SA2157 - Adalimumab (Humira - Alternative brand)

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APPLICANT (stamp or sticker acceptable)		PATIENT NHI:	REFERRER Reg No:	
Reg No:		First Names:	First Names:	
Name	:	Surname:	Surname:	
Addre	ss:	DOB:	Address:	
		Address:		
	umber:		Fax Number:	
Appl	Patient has developed symp (Amgevita) and clinician attr and Patient has received a maximum of		of 4 weeks treatment with adalimumab	
	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			
Rene	ewal — Behcet's disease – severe			
Curre	ent approval Number (if known):			
	cations from any relevant practitioner. Appro equisites(tick boxes where appropriate)	vals valid for 6 months.		
		al response to treatment with measurably improved qu	uality of life	
	Adalimumab to be administered at	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)				
	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 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	
		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:		
For North and		For Northern	
Fax Number:		Fax Number:	
Adalimumab (Humira - Alternative bran	d) - continued		
Renewal — Hidradenitis suppurativa			
Current approval Number (if known):			
Applications only from a dermatologist or Practition Prerequisites (tick boxes where appropriate)	er 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 Practition Prerequisites(tick boxes where appropriate)	plaque ner on the recommendation of a dermatologist. Appr	rovals valid for 6 months.	
The patient has experienced or	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 or and	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		

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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	and 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	
	or Patient had severe che and Following each for all 3 of erytle			f 5 or more, when compared with the pre-treatment ba	
				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 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 Patient has received a maximum 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		

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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)	ctitioner on the recommendation of a gastroenterolog	ist. Approvals valid for 6 months.	
or and a maximum of 6 months Patient has developed symp 6 months treatment with Am or	d intolerable side effects from adalimumab (Amgevita treatment with Amgevita streatment with Amgevita streatment with Amgevita streatment with Amgevita and clinician attributes this loss of disease resonsidered 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 Patient has previously had a Spec	ial Authority approval for the Humira brand of adalimed doses no greater than 40 mg every 14 days		
Renewal — Crohn's disease - children			
Current approval Number (if known):Applications only from a gastroenterologist or Prace Prerequisites(tick boxes where appropriate)	titioner on the recommendation of a gastroenterologi	st. Approvals valid for 6 months.	
PCDAI score has reduced b	y 10 points from the PCDAI score when the patient w	ras initiated on adalimumab	
PCDAI score is 15 or less			
	ed an adequate response to treatment, but PCDAI sc	ore cannot be assessed	
Adalimumab to be administered at	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	iist. Approvals valid for 6 months.	
and a maximum of 6 months	d intolerable side effects from adalimumab (Amgevita s treatment with Amgevita) following a minimum of 4 weeks treatment,	
6 months treatment with Am	otoms of loss of disease control following a minimum gevita and clinician attributes this loss of disease res		
Patient has Crohn's and is c	onsidered to be at risk of disease destabilisation if th	ere were to be a change to current treatment	
and Patient has previously had a Spec	ial Authority approval for the Humira brand of adalim	umab for this indication	
	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: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.		
or There has been a marked r	g fistulae have decreased from baseline by at least 5 eduction in drainage of all fistula(e) from baseline as or with less induration and patient-reported pain			
Adalimumab to be administered at 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 cha	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	Adalimumab to be administered at doses no greater than 40 mg every 14 days			

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APPLIC	CANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	:	First Names:	First Names:
Name:		Surname:	Surname:
Address	Σ	DOB:	Address:
		Address:	
	mber:		Fax Number:
Adalin	numab (Humira - Alternative brai	nd) - continued	
Current Applica	t approval Number (if known):ations from any relevant practitioner. Approximations (tick boxes where appropriate)		
а	or Following each 12-month tre Nomenclature (SUN) criteria of uveitic cystoid macular oe or Following each 12-month tre < 10mg daily, or steroid drop	clinical response following 12 weeks' initial treatment eatment period, the patient has had a sustained reduct 1 1/2+ anterior chamber or vitreous cells, absence of dema) reatment period, the patient has a sustained steroid spos less than twice daily if under 18 years old doses no greater than 40 mg every 14 days	ction in inflammation (Standardisation of Uveitis active vitreous or retinal lesions, or resolution
Applica	application — Ocular inflammation – sev ations from any relevant practitioner. Appro uisites(tick boxes where appropriate)		
	or Patient has developed symp maximum of 6 months treatment or Patient has developed symp maximum of 6 months treatment regimen Patient has uveitis and is co	d intolerable side effects from adalimumab (Amgevita) is treatment with Amgevita streatment with Amgevita streatment with Amgevita and clinician attributes this loss of ment with Amgevita and clinician attributes this loss of the strick of vision loss if they were to characteristic and Authority approval for the Humira brand of adalimumal for the Humira brand of adalimum for the Humira brand of adalimumal for the Humira brand of adalimumal for the Humira brand of adalimum for the Humira brand of the Humira brand of adalimum for the Humira brand of the Humira bra	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	

