## SA2399 - Etanercept

Arthritis - rheumatoid - Renewal	10
Arthritis - rheumatoid - Initial application	
Adult-onset Still's disease - Initial application	
Adult-onset Still's disease - Renewal	2
Ankylosing spondylitis - Initial application	
Ankylosing spondylitis - Renewal	
Oligoarticular course juvenile idiopathic arthritis - Initial application	
Oligoarticular course juvenile idiopathic arthritis - Renewal	
Polyarticular course juvenile idiopathic arthritis - Initial application	
Polyarticular course juvenile idiopathic arthritis - Renewal	5
Psoriatic arthritis - Initial application	7
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Pyoderma gangrenosum - Initial application	
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Severe chronic plaque psoriasis - Initial application	11
Severe chronic plaque psoriasis - Renewal	12
Undifferentiated spondyloarthritis - Initial application	
Undifferentiated spondyloarthritis - Renewal	
Chambroniated openational frontieral minimum management and a second sec	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)		sticker acceptable)	PATIENT NHI:	REFERRER Reg No:		
Reg No:			First Names:	First Names:		
Name	e:				Surname:	Surname:
Addre	ess:				DOB:	Address:
					Address:	
Fax N	lumbe	r:				Fax Number:
Etan	erce	pt				
App	lication	ns only	/ fron	adult-onset Still's disease n a rheumatologist. Approva xes where appropriate)		
		and	or		n initial Special Authority approval for adalimumab for started on tocilizumab for AOSD in a Health NZ Hosp	
			or	The patient has receiv	ed insufficient benefit from at least a three-month tria enewal criteria for AOSD	
or		and		Patient has tried and not res anti-inflammatory drugs (NS	D according to the Yamaguchi criteria (J Rheumatol 1 ponded to at least 6 months of glucocorticosteroids a AIDs) and methotrexate oms of disabling poorly controlled and active disease	at a dose of at least 0.5 mg/kg, non-steroidal
Renewal — adult-onset Still's disease						
Appl	Current approval Number (if known):					
or  Applicant is a rheumatologist  Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the continues with etanercept treatment					r, email or fax recommending that the patient	
and  The patient has a sustained improvement in inflammatory markers and functional status				<b>S</b>		

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APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
Fax Number:		Fax Number:
Etanercept - continued		
Initial application — ankylosing spondylitis Applications only from a rheumatologist. Approva Prerequisites(tick boxes where appropriate)	als valid for 6 months.	
The patient has had an initial	al Special Authority approval for adalimumab for anky	losing spondylitis
<u> </u>	rienced intolerable side effects from adalimumab	
The patient has recei spondylitis	ved insufficient benefit from adalimumab to meet the i	renewal criteria for adalimumab for ankylosing
or		
Patient has a confirmed dia	gnosis of ankylosing spondylitis present for more than	six months
	and stiffness that is relieved by exercise but not by rest	
and Patient has bilateral sacroili	itis demonstrated by plain radiographs, CT or MRI sca	an
and Patient's ankylosing spondy	litis has not responded adequately to treatment with t	wo or more non-steroidal anti-inflammatory
drugs (NSAIDs), in combina exercise regimen for ankylo	ttion with anti-ulcer therapy if indicated, while patient valies ing spondylitis	was undergoing at least 3 months of a regular
and		
Bath Ankylosing Spor	of motion of the lumbar spine in the sagittal and the findylitis Metrology Index (BASMI) measures: a modified in measurement of less than or equal to 10 cm (mear	ed Schober's test of less than or equal to 4 cm
Patient has limitation gender (see Notes)	of chest expansion by at least 2.5 cm below the aver-	age normal values corrected for age and
and A Bath Ankylosing Spondyli	tis Disease Activity Index (BASDAI) of at least 6 on a	0-10 scale
measure must be no more than 1 month old at the Average normal chest expansion corrected for age		or to ceasing NSAID treatment. The BASDAI
18-24 years - Male: 7.0 cm; Female: 5.5 cm 25-34 years - Male: 7.5 cm; Female: 5.5 cm		
35-44 years - Male: 6.5 cm; Female: 4.5 cm 45-54 years - Male: 6.0 cm; Female: 5.0 cm		
55-64 years - Male: 5.5 cm; Female: 4.0 cm 65-74 years - Male: 4.0 cm; Female: 4.0 cm		

