SA2157 - Adalimumab (Humira - Alternative brand)

Arthritis - polyarticular course juvenile idiopathic - Initial application	10
Arthritis - polyarticular course juvenile idiopathic - Renewal	
Arthritis - psoriatic - Initial application	
Arthritis - psoriatic - Renewal	11
Arthritis – oligoarticular course juvenile idiopathic - Initial application	
Arthritis – oligoarticular course juvenile idiopathic - Renewal	
Arthritis – rheumatoid - Initial application	
Arthritis – rheumatoid - Renewal	12
Behcet's disease – severe - Initial application	2
Behcet's disease – severe - Renewal	
Crohn's disease - adult - Initial application	
Crohn's disease - adult - Renewal	5
Crohn's disease - children - Initial application	
Crohn's disease - children - Renewal	6
Crohn's disease - fistulising - Initial application	
Crohn's disease - fistulising - Renewal	
Hidradenitis suppurativa - Initial application	
Hidradenitis suppurativa - Renewal	
Ocular inflammation – chronic - Initial application	
Ocular inflammation – chronic - Renewal	
Ocular inflammation – severe - Initial application	8
Ocular inflammation – severe - Renewal	9
Psoriasis - severe chronic plaque - Initial application	
Psoriasis - severe chronic plaque - Renewal	
Pyoderma gangrenosum - Initial application	4
Pyoderma gangrenosum - Renewal	5
Still's disease – adult-onset (AOSD) - Initial application	
Still's disease – adult-onset (AOSD) - Renewal	12
Ankylosing spondylitis - Initial application	
Ankylosing spondylitis - Renewal	

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 2 Form SA2157 May 2025

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Adalimumab (Humira - Alternative brar	nd)	
	vals valid for 6 months. I intolerable side effects from adalimumab (Amgevita)) following a minimum of 4 weeks treatment
Patient has developed symp (Amgevita) and clinician attri	toms of loss of disease control following a minimum of butes this loss of disease response to a change in tro	of 4 weeks treatment with adalimumab eatment 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		
Renewal — Behcet's disease – severe		
Current approval Number (if known):		
Applications from any relevant practitioner. Approv Prerequisites (tick boxes where appropriate)	als valid for 6 months.	
The patient has had a good clinica	I response to treatment with measurably improved qu	uality of life
and Adalimumab to be administered at doses no greater than 40 mg every 14 days		
Initial application — Hidradenitis suppurativa Applications only from a dermatologist or Practitio Prerequisites(tick boxes where appropriate)	ner on the recommendation of a dermatologist. Appr	rovals valid for 6 months.
The patient has experienced	intolerable side effects from adalimumab (Amgevita)) following a minimum of 4 weeks treatment
Patient has developed symp	toms of loss of disease control following a minimum obutes this loss of disease response to a change in tro	
1 . 	f 6 months treatment with Amgevita	
	al Authority approval for the Humira brand of adalimu	umab for this indication
Adalimumab to be administered at	doses no greater than 40 mg every 7 days. Fortnigh	atly dosing has been considered

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 3 Form SA2157 May 2025

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:	First Names:	First Names:	
Name:	Surname:	Surname:	
Address:	DOB:	Address:	
	Address:		
Fax Number:		Fax Number:	
Adalimumab (Humira - Alternative brar	nd) - continued		
Renewal — Hidradenitis suppurativa			
Current approval Number (if known):			
Initial application — Psoriasis - severe chronic Applications only from a dermatologist or Practitio Prerequisites(tick boxes where appropriate)	plaque ner on the recommendation of a dermatologist. Appr	rovals valid for 6 months.	
The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment 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 previously had a Speci	f 6 months treatment with Amgevita al Authority approval for the Humira brand of adalimu	umab for this indication	
Adalimumab to be administered at	doses no greater than 40 mg every 14 days		

