		
Re-a	ssessme equisite Pre	ION – Hidradenitis suppurativa ent required after 2 years s (tick boxes where appropriate) scribed by, or recommended by any relevant practitioner, or in accorda Hospital.	nce with a protocol or guideline that has been endorsed by the Health		
aa	and	The patient has a reduction in active lesions (e.g. inflammatory nod The patient has a DLQI improvement of 4 or more from baseline	ules, abscesses, draining fistulae) of 25% or more from baseline		

PRES	CRIB	ER			PATIENT:
Name	:				
Ward:					NHI:
Adal	imur	nab	(An	ngev	ita) - continued
Re-a	INITIATION – Plaque psoriasis - severe chronic Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)				
(and		Prescri Hospita		by, or	recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and	C	Patie	ent has had an initial Special Authority approval for etanercept for severe chronic plaque psoriasis
			or	0	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 or	0	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
		and (and	_ Э Э	follov	than 10 In that tried, but had an inadequate response to, or has experienced intolerable side effects from, at least three of the ving (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

PRESCRIBER PATIENT:				PATIENT:		
Name: Name:			Name:			
Ward:	/ard:NHI:					
Adal	imur	nab (A	mgev	rita) - continued		
CON	TINU	ATION –	Plaque	psoriasis - severe chronic		
			-	fter 2 years where appropriate)		
		and) Patie	ent had "whole body" severe chronic plaque psoriasis at the start of treatment		
			or O	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		
			0	The patient has a DLQI improvement of 5 or more, when compared with the pre-treatment baseline value		
	or					
		and _	Patie	ent had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment		
			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		
			or O	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) Patie	ent had severe chronic localised genital or flexural plaque psoriasis at the start of treatment		
			or O	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		
				Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing adalimumab		
				gangrenosum where appropriate)		
(`	`				
		rescribe Iospital.	a by, oi	recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
and	(O Pat	ient has	s pyoderma gangrenosum*		
	and (s received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, i.e., or methotrexate) and not received an adequate response		
Note	Indic	ations n	narked	with * are unapproved indications.		

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

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.

PRES	CRII	BER	PATIENT:
Name	e:		
Ward	:		NHI:
Adal	imu	mal	o (Amgevita) - continued
INITI Re-a	ATIO ssess equis	Pressive NZ H	Crohn's disease - adults t 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. 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
			and corticosteroids
Re-a	ssess equis	smer sites Preso	N – Crohn's disease - adults t 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 ospital. 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	ssess equis	smer sites Preso	Crohn's disease - children t 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	O	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 tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids

I confirm that the above details are correct:

Signed: Date:

August 2025

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:			
lame:				
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 O PCDAI score has reduced by 10 points from the PCDAI score	ccordance with a protocol or guideline that has been endorsed by the Health			
or O PCDAI score is 15 or less or O The patient has demonstrated an adequate response to treat				
INITIATION – Crohn's disease - fistulising Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Or Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health			
Patient has confirmed Crohn's disease				
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	terocutaneous fistula(e)			
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 a NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health			
O The number of open draining fistulae have decreased from be or O There 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			

I confirm that the above details are correct:

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Signeg	 Date	

PRES	ESCRIBER PATIENT:				
Name	ne: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.		
	The patient has had a good clinical response following 12 weeks' initial treatment 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 Uveit Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolut 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		

August 2025

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Amgevita) - continued	
INITIATION – Ocular inflammation - severe Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	ccordance with a protocol or guideline that has been endorsed by the Health
and Patient has had an initial Special Authority approval for inflixing or Patient has had an initial Special Authority approval for inflixing or Patient has had an initial Special Authority approval for inflixing or Patient has had an initial Special Authority approval for inflixing or Patient has had an initial Special Authority approval for inflixing or Patient has had an initial Special Authority approval for inflixing or Patient has had an initial Special Authority approval for inflixing or Patient has had an initial Special Authority approval for inflixing or Patient has had an initial Special Authority approval for inflixing or Patient has had an initial Special Authority approval for inflixing or Patient has had an initial Special Authority approval for inflixing or Patient has had an initial Special Authority approval for inflixing or Patient had a patient had a patient had been approval for the patient had a patient had a patient had been approval for the patient had ben approval for the patient had been approval for the patient had	nab for severe ocular inflammation
Patient has severe, vision-threatening ocular inflammati	on requiring rapid control
or O Patient developed new inflammatory symptoms w	ethylprednisolone) followed by high dose oral steroids has proven thile receiving high dose steroids high dose oral steroids and other immunosuppressants has proven
CONTINUATION – Ocular inflammation - severe Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in an NZ Hospital.	ocordance with a protocol or guideline that has been endorsed by the Health
Nomenclature (SUN) criteria < ½+ anterior chamber or vitreor uveitic cystoid macular oedema)	a sustained reduction in inflammation (Standardisation of Uveitis us cells, absence of active vitreous or retinal lesions, or resolution of
Following each 2 year treatment period, the patient has a sus daily, or steroid drops less than twice daily if under 18 years of the steroid drops less than twith the steroid drops less than twice daily if under 18 y	tained steroid sparing effect, allowing reduction in prednisone to < 10mg

