## SA2157 - Adalimumab (Humira - Alternative brand)

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Reg No:		First Names:	First Names:	
Name:		Surname:	Surname:	
Addre	ss:	DOB:	Address:	
		Address:		
Fax N	umber:		Fax Number:	
Adali	mumab (Humira - Alternative bra	nd)		
Appl	l application — Behcet's disease – severe ications from any relevant practitioner. Appropriates (tick boxes where appropriate)	ovals valid for 6 months.		
	or Patient has developed symp	d intolerable side effects from adalimumab (Amgevita otoms of loss of disease control following a minimum ributes this loss of disease response to a change in tr	of 4 weeks treatment with adalimumab	
	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			
	ewal — Behcet's disease – severe			
Appli	ent approval Number (if known): cations from any relevant practitioner. Appro equisites(tick boxes where appropriate)			
The patient has had a good clinical response to treatment with measurably improved quality of life		uality of life		
		t doses no greater than 40 mg every 14 days		
Initial application — Hidradenitis suppurativa Applications only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)				
	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 ributes this loss of disease response to a change in tr		
	Patient has received a maximum of and	of 6 months treatment with Amgevita		
	Patient has previously had a Spec	ial Authority approval for the Humira brand of adalim	umab for this indication	
		t doses no greater than 40 mg every 7 days. Fortnigh	ntly dosing has been considered	

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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:	
Adalimumab (Humira - Alternative brar Renewal — Hidradenitis suppurativa	nd) - continued		
Current approval Number (if known):  Applications only from a dermatologist or Practition  Prerequisites(tick boxes where appropriate)	ner on the recommendation of a dermatologist. Appro	ovals valid for 6 months.	
The patient has a reduction in active lesions (e.g. inflammatory nodules, abscesses, draining fistulae) of 25% or more from baseline  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			
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	ovals valid for 6 months.	
or Patient has developed symp	I intolerable side effects from adalimumab (Amgevita) toms of loss of disease control following a minimum of	of 4 weeks treatment with adalimumab	
and	of 6 months treatment with Amgevita	umab for this indication	
and	doses no greater than 40 mg every 14 days		

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APPL	ICAN <sup>*</sup>	<b>T</b> (sta	mp or	sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	10:				First Names:	First Names:
Name	:				Surname:	Surname:
Addre	ss:				DOB:	Address:
					Address:	
Fax N	umbe	r:				Fax Number:
Adal	imun	nab	(Hun	nira - Alternative brar	nd) - continued	
Rene	ewal –	– Psc	riasis	s - severe chronic plaque		
Curre	ent ap	prova	Numk	ber (if known):		
		•		,	ner on the recommendation of a dermatologist. Appro	ovals valid for 6 months.
Prer	equisi	ites(ti	ck box	kes where appropriate)		
			and	_	dy" severe chronic plaque psoriasis at the start of tre	atment
					prior adalimumab treatment course the patient has a	
				or	ained at this level, when compared with the pre-adali	
				prior adalimumab treatment course the patient has a Dermatology Quality of Life Index (DLQI)  f 5 or more, when compared with the pre-treatment baseline value		
		or				
	and		Patient had severe ch	ronic plaque psoriasis of the face, or palm of a hand	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	
				or	e baseline values	reduction of 759/ or more in the skip area
					prior adalimumab treatment course the patient has a tained at this level, as compared to the pre-adalimum	
	and					
	[		Adalim	numab to be administered at	doses no greater than 40 mg every 14 days	
App	licatio	ns onl	y from	Pyoderma gangrenosum n a dermatologist. Approvals	s valid for 6 months.	
Prer	equisi	ites(ti	ck box	kes where appropriate)		
			Π-	The patient has experienced	d intolerable side effects from adalimumab (Amgevita	) following a minimum of 4 weeks treatment
		or			otoms of loss of disease control following a minimum	-
					ibutes this loss of disease response to a change in tr	
	and	— ,	) ationt	t has reasined a maximum s	of Compaths treatment with America	
	and	_			of 6 months treatment with Amgevita	
	and	「	atient	t has previously had a Speci	ial Authority approval for the Humira brand of adalimu	umab for this indication
		/	A maxi	imum of 8 doses		