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 4 Form SA2157 May 2025

APPL	ICAN	T (stai	mp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	۱o:			First Names:	First Names:
Name	e:			Surname:	Surname:
Addre	ess:			DOB:	Address:
				Address:	
Fax N	lumbei	r:			Fax Number:
Adal	imun	nab	(Humira - Alternative bra	nd) - continued	
Rene	ewal –	– Pso	riasis - severe chronic plaque		
Curre	ent ap _l	proval	Number (if known):		
		-		ner on the recommendation of a dermatologist. Appro	ovals valid for 6 months.
Prer	equisi	ites(tid	ck boxes where appropriate)		
			Patient had "whole ho	ody" severe chronic plaque psoriasis at the start of tre	atment
			and	as severe emonic plaque psonasis at the start of the	aunen
				prior adalimumab treatment course the patient has a ained at this level, when compared with the pre-adalii	
			or	prior adalimumab treatment course the patient has a	
				f 5 or more, when compared with the pre-treatment ba	
		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		or sole of a foot at the start of treatment			
				prior adalimumab treatment course the patient has a	reduction in the PASI symptom subscores
			for all 3 of eryth	nema, thickness and scaling, to slight or better, or sus se baseline values	
			or	prior adalimumab treatment course the patient has a	reduction of 75% or more in the skin area
			affected, or sus	tained at this level, as compared to the pre-adalimum	ab treatment baseline value
	and				
			dalimumab to be administered at	t doses no greater than 40 mg every 14 days	
Initia	al appl	licatio	on — Pyoderma gangrenosum		
App	lication	ns onl	y from a dermatologist. Approvals ck boxes where appropriate)	s valid for 6 months.	
rici	cquisi	ites(iii			
			The patient has experienced	d intolerable side effects from adalimumab (Amgevita)	following a minimum of 4 weeks treatment
		or	Patient has developed symp	otoms of loss of disease control following a minimum	of 4 weeks treatment with adalimumab
			(Amgevita) and clinician attr	ibutes this loss of disease response to a change in tre	eatment regimen
	and [F	oatient has received a maximum o	of 6 months treatment with Amgevita	
	and	_		ial Authority approval for the Humira brand of adalimu	umab for this indication
	and			and the second s	
			A maximum of 8 doses		

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 5 Form SA2157 May 2025

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Adalimumab (Humira - Alternative bra	nd) - continued	
Renewal — Pyoderma gangrenosum		
Current approval Number (if known):		
Applications only from a dermatologist. Approval		
Prerequisites(tick boxes where appropriate)		
· · ·	nical improvement and continues to require treatment	
and A maximum of 8 doses		
Initial application — Crohn's disease - adult Applications only from a gastroenterologist or Pri	actitioner on the recommendation of a gastroenterolog	ist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)		ion perovale valid for emotion
and a maximum of 6 month	d intolerable side effects from adalimumab (Amgevita is treatment with Amgevitat) following a minimum of 4 weeks treatment,
	ptoms of loss of disease control following a minimum	
or	ngevita and clinician attributes this loss of disease res	
Patient has Crohn's and is	considered to be at risk of disease destabilisation if th	ere were to be a change to current treatment
and Patient has previously had a Spe	cial Authority approval for the Humira brand of adalim	umab for this indication
and		
Adalinumab to be administered a	tt doses no greater than 40 mg every 14 days	
Renewal — Crohn's disease - adult		
Current approval Number (if known):		
	ctitioner on the recommendation of a gastroenterologic	st. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)		
CDAI score has reduced by	v 100 points from the CDAI score when the patient wa	s initiated on adalimumah
or	100 points from the ODAL Score when the patient wa	5 milacod off adamindfilab
or CDAI score is 150 or less		
The patient has demonstra	ted an adequate response to treatment, but CDAI sco	re cannot be assessed
and Adalimumab to be administered a	at doses no greater than 40 mg every 14 days	

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 6 Form SA2157 May 2025

APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	lo:	First Names:	First Names:
Name	·	Surname:	Surname:
Addre	SS:	DOB:	Address:
		Address:	
Fax N	umber:		Fax Number:
Adal	imumab (Humira - Alternative brar	nd) - continued	
Appl	al application — Crohn's disease - children lications only from a gastroenterologist or Prace equisites(tick boxes where appropriate)	ctitioner on the recommendation of a gastroenterolog	ist. Approvals valid for 6 months.
	and a maximum of 6 months Patient has developed symp 6 months treatment with Am Patient has Crohn's and is co and Patient has previously had a Speci	intolerable side effects from adalimumab (Amgevita) treatment with Amgevita toms of loss of disease control following a minimum of gevita and clinician attributes this loss of disease responsidered to be at risk of disease destabilisation if the all Authority approval for the Humira brand of adalimut doses no greater than 40 mg every 14 days	of 4 weeks treatment, and a maximum of ponse to a change in treatment regimen ere were to be a change to current treatment
Appli	equisites(tick boxes where appropriate)	titioner on the recommendation of a gastroenterologition of a gastroenterologity of the recommendation of a gastroenterologic of the recommendation of a gastroenterologic of the recommendation of a gastroenterologic	
	or PCDAI score is 15 or less		
	The patient has demonstrate	ed an adequate response to treatment, but PCDAI sco	ore cannot be assessed
	and Adalimumab to be administered at	doses no greater than 40 mg every 14 days	
Appl	al application — Crohn's disease - fistulisin lications only from a gastroenterologist or Prace equisites(tick boxes where appropriate)	g titioner on the recommendation of a gastroenterolog	ist. Approvals valid for 6 months.
	or Patient has developed symp 6 months treatment with Am or Patient has Crohn's and is co	intolerable side effects from adalimumab (Amgevita) treatment with Amgevita toms of loss of disease control following a minimum of gevita and clinician attributes this loss of disease responsidered to be at risk of disease destabilisation if the	of 4 weeks treatment, and a maximum of ponse to a change in treatment regimen
	and	al Authority approval for the Humira brand of adalimudoses no greater than 40 mg every 14 days	umab for this indication