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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	
Rene	ewal — Ocular inflammation – severe		
Appli	ent approval Number (if known):cations from any relevant practitioner. Approvequisites (tick boxes where appropriate)		
	or Following each 12-month tre Nomenclature (SUN) criteria of uveitic cystoid macular oe or Following each 12-month tre	clinical response following 3 initial doses eatment period, the patient has had a sustained reduct 1. 1/2+ anterior chamber or vitreous cells, absence of dema) eatment period, the patient has a sustained steroid sp is less than twice daily if under 18 years old	active vitreous or retinal lesions, or resolution
Adalimumab to be administered at doses no greater than 40 mg every 14 days Initial application — ankylosing spondylitis Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.			
ricit	equisites(tick boxes where appropriate)		
	The patient has experienced or	intolerable side effects from adalimumab (Amgevita)	following a minimum of 4 weeks treatment
		toms of loss of disease control following a minimum of	of 4 weeks treatment with adalimumab
	Patient has received a maximum c	f 6 months treatment with Amgevita	
	Patient has previously had a Spec	al Authority approval for the Humira brand of adalimu	ımab for this indication
		doses no greater than 40 mg every 14 days	
Renewal — ankylosing spondylitis			
Appli	ent approval Number (if known):cations only from a rheumatologist or Practition equisites (tick boxes where appropriate)	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.
	Treatment has resulted in an impro improvement in BASDAI of 50%, w	ovement in BASDAI of 4 or more points from pre-trea rhichever is less	tment baseline on a 10 point scale, or an
		doses no greater than 40 mg every 14 days	

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		July 2023	
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			
Initial application — Arthritis – oligoarticular of Applications only from a named specialist, rheum valid for 6 months. Prerequisites(tick boxes where appropriate)	course juvenile idiopathic natologist or Practitioner on the recommendation of a	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 ributes this loss of disease response to a change in tr		
and	of 6 months treatment with Amgevita	umab for this indication	
Renewal — Arthritis – oligoarticular course ju	venile idionathic		
Current approval Number (if known):			
Applications only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist. Approvals valid for 6 months.			
Prerequisites(tick box where appropriate)			
The patient demonstrates at least a con assessment from baseline	tinuing 30% improvement in active joint count and co	ntinued improvement in physician's global	
Initial application — Arthritis - polyarticular co Applications only from a named specialist, rheum valid for 6 months. Prerequisites(tick boxes where appropriate)	ourse juvenile idiopathic natologist or Practitioner on the recommendation of a	named specialist or rheumatologist. Approvals	
The patient has experience or	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		
and Patient has received a maximum and	of 6 months treatment with Amgevita		
Patient has previously had a Spec	cial Authority approval for the Humira brand of adalim	umab for this indication	
Renewal — Arthritis - polyarticular course juvenile idiopathic			
Current approval Number (if known):			
Applications only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist. Approvals valid for 6 months. Prerequisites(tick box where appropriate)			
	tinuing 30% improvement in active joint count and co	ntinued improvement in physician's global	

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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 braı	nd) - continued		
Initial application — Arthritis - psoriatic Applications only from a named specialist, rheums valid for 6 months. Prerequisites(tick boxes where appropriate)	atologist or Practitioner on the recommendation of a	named specialist or rheumatologist. Approvals	
or	d intolerable side effects from adalimumab (Amgevita	,	
(Amgevita) and clinician attr	toms of loss of disease control following a minimum ibutes this loss of disease response to a change in tr		
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	
Adalimumab to be administered at	doses no greater than 40 mg every 14 days		
Renewal — Arthritis - psoriatic			
nenewai — Artifilis - psoriatic			
Current approval Number (if known):	tologist or Practitioner on the recommendation of a r	named energaliet or rhaumatologiet. Approvale	
valid for 6 months. Prerequisites(tick boxes where appropriate)	action of a raction of the recommendation of a r	iameu specialist of medinatologist. Approvais	
to prior adalimumab treatment in the	a continuing 30% improvement in active joint count fine opinion of the treating physician	rom baseline and a clinically significant response	
and Adalimumab to be administered at	doses no greater than 40 mg every 14 days		
Initial application — Arthritis – rheumatoid Applications only from a rheumatologist or Practiti Prerequisites(tick boxes where appropriate)	oner on the recommendation of a rheumatologist. A	pprovals 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 ibutes this loss of disease response to a change in tr	of 4 weeks treatment with adalimumab eatment regimen	
and Patient has received a maximum of and	of 6 months treatment with Amgevita		
	ial Authority approval for the Humira brand of adalim	umab for this indication	
Adalimumab to be administe	ered at doses no greater than 40 mg every 14 days		
	itant methotrexate and requires doses of adalimumat	o higher than 40 mg every 14 days to maintain	
L			

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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	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	I 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 ibutes this loss of disease response to a change in tre	
and Patient has received a maximum c	of 6 months treatment with Amgevita	
Patient has previously had a Speci	ial Authority approval for the Humira brand of adalimu	mab for this indication
Renewal — Still's disease – adult-onset (AOSD)	
Current approval Number (if known):		
Applications only from a rheumatologist or Practition Prerequisites (tick box where appropriate)	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.
The patient has demonstrated a sustained	ed improvement in inflammatory markers and function	al status