**RS1922 - Adalimumab (Humira - Alternative brand)**

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**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Adalimumab (Humira - Alternative brand)

**INITIATION – Behcet's disease – severe**
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 the Health NZ Hospital.

**and**

- ○ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

- ○ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

- ○ Patient has received a maximum of 6 months treatment with Amgevita

**and**

- ○ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**CONTINUATION – Behcet's disease – severe**
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 the Health NZ Hospital.

**and**

- ○ The patient has had a good clinical response to treatment with measurably improved quality of life

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**INITIATION – Hidradenitis suppurativa**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a dermatologist or Practitioner on the recommendation of a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

- ○ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

- ○ Patient has received a maximum of 6 months treatment with Amgevita

**and**

- ○ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 7 days. Fortnightly dosing has been considered

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.

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Adalimumab (Humira - Alternative brand) *- continued*

**CONTINUATION – Hidradenitis suppurativa**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a dermatologist or Practitioner on the recommendation of a dermatologist, 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

**and**

- ○ The patient has a Dermatology Quality of Life Index improvement of 4 or more from baseline

**and**

- ○ Adalimumab is to be administered at doses no greater than 40mg every 7 days. Fortnightly dosing has been considered

**INITIATION – Psoriasis - severe chronic plaque**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a dermatologist or Practitioner on the recommendation of a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

- ○ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

- ○ Patient has received a maximum of 6 months treatment with Amgevita

**and**

- ○ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days



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.

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Adalimumab (Humira - Alternative brand) *- continued*

**CONTINUATION – Psoriasis - severe chronic plaque**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a dermatologist or Practitioner on the recommendation of a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ Patient had "whole body" severe chronic plaque psoriasis at the start of treatment

  **and**

  - ○ Following each prior adalimumab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-adalimumab treatment baseline value

    **or**

  - ○ Following each prior adalimumab treatment course the patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, when compared with the pre-treatment baseline value

**or**

- ○ Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment

  **and**

  - ○ Following each prior adalimumab treatment course the patient has 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**

  - ○ Following each prior adalimumab treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-adalimumab treatment baseline value

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**INITIATION – Pyoderma gangrenosum**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ 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**

- ○ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

  **or**

- ○ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

- ○ Patient has received a maximum of 6 months treatment with Amgevita

**and**

- ○ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ○ A maximum of 8 doses

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.

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Adalimumab (Humira - Alternative brand) *- continued*

**CONTINUATION – Pyoderma gangrenosum**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ 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**

- ○ The patient has demonstrated clinical improvement and continues to require treatment

**and**

- ○ A maximum of 8 doses

**INITIATION – Crohn's disease - adult**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita

**or**

- ○ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen

**or**

- ○ Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment

**and**

- ○ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**CONTINUATION – Crohn's disease - adult**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ CDAI score has reduced by 100 points from the CDAI score when the patient was initiated on adalimumab

**or**

- ○ CDAI score is 150 or less

**or**

- ○ The patient has demonstrated an adequate response to treatment, but CDAI score cannot be assessed

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days



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.

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Adalimumab (Humira - Alternative brand) *- continued*

**INITIATION – Crohn's disease - children**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita

**or**

- ○ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen

**or**

- ○ Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment

**and**

- ○ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**CONTINUATION – Crohn's disease - children**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on adalimumab

**or**

- ○ PCDAI score is 15 or less

**or**

- ○ The patient has demonstrated an adequate response to treatment, but PCDAI score cannot be assessed

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**INITIATION – Crohn's disease - fistulising**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita

**or**

- ○ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen

**or**

- ○ Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment

**and**

- ○ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

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.

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Adalimumab (Humira - Alternative brand) *- continued*

**CONTINUATION – Crohn's disease - fistulising**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ The number of open draining fistulae have decreased from baseline by at least 50%

**or**

- ○ There has been a marked reduction in drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula Assessment score, together with less induration and patient-reported pain

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**INITIATION – Ocular inflammation – chronic**
Re-assessment required after 12 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 the Health NZ Hospital.