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

PRESCRI	BER	PATIENT:
Name:		
Ward:		NHI:
Adalimu	ımab (Aı	mgevita) - continued
Re-asses Prerequi	sment requestes (tick	losing spondylitis uired after 6 months boxes where appropriate) d 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
	OI	
		The patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis
or	and and on and and and	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 sacroillitis 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-asses	sment requ	ankylosing spondylitis uired after 2 years box where appropriate)
Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been NZ Hospital.		by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.
		ations where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point in improvement in BASDAI of 50%, whichever is less

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PRES	SCRI	RIBER PA	TIENT:		
Name	e:	N:	ıme:		
Ward	:	N	H:		
Ada	limu	numab (Amgevita) - continued			
INIT Re-a	IATIC asses equi	Prescribed by, or recommended by a named specialist or rheumatologic by the Health NZ Hospital. The patient has had an initial Special Authority approval for and Patient has received insufficient benefit to meet the received and Patient has had oligoarticular course JIA for 6 months dura and	etanercept for oligoarticular course juvenile idiopathic arthritis (JIA) enewal criteria for oligoarticular course JIA nerapy where use of methotrexate is limited by toxicity or intolerance ion or longer		
		or maximum tolerated dose)	reater than 1.5) with poor prognostic features after a 3-month trial		
CON	ITINU	NUATION – Arthritis - oligoarticular course juvenile idiopathic			
Re-a	sses	essment required after 2 years uisites (tick boxes where appropriate)			
and		Prescribed by, or recommended by any relevant practitioner, or in accornZ Hospital.	dance with a protocol or guideline that has been endorsed by the Health		
	or	Following initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline			
		On subsequent reapplications, the patient demonstrates at least a improvement in physician's global assessment from baseline	a continuing 30% improvement in active joint count and continued		

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER						PATIENT:
Name:						
Ward	:					NHI:
Adal	limu	mab	(An	ng	evi	ta) - continued
Re-a	equis	sment sites (t Prescri	requ ick b ibed	ire ox by,	d aft es w or r	lyarticular course juvenile idiopathic er 6 months here appropriate) ecommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed Hospital.
		and	0	Pa	atier	t has had an initial Special Authority approval for etanercept for polyarticular course juvenile idiopathic arthritis (JIA)
		dilu	or	(_	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		atier	used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance it 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	equi:	sment sites (t Prescri	requ ick b ibed	ired Oxe by,	d aft es w	s - polyarticular course juvenile idiopathic er 2 years here appropriate) ecommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
and	NZ Hospital. and					
	or	O^{ϵ}	asse: On si	ssn ubs	nent equ	tial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global from baseline ent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued t in physician's global assessment from baseline

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

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PRESCRIBER					PATIENT:		
Name:							
Ward	Vard:NHI:						
Adal	imu	mab	(An	ngev	ita) - continued		
Re-a	sses equi:	sment sites (t	requi ick b bed	red a oxes	soriatic fter 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	\bigcirc	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		
	or		$\overline{}$				
		and		Patie Patie	and has had active psoriatic arthritis for six months duration or longer and has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated) and has tried and not responded to at least three months of sulfasalazine or leflunomide at maximum tolerated doses as contraindicated)		
		and	or	O O	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-a	sses equi:	sment sites (t	requi ick b	red a	is - psoriatic fter 2 years where appropriate)		
and		Prescri NZ Hos			recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health		
	or				nitial treatment, the patient has at least a 50% decrease in swollen joint count from baseline and a clinically significant in the opinion of the physician		
					nonstrates at least a continuing 30% improvement in swollen joint count from baseline and a clinically significant response on of the treating physician		

I confirm that the above details are correct:

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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.