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 7 Form SA2157 May 2025

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Adalimumab (Humira - Alternative brar	nd) - continued	
Prerequisites(tick boxes where appropriate) The number of open draining or There has been a marked re Assessment score, together and	titioner on the recommendation of a gastroenterological fistulae have decreased from baseline by at least 50 duction in drainage of all fistula(e) from baseline as of with less induration and patient-reported pain doses no greater than 40 mg every 14 days	0%
or Patient has developed symp maximum of 6 months treatr regimen or Patient has developed symp maximum of 6 months treatr regimen and and	vals valid for 12 months. intolerable side effects from adalimumab (Amgevita)	of 4 weeks treatment with Amgevita, and a of disease response to a change in treatment ange treatment
Adalimumab to be administered at	doses no greater than 40 mg every 14 days	

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 8 Form SA2157 May 2025

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Adalimumab (Humira - Alternative brai	nd) - continued	
Renewal — Ocular inflammation – chronic		
Current approval Number (if known):		
Applications from any relevant practitioner. Approx	als valid for 12 months.	
Prerequisites(tick boxes where appropriate)		
The patient has had a good clinical response following 12 weeks' initial treatment 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) 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 Adalimumab to be administered at doses no greater than 40 mg every 14 days		
Initial application — Ocular inflammation — sev Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)		
or Patient has developed symp maximum of 6 months treat regimen or	I intolerable side effects from adalimumab (Amgevita streatment with Amgevita stoms of loss of disease control following a minimum ment with Amgevita and clinician attributes this loss of the strick of vision loss if they were to characteristics.	of 4 weeks treatment with Amgevita, and a of disease response to a change in treatment
and	ial Authority approval for the Humira brand of adalimu	umab for this indication
	access no greater than 40 mg every 14 days	

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 9 Form SA2157 May 2025

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	g No: First Names: First Names: First Names:	
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Adalimumab (Humira - Alternative brai	nd) - continued	
Renewal — Ocular inflammation – severe		
Current approval Number (if known):		
Applications from any relevant practitioner. Appro-		
Prerequisites(tick boxes where appropriate)		
The patient has had a good	clinical response following 3 initial doses	
or	eatment period, the patient has had a sustained reduc	rtion in inflammation (Standardisation of Liveitie
	$a < \frac{1}{2}$ + anterior chamber or vitreous cells, absence of	
or	eatment period, the patient has a sustained steroid sp	paring offect, allowing reduction in produicans to
	os less than twice daily if under 18 years old	aring effect, allowing reduction in prediffsore to
and Adelimumah to be administered at	doses no greater than 40 mg every 14 days	
Adaimumab to be administered at	doses no greater than 40 mg every 14 days	
Initial application — ankylosing spondylitis		
Applications only from a rheumatologist or Practit Prerequisites (tick boxes where appropriate)	ioner on the recommendation of a rheumatologist. Ap	oprovals valid for 6 months.
The patient has experienced or	d intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment
Patient has developed symp	otoms of loss of disease control following a minimum	of 4 weeks treatment with adalimumab
(Amgevita)		
Patient has received a maximum of	of 6 months treatment with Amgevita	
	ial Authority approval for the Humira brand of adalimu	umab for this indication
and Adalimumab to be administered at	doses no greater than 40 mg every 14 days	
Renewal — ankylosing spondylitis		
Current approval Number (if known):		
Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.		
Prerequisites(tick boxes where appropriate)		
Treatment has resulted in an impro improvement in BASDAI of 50%, v	ovement in BASDAI of 4 or more points from pre-trea	tment baseline on a 10 point scale, or an
and		
Adalimumab to be administered at	doses no greater than 40 mg every 14 days	