**and**

- ○ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita

**or**

- ○ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with Amgevita, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen

**or**

- ○ Patient has uveitis and is considered to be at risk of vision loss if they were to change treatment

**and**

- ○ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**CONTINUATION – Ocular inflammation – chronic**
Re-assessment required after 12 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 the Health NZ Hospital.

**and**

- ○ The patient has had a good clinical response following 12 weeks' initial treatment

**or**

- ○ Following each 12-month 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)

**or**

- ○ Following each 12-month 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

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

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.

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Adalimumab (Humira - Alternative brand) *- continued*

**INITIATION – Ocular inflammation – severe**
Re-assessment required after 12 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 the Health NZ Hospital.

**and**

❍ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita

**or**

❍ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with Amgevita, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen

**or**

❍ Patient has uveitis and is considered to be at risk of vision loss if they were to change treatment

**and**

❍ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

❍ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**CONTINUATION – Ocular inflammation – severe**
Re-assessment required after 12 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 the Health NZ Hospital.

**and**

❍ The patient has had a good clinical response following 3 initial doses

**or**

❍ Following each 12-month 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)

**or**

❍ Following each 12-month 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

**and**

❍ Adalimumab to be administered at doses no greater than 40 mg every 14 days



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.

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Adalimumab (Humira - Alternative brand) *- continued*

**INITIATION – ankylosing spondylitis**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

- ○ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita)

**and**

- ○ Patient has received a maximum of 6 months treatment with Amgevita

**and**

- ○ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**CONTINUATION – ankylosing spondylitis**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ Treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**INITIATION – Arthritis – oligoarticular course juvenile idiopathic**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

- ○ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

- ○ Patient has received a maximum of 6 months treatment with Amgevita

**and**

- ○ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication



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.

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Adalimumab (Humira - Alternative brand) *- continued*

**CONTINUATION – Arthritis – oligoarticular course juvenile idiopathic**
Re-assessment required after 6 months
**Prerequisites** (tick box where appropriate)

- ○ Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ For patients that demonstrate at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

**INITIATION – Arthritis - polyarticular course juvenile idiopathic**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

- ○ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

- ○ Patient has received a maximum of 6 months treatment with Amgevita

**and**

- ○ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**CONTINUATION – Arthritis - polyarticular course juvenile idiopathic**
Re-assessment required after 6 months
**Prerequisites** (tick box where appropriate)

- ○ Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ For patients that demonstrate at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

**INITIATION – Arthritis - psoriatic**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

- ○ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

- ○ Patient has received a maximum of 6 months treatment with Amgevita

**and**

- ○ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

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.

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Adalimumab (Humira - Alternative brand) *- continued*

**CONTINUATION – Arthritis - psoriatic**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

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

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**INITIATION – Arthritis – rheumatoid**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

- ○ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

- ○ Patient has received a maximum of 6 months treatment with Amgevita

**and**

- ○ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**or**

- ○ Patient cannot take concomitant methotrexate and requires doses of adalimumab higher than 40 mg every 14 days to maintain an adequate response

**CONTINUATION – Arthritis – rheumatoid**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

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

**and**

- ○ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**or**

- ○ Patient cannot take concomitant methotrexate and requires doses of adalimumab higher than 40 mg every 14 days to maintain an adequate response



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.

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Adalimumab (Humira - Alternative brand) *- continued*

**INITIATION – Still's disease – adult-onset (AOSD)**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

❍ Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

❍ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

❍ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

❍ Patient has received a maximum of 6 months treatment with Amgevita

**and**

❍ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**CONTINUATION – Still's disease – adult-onset (AOSD)**
Re-assessment required after 6 months
**Prerequisites** (tick box where appropriate)

❍ Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

❍ The patient has demonstrated a sustained improvement in inflammatory markers and functional status



I confirm that the above details are correct:

Signed: ..... Date: .....