75+ years - Male: 3.0 cm; Female: 2.5 cm

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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:
Etanercept - continued		
Renewal — ankylosing spondylitis		
Current approval Number (if known):		
	ioner on the recommendation of a rheumatologist. Ap	oprovals valid for 6 months.
Prerequisites(tick boxes where appropriate)		
Applicant is a rheumatologi	st	
or		or amail or fav recommending that the nations
continues with etanercept to	nd confirms that a rheumatologist has provided a lette reatment	er, email or lax recommending that the patient
and Following 12 weeks' initial treatm	ent and for subsequent renewals, treatment has result	ted in an improvement in PASDAL of 4 or more
	e on a 10 point scale, or an improvement in BASDAI o	
Physician considers that the patie	nt has benefited from treatment and that continued tre	eatment is appropriate
Etanercept to be administered at	doses no greater than 50 mg every 7 days	
Initial application — polyarticular course juver Applications only from a named specialist or rheu		
Prerequisites(tick boxes where appropriate)	The state of the s	
The contract of the contract o	al Consist Authority and the state of the st	
and	al Special Authority approval for adalimumab for polya	articular course juvenile idiopatnic artiritis (JIA)
The patient has expe	rienced intolerable side effects from adalimumab	
The patient has recei	ved insufficient benefit from adalimumab to meet the	renewal criteria for adalimumab for polyarticular
course JIA		
or Taba yaad aa aa adiyyaatta		and the state of t
and	methotrexate therapy or monotherapy where use of r	nethotrexate is infined by toxicity of intolerance
Patient has had polyarticula	r course JIA for 6 months duration or longer	
	s and at least 3 joints with limited range of motion, pa	ain or tenderness after a 3-month trial of
or	maximum tolerated dose)	
Moderate or high disc tolerated dose)	ease activity (cJADAS10 score of at least 2.5) after a	3-month trial of methotrexate (at the maximum
	cJADAS10 score between 1.1 and 2.5) after a 6-mon	th trial of methotrexate

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APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	
Name:	Surname:	
Address:	DOB:	Address:
	Address:	
		Fax Number:
Etanercept - continued  Renewal — polyarticular course juvenile idiopa	athic authritia	
Henewai — polyarticular course juvenile idiopa	arme arminis	
Current approval Number (if known):		
Applications only from a named specialist, rheuma valid for 6 months.	atologist or Practitioner on the recommendation of a n	amed specialist or rheumatologist. Approvals
Prerequisites(tick boxes where appropriate)		
l l . <del></del>	strexate therapy or monotherapy where use of methot	rexate is limited by toxicity or intolerance
Following 3 to 4 months' init	tial treatment, the patient has at least a 50% decreas	o in active joint count and an improvement in
physician's global assessme		e in active joint count and an improvement in
On subsequent reapplication	ns, the patient demonstrates at least a continuing 30	% improvement in active joint count and
continued improvement in p	hysician's global assessment from baseline	
	alla talla madeta andralita	
Initial application — oligoarticular course juve Applications only from a named specialist or rheu		
Prerequisites(tick boxes where appropriate)		
The patient has had an initia	al Special Authority approval for adalimumab for oligo	articular course juvenile idiopathic arthritis (JIA)
The patient has exper	ienced intolerable side effects from adalimumab	
or The patient has receive	ved insufficient benefit from adalimumab to meet the	renewal criteria for adalimumab for oligoarticular
course JIA		
or		
To be used as an adjunct to	methotrexate therapy or monotherapy where use of r	methotrexate is limited by toxicity or intolerance
Patient has had oligoarticula	ar course JIA for 6 months duration or longer	
At least 2, active joints	s with limited range of motion, pain or tenderness afte	or a 2 month trial of mathetrovate (at the
maximum tolerated do		a o month that of motionexate (at the
Moderate or high dise	ase activity (cJADAS10 score greater than 1.5) with pnaximum tolerated dose)	poor prognostic features after a 3-month trial of
or	cJADAS10 score greater than 4) after a 6-month trial	of methotrexate
	- '	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:			
Etanercept - continued					
Renewal — oligoarticular course juvenile idiop	athic arthritis				
Current approval Number (if known):					
Applications only from a named specialist, rheuma valid for 6 months.	tologist or Practitioner on the recommendation of a n	amed specialist or rheumatologist. Approvals			
Prerequisites(tick boxes where appropriate)					
Subsidised as an adjunct to metho	Subsidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance				
Following 3 to 4 months' ini physician's global assessme	cial treatment, the patient has at least a 50% decrease ent from baseline	e in active joint count and an improvement in			
On subsequent reapplication	ns, the patient demonstrates at least a continuing 30% hysician's global assessment from baseline	6 improvement in active joint count and			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			mp oı	sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:					First Names:	First Names:
Name	Name:				Surname:	Surname:
Addre	ess:				DOB:	Address:
					Address:	
Fax N	lumbe					Fax Number:
Etan	erce	<b>pt</b> - <i>c</i>	contin	ued		
App	licatio	ns only	y fron	psoriatic arthritis n a rheumatologist. Approval xes where appropriate)	s valid for 6 months.	
		and		The patient has had an initia	Special Authority approval for adalimumab or secuk	inumab for psoriatic arthritis
			or	The patient has experi	enced intolerable side effects from adalimumab or se	ecukinumab
	The patient has received		The patient has receive or secukinumab for ps	ved insufficient benefit from adalimumab or secukinumab to meet the renewal criteria for adalimumab soriatic arthritis		
or		and and	or	Patient has tried and not respond a maximum tolerated dose Patient has tried and not respond on the patient has persistent Patient has persistent Patient has persistent	conded to at least three months of sulfasalazine at a	dose of at least 2 g per day or leflunomide at a at least 15 swollen, tender joints
		and			·	
Patient has a C-reactive protein level greater than 15 mg/L measured no more tapplication		ore than one month prior to the date of this				
			or	Patient has an elevate	d erythrocyte sedimentation rate (ESR) greater than	25 mm per hour
				ESR and CRP not mea	asured as patient is currently receiving prednisone th ore than three months	erapy at a dose of greater than 5 mg per day