PATIENT:
NHI:
gevita) - continued
redumatoid after 6 months res where appropriate) y, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
he patient has had an initial Special Authority approval for etanercept for rheumatoid arthritis
The patient has experienced intolerable side effects The patient has received insufficient benefit from etanercept to meet the renewal criteria for rheumatoid arthritis
reatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity r intolerance ratient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated)
Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide
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
hritis - rheumatoid ad after 2 years wes where appropriate) or, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health and initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant see 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:

Signed: Date:

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	SCRI	BER	PATIENT:
Name	e:		
Ward	:		NHI:
Ada	limu	ımab (Aı	mgevita) - continued
		sites (tick l	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	
	or	0	Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab 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
			Patient has persistent symptoms of disabling poorly controlled and active disease
Re-a	equi	Prescribed NZ Hospital Or Or O	ative colitis uired after 6 months boxes where appropriate) It by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al. The patient's SCCAI score is greater than or equal to 4 Patient's PUCAI score is greater than or equal to 20 The patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators
	and	and	systemic corticosteroids gery (or further surgery) is considered to be clinically inappropriate
Re-a	equi	sment requ	ulcerative colitis uired after 2 years boxes where appropriate) I 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		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

PRESCRIBER			PATIENT:	PATIENT:		
Name	e:					
Ward	:		NHI:			
Adal	imu	ımak	(Amgevita) - continued			
Re-a	sses equi:	smen sites	differentiated spondyloarthiritis required after 6 months ck boxes where appropriate)			
and		Preso Hosp	bed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Heali al.	h NZ		
	anc		ratient has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the following rist, elbow, knee, ankle, and either shoulder or hip	g:		
	and	0	ratient has tried and not responded to at least three months of each of methotrexate, sulphasalazine and leflunomide, at maximular doses (unless contraindicated)	m		
		or	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			
			SSR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day ar has done so for more than three months	ıd		
Note	: Ind	licatio	marked with * are unapproved indications.			
Re-a	sses equi:	smen sites Preso	- undifferentiated spondyloarthiritis required after 2 years ck boxes where appropriate) bed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the spital.	e Health		
	or	0	following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant esponse 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			
			esponse in the opinion of the treating physician			
Re-a	sses equi:	smen sites	equired after 6 months ck boxes where appropriate)			
and		Preso	bed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Healtal.	th NZ		
	anc	\circ	atient has a diagnosis of active ulcerative colitis or active Crohn's disease			
	and	0	atient has axial inflammatory pain for six months or more			
	and		ratient is unable to take NSAIDs			
	and		atient has unequivocal sacroiliitis demonstrated by radiological imaging or MRI atient has not responded adequately to prior treatment consisting of at least 3 months of an exercise regime supervised by a			
	and	i	hysiotherapist	rical		
			BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological ment	Jicai		

PRESC	RIBER	PATIENT:		
Name:		Name:		
Ward:		. NHI:		
Adalir	numab (Amgevita) - continued			
CONT Re-ass	NUATION – inflammatory bowel arthritis – axial essment required after 2 years uisites (tick box where appropriate) Prescribed by, or recommended by any relevant practitioner, or in NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health or more points from pre-treatment baseline on a 10 point scale, or an		
Prerect and	Hospital. Patient has a diagnosis of active ulcerative colitis or active Cond Patient has active arthritis in at least four joints from the followsternoclavicular Patient has tried and not experienced a response to at least dose (unless contraindicated)	crohn's disease owing: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, three months of methotrexate, or azathioprine at a maximum tolerated three months of sulphasalazine at a maximum tolerated dose (unless		
•	contraindicated) O Patient has a CRP level greater than 15 mg/L measure or O Patient has an ESR greater than 25 mm per hour or	ed no more than one month prior to the date of this application ceiving prednisone therapy at a dose of greater than 5 mg per day and		
Prerec	NUATION – inflammatory bowel arthritis – peripheral essment required after 2 years uisites (tick boxes where appropriate) Prescribed by, or recommended by any relevant practitioner, or in NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health		
and	response to treatment in the opinion of the physician	crease in active joint count from baseline and a clinically significant at in active joint count from baseline in the opinion of the treating physician		

I confirm that the above details are correct:						
Cianadi	Data					