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 10 Form SA2157 May 2025

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Adalimumab (Humira - Alternative bra	nd) - continued	
Initial application — Arthritis – oligoarticular constant Applications only from a named specialist, rheums valid for 6 months. Prerequisites(tick boxes where appropriate)	ourse juvenile idiopathic atologist or Practitioner on the recommendation of a r	named specialist or rheumatologist. Approvals
or Patient has developed symp	d intolerable side effects from adalimumab (Amgevita) stoms of loss of disease control following a minimum of the control	of 4 weeks treatment with adalimumab
and	of 6 months treatment with Amgevita ial Authority approval for the Humira brand of adalimu	umab for this indication
Renewal — Arthritis – oligoarticular course juv	renile idiopathic	
Current approval Number (if known): Applications only from a named specialist, rheuma valid for 6 months. Prerequisites(tick box where appropriate)	tologist or Practitioner on the recommendation of a n	amed specialist or rheumatologist. Approvals
The patient demonstrates at least a cont assessment from baseline	inuing 30% improvement in active joint count and cor	ntinued improvement in physician's global
Initial application — Arthritis - polyarticular con Applications only from a named specialist, rheums valid for 6 months. Prerequisites(tick boxes where appropriate)	urse juvenile idiopathic atologist or Practitioner on the recommendation of a r	named specialist or rheumatologist. Approvals
	d intolerable side effects from adalimumab (Amgevita)) following a minimum of 4 weeks treatment
	otoms of loss of disease control following a minimum of ibutes this loss of disease response to a change in tro	
and Patient has received a maximum of	of 6 months treatment with Amgevita	
Patient has previously had a Spec	ial Authority approval for the Humira brand of adalimu	umab for this indication
Renewal — Arthritis - polyarticular course juve	nile idiopathic	
Current approval Number (if known):	utologist or Practitioner on the recommendation of a n	named specialist or rheumatologist. Approvals
The patient demonstrates at least a cont assessment from baseline	inuing 30% improvement in active joint count and cor	ntinued improvement in physician's global

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 11 Form SA2157 May 2025

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Adalimumab (Humira - Alternative bra	nd) - continued	
Initial application — Arthritis - psoriatic Applications only from a named specialist, rheum valid for 6 months. Prerequisites(tick boxes where appropriate)	atologist or Practitioner on the recommendation of a r	named specialist or rheumatologist. Approvals
or	d intolerable side effects from adalimumab (Amgevita)	·
	ributes this loss of disease response to a change in tri	
and Patient has received a maximum of and	of 6 months treatment with Amgevita	
Patient has previously had a Spec	cial Authority approval for the Humira brand of adalimu	umab for this indication
Adalimumab to be administered a	t doses no greater than 40 mg every 14 days	
Renewal — Arthritis - psoriatic		
Current approval Number (if known):	atologist or Practitioner on the recommendation of a n	amed specialist or rheumatologist. Approvals
to prior adalimumab treatment in t	a continuing 30% improvement in active joint count fr he opinion of the treating physician	om baseline and a clinically significant response
Adalimumab to be administered a	t doses no greater than 40 mg every 14 days	
Initial application — Arthritis – rheumatoid Applications only from a rheumatologist or Practit Prerequisites(tick boxes where appropriate)	ioner on the recommendation of a rheumatologist. Ap	oprovals valid for 6 months.
The patient has experienced	d intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment
	otoms of loss of disease control following a minimum or ibutes this loss of disease response to a change in tro	
Patient has received a maximum of	of 6 months treatment with Amgevita	
Patient has previously had a Spec	cial Authority approval for the Humira brand of adalimu	umab for this indication
	ered at doses no greater than 40 mg every 14 days	
Patient cannot take concom an adequate response	itant methotrexate and requires doses of adalimumab	higher than 40 mg every 14 days to maintain

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 12 Form SA2157 May 2025

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Adalimumab (Humira - Alternative brar	nd) - continued	
Renewal — Arthritis – rheumatoid		
Current approval Number (if known): Applications only from a rheumatologist or Practition Prerequisites(tick boxes where appropriate)	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.
The patient demonstrates at least to prior adalimumab treatment in the	a continuing 30% improvement in active joint count fr ne opinion of the treating physician	om baseline and a clinically significant response
or	red at doses no greater than 40 mg every 14 days tant methotrexate and requires doses of adalimumab	higher than 40 mg every 14 days to maintain
Initial application — Still's disease – adult-onse Applications only from a rheumatologist or Practiti Prerequisites(tick boxes where appropriate)	et (AOSD) oner on the recommendation of a rheumatologist. Ap	oprovals valid for 6 months.
The patient has experienced or	intolerable side effects from adalimumab (Amgevita)) following a minimum of 4 weeks treatment
Patient has developed symp	toms of loss of disease control following a minimum obutes this loss of disease response to a change in tro	
and Patient has received a maximum o	f 6 months treatment with Amgevita	
Patient has previously had a Speci	al Authority approval for the Humira brand of adalimu	umab for this indication
Renewal — Still's disease – adult-onset (AOSD		
Prerequisites(tick box where appropriate)	oner on the recommendation of a rheumatologist. Ap	
The patient has demonstrated a sustained	d improvement in inflammatory markers and function	nal status