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:			
Etanercept - continued					
Renewal — psoriatic arthritis					
Current approval Number (if known):  Applications only from a rheumatologist or  Prerequisites(tick boxes where appropriat	Practitioner on the recommendation of a rheu	matologist. Approvals valid for 6 months.			
or Applicant is a rheum Applicant is a Practit continues with etane	ioner and confirms that a rheumatologist has	provided a letter, email or fax recommending that the patient			
or  Following 3 to 4 mode clinically significant response to prior etail	The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior etanercept treatment in the opinion of the treating physician				
Etanercept to be administe	red at doses no greater than 50 mg every 7 d	ays			
Initial application — pyoderma gangrend Applications only from a dermatologist. Ap Prerequisites(tick boxes where appropriat	pprovals valid for 4 months.				
Patient has pyoderma gangrenosum*  and Patient has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporine, azathioprine, or methotrexate) and not received an adequate response  A maximum of 8 doses					
Note: Indications marked with * are unappr	oved indications.				
Renewal — pyoderma gangrenosum					
Current approval Number (if known):  Applications only from a dermatologist or P Prerequisites(tick boxes where appropriat  Patient has shown clinical i	ractitioner on the recommendation of a derma	atologist. Approvals valid for 4 months.			
Patient continues to require and A maximum of 8 doses	treatment				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)		r sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:				First Names:	First Names:
Name:				Surname:	Surname:
Address:				DOB:	Address:
				Address:	
					Fax Number:
Etanerce	<b>ept</b> - c	ontin	nued		
Application	ons only	fror	Arthritis - rheumatoid n a rheumatologist. Approva xes where appropriate)	ls valid for 6 months.	
	and		The patient has had an initia	al Special Authority approval for adalimumab for rheur	matoid arthritis
	or The patient has exper			ienced intolerable side effects red insufficient benefit to meet the renewal criteria for	rheumatoid arthritis
or	or				
			Patient has had rheumatoid antibody positive) for six mo	arthritis (either confirmed by radiology imaging, or the nths duration or longer	e patient is cyclic citrullinated peptide (CCP)
	and		Treatment is to be used as a intolerance	an adjunct to methotrexate therapy or monotherapy when	here use of methotrexate is limited by toxicity or
	and and		Patient has tried and not res	ponded to at least three months of methotrexate at a	maximum tolerated dose (unless contraindicated)
	and			esponded to at least three months of methotrexate in combination with sulfasalazine ar rated doses unless contraindicated)	ombination with sulfasalazine and hydroxychloroquine
	anu		Patient has tried and a	not responded to at least three months of methotrexat	te in combination with the maximum tolerated
	or		Patient has tried and r	not responded to at least three months of therapy at the with methotrexate	he maximum tolerated dose of leflunomide
	and				
		or	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 ad either shoulder or hip	at least four joints from the following: wrist,