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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:	
	nd) - continued	Fax Number:
Renewal — Pyoderma gangrenosum	ia) - commueu	
Current approval Number (if known):		
Applications only from a dermatologist. Approvals  Prerequisites(tick boxes where appropriate)		
The patient has demonstrated clin and A maximum of 8 doses	ical improvement and continues to require treatment	
Prerequisites (tick boxes where appropriate)  The patient has experienced and a maximum of 6 months or Patient has developed symp 6 months treatment with Amor Patient has Crohn's and is companded and Patient has previously had a Speciand	d intolerable side effects from adalimumab (Amgevita) is treatment with Amgevitat browns of loss of disease control following a minimum of a gevita and clinician attributes this loss of disease resistant of the attributes the loss of disease resistant and clinician attributes the loss of disease resistant and clinician attributes the loss of disease resistant and the loss of disease destabilisation if the	of 4 weeks treatment, and a maximum of ponse to a change in treatment regimen ere were to be a change to current treatment
Renewal — Crohn's disease - adult		
Current approval Number (if known):  Applications only from a gastroenterologist or Prace  Prerequisites(tick boxes where appropriate)	ctitioner on the recommendation of a gastroenterologi	st. Approvals valid for 6 months.
or CDAI score has reduced by CDAI score is 150 or less	100 points from the CDAI score when the patient was	s initiated on adalimumab
	ed an adequate response to treatment, but CDAI scor	re cannot be assessed
and Adalimumab to be administered at	t doses no greater than 40 mg every 14 days	

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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:		
Adalimumab (Humira - Alternative brai	nd) - continued			
Initial application — Crohn's disease - children Applications only from a gastroenterologist or Pra Prerequisites(tick boxes where appropriate)	n ctitioner on the recommendation of a gastroenterolog	gist. Approvals valid for 6 months.		
and a maximum of 6 months	d intolerable side effects from adalimumab (Amgevita s treatment with Amgevita otoms of loss of disease control following a minimum			
or 6 months treatment with Am	ngevita and clinician attributes this loss of disease rest considered to be at risk of disease destabilisation if the	sponse to a change in treatment regimen		
and	Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication			
Renewal — Crohn's disease - children				
Current approval Number (if known):				
Applications only from a gastroenterologist or Prace <b>Prerequisites</b> (tick boxes where appropriate)	ctitioner on the recommendation of a gastroenterologi	ist. Approvals valid for 6 months.		
PCDAI score has reduced b	y 10 points from the PCDAI score when the patient w	vas initiated on adalimumah		
or	y to points norm the FODAL score when the patient w	as illuated on adaminumab		
PCDAI score is 15 or less				
	ed an adequate response to treatment, but PCDAI sc	ore cannot be assessed		
Adalimumab to be administered at	t doses no greater than 40 mg every 14 days			
Initial application — Crohn's disease - fistulisin Applications only from a gastroenterologist or Pra Prerequisites(tick boxes where appropriate)	ng ctitioner on the recommendation of a gastroenterolog	gist. Approvals valid for 6 months.		
	d intolerable side effects from adalimumab (Amgevita	) following a minimum of 4 weeks treatment.		
	s treatment with Amgevita	, 10.10.1		
Patient has developed symp 6 months treatment with Am	s treatment with Amgevita  otoms of loss of disease control following a minimum of the control following as the control following a minimum of the control following and the control following a minimum of the control following	of 4 weeks treatment, and a maximum of		
Patient has developed symp 6 months treatment with Am	otoms of loss of disease control following a minimum	of 4 weeks treatment, and a maximum of sponse to a change in treatment regimen		
or Patient has developed symp 6 months treatment with Am Patient has Crohn's and is c	otoms of loss of disease control following a minimum or a	of 4 weeks treatment, and a maximum of sponse to a change in treatment regimen ere were to be a change to current treatment		

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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:Adalimumab (Humira - Alternative bra	nd) - continued	Fax Number:
Renewal — Crohn's disease - fistulising		
Current approval Number (if known):	ctitioner on the recommendation of a gastroenterologi	st. Approvals valid for 6 months.
The number of open draining fistulae have decreased from baseline by at least 50%  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		
Adalimumab to be administered a	t doses no greater than 40 mg every 14 days	
Initial application — Ocular inflammation – chi Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)		
The patient has experience and a maximum of 6 month	d intolerable side effects from adalimumab (Amgevita) s treatment with Amgevita	) following a minimum of 4 weeks treatment,
Patient has developed sym	otoms of loss of disease control following a minimum of ment with Amgevita and clinician attributes this loss of	
	ensidered to be at risk of vision loss if they were to char	ange treatment
and 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	

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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:
Adalimumab (Humira - Alternative bran	nd) - continued	
Renewal — Ocular inflammation – chronic		
Current approval Number (if known):		
Applications from any relevant practitioner. Approv		
Prerequisites(tick boxes where appropriate)		
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)  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 — severe		
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick boxes where appropriate)	vals valid for 12 months.	
or Patient has developed symposismen and a maximum of 6 months treatment regimen	intolerable side effects from adalimumab (Amgevita) treatment with Amgevita toms of loss of disease control following a minimum of ment with Amgevita and clinician attributes this loss of	of 4 weeks treatment with Amgevita, and a f disease response to a change in treatment
and	al Authority approval for the Humira brand of adalimudoses no greater than 40 mg every 14 days	umab for this indication
	asses no grouter than to my every 14 days	