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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:		
Etanercept - continued				
Current approval Number (if known):				
or response to treatment in the	e patient has at least a 50% decrease in active joint count from baseline and a clinically significant opinion of the physician s, the patient demonstrates at least a continuing 30% improvement in active joint count from ficant response to treatment in the opinion of the physician			
and Etanercept to be administered at d	oses no greater than 50 mg every 7 days			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acc	ceptable) PATIENT NHI:	REFERRER Reg No:	
Reg No:	First Names:	First Names:	
Name:	Surname:	Surname:	
Address:	DOB:	Address:	
	Address:		
Fax Number:		Fax Number:	
Etanercept - continued  Initial application — severe che Applications only from a dermate	ronic plaque psoriasis ologist or any relevant practitioner on the recommenda	ation of a dermatologist. Approvals valid for 4 months.	
Prerequisites (tick boxes where and The patient or The	appropriate)  It has had an initial Special Authority approval for adali  patient has experienced intolerable side effects from a  patient has received insufficient benefit from adalimun	mumab for severe chronic plaque psoriasis	
chronic plaque psoriasis  Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (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 than 10  and  Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin  A PASI assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course  The most recent PASI or DLQI assessment is no more than 1 month old at the time of application			
while still on treatment but no lon face, hand, foot, genital or flexura severe, and for the face, palm of	nger than 1 month following cessation of the most rece al areas at least 2 of the 3 PASI symptom subscores f	riasis, a PASI score of greater than 10, as assessed preferably ent prior treatment; for severe chronic plaque psoriasis of the for erythema, thickness and scaling are rated as severe or very or more of the face, palm of a hand or sole of a foot, as assessed most recent prior treatment.	

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APPLICANT (stamp or sticker acceptable)		sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:			First Names:	First Names:
Name:			Surname:	Surname:
Address:			DOB:	Address:
			Address:	
Fax Number: .				Fax Number:
Etanercept	- continu	ued		
Renewal — s	evere ch	ronic plaque psoriasis		
Applications fr	om any r	per (if known):elevant practitioner. Approres where appropriate)		
	and	Following each or is sustained Following each	dy" severe chronic plaque psoriasis at the start of tre prior etanercept treatment course the patient has a P at this level, when compared with the pre-treatment b prior etanercept treatment course the patient has a D 5 or more, when compared with the pre-treatment ba	ASI score which is reduced by 75% or more, aseline value
O	and	Following each all 3 of erythem course baseline  Following each	prior etanercept treatment course the patient has a real, thickness and scaling, to slight or better, or sustain evalues  prior etanercept treatment course the patient has a real treatment course the patient has a real treatment etanercept treatment course the patient has a real treatment at this level, as compared to the pre-treatment	eduction in the PASI symptom subscores for ed at this level, as compared to the treatment eduction of 75% or more in the skin area
and	and	or  Patient has a D prior to commen	experienced a reduction of 75% or more in the skin as pre-treatment baseline value ermatology Quality of Life Index (DLQI) improvement noing etanercept	area affected, or sustained at this level, as
Note: A treatn			loses no greater than 50 mg every 7 days n of 12 weeks of etanercept treatment	

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APPLICANT (stamp or sticker acceptable)  Reg No:			PATIENT NHI:	REFERRER Reg No:	
			First Names:	First Names:	
Name:			Surname:	Surname:	
Address:			DOB:	Address:	
			Address:		
Fax Numb	oer:			Fax Number:	
Initial ap	ions only fr	<ul> <li>undifferentiated spondylo</li> <li>om a rheumatologist. Approva</li> <li>coxes where appropriate)</li> </ul>			
an	Patient has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the followrist, elbow, knee, ankle, and either shoulder or hip  Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg were maximum tolerated dose				
an					
an	dos	Patient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day (or maximum tolerated dose)			
an		Patient has tried and not responded to at least three months of leflunomide at a dose of up to 20 mg daily (or maximum tolerated dose)			
	or	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application			
	or	Patient has an elevated eryl prior to the date of this appli	throcyte sedimentation rate (ESR) greater than 25 mm cation	n per hour measured no more than one month	
		ESR and CRP not measure done so for more than three	d as patient is currently receiving prednisone therapy months	at a dose of greater than 5 mg per day and has	
Note: Indications marked with * are unapproved indications.					
Renewal — undifferentiated spondyloarthritis					
Applicati	ons only fro	umber (if known): om a rheumatologist or Practiti poxes where appropriate)	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.	
	or	Applicant is a rheumatologis	st		
		Applicant is a Practitioner a continues with etanercept tr	nd confirms that a rheumatologist has provided a lette eatment	er, email or fax recommending that the patient	
an	or _		itial treatment, the patient has at least a 50% decreas e to treatment in the opinion of the physician	e in active joint count from baseline and a	
			t least a continuing 30% improvement in active joint of treatment in the opinion of the treating physician	ount from baseline and a clinically significant	
an		nercept to be administered at o	doses no greater than 50 mg dose every 7 days		