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APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:	First Names:	First Names:	
Name: Surname: Surname: Surname:		Surname:	
Address:	DOB:	Address:	
	Address:		
Fax Number:		Fax Number:	
Adalimumab (Humira - Alternative brar	nd) - continued		
Renewal — Ocular inflammation – severe			
Current approval Number (if known):			
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick boxes where appropriate)	als valid for 12 months.		
The patient has had a good	clinical response following 3 initial doses		
Following each 12-month tre Nomenclature (SUN) criteria of uveitic cystoid macular oe	eatment period, the patient has had a sustained reduct $4 < \frac{1}{2} +$ anterior chamber or vitreous cells, absence of edema)		
	eatment period, the patient has a sustained steroid sp os less than twice daily if under 18 years old	paring effect, allowing reduction in prednisone to	
and Adalimumab to be administered at	and Adalimumab to be administered at doses no greater than 40 mg every 14 days		
Initial application — ankylosing spondylitis Applications only from a rheumatologist or Practiti Prerequisites(tick boxes where appropriate)	ioner on the recommendation of a rheumatologist. A	oprovals valid for 6 months.	
The patient has experienced or	d intolerable side effects from adalimumab (Amgevita	) following a minimum of 4 weeks treatment	
	stoms of loss of disease control following a minimum	of 4 weeks treatment with adalimumab	
and Patient has received a maximum o	of 6 months treatment with Amgevita		
Patient has previously had a Spec	ial Authority approval for the Humira brand of adalime	umab for this indication	
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 Practitic  Prerequisites(tick boxes where appropriate)	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.	
improvement in BASDAI of 50%, w	ovement in BASDAI of 4 or more points from pre-trear hichever is less	atment baseline on a 10 point scale, or an	
Adalimumab to be administered at doses no greater than 40 mg every 14 days			

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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:
Adalimumab (Humira - Alternative brai	nd) - continued	
Initial application — Arthritis – oligoarticular consequence Applications only from a named specialist, rheums valid for 6 months.  Prerequisites(tick boxes where appropriate)	purse juvenile idiopathic atologist or Practitioner on the recommendation of a r	named specialist or rheumatologist. Approvals
<u> </u>	I 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 tre	
and	of 6 months treatment with Amgevita	mab for this indication
Renewal — Arthritis – oligoarticular course juv	enile idiopathic	
Current approval Number (if known):		
	tologist or Practitioner on the recommendation of a n	amed specialist or rheumatologist. Approvals
Prerequisites(tick box where appropriate)		
The patient demonstrates at least a cont assessment from baseline	inuing 30% improvement in active joint count and cor	tinued 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
	I 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 tre	
and Patient has received a maximum of	of 6 months treatment with Amgevita	
	ial Authority approval for the Humira brand of adalimu	mab for this indication
Renewal — Arthritis - polyarticular course juve	nile 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	tinued improvement in physician's global

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Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Adalimumab (Humira - Alternative brar	nd) - continued	
Initial application — Arthritis - psoriatic Applications only from a named specialist, rheuma valid for 6 months.  Prerequisites(tick boxes where appropriate)	atologist or Practitioner on the recommendation of a r	named specialist or rheumatologist. Approvals
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	
and Patient has received a maximum o	f 6 months treatment with Amgevita	
	al Authority approval for the Humira brand of adalimu	umab for this indication
	doses no greater than 40 mg every 14 days	
valid for 6 months.	tologist or Practitioner on the recommendation of a n	amed specialist or rheumatologist. Approvals
Prerequisites(tick boxes where appropriate)		
The patient demonstrates at least a 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
	doses no greater than 40 mg every 14 days	
Initial application — Arthritis – rheumatoid Applications only from a rheumatologist or Practition Prerequisites(tick boxes where appropriate)	oner on the recommendation of a rheumatologist. Ap	oprovals valid for 6 months.
The patient has experienced	intolerable side effects from adalimumab (Amgevita)	) following a minimum of 4 weeks treatment
	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	
	al Authority approval for the Humira brand of adalimu	umab for this indication
Adalimumab to be administe	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

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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:
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 and	a continuing 30% improvement in active joint count fr ne opinion of the treating physician	om baseline and a clinically significant response
or	ered at doses no greater than 40 mg every 14 days itant 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	l intolerable side effects from adalimumab (Amgevita	) following a minimum of 4 weeks treatment
	toms of loss of disease control following a minimum of butes this loss of disease response to a change in tro	
and	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 — Still's disease – adult-onset (AOSD	)	
Prerequisites(tick box where appropriate)	oner on the recommendation of a rheumatologist. Ap	
	,,,	