## SA2400 - Adalimumab (Amgevita)

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# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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 (Amgevita)		
App Prer	The patient has severe Behcet's diand  The patient has severe Behcet's diand  The patient has severe ocula treatment(s) appropriate for The patient has severe gasti	rointestinal, rheumatological, and/or mucocutaneous opropriate for the particular symptom(s)	not responded adequately to one or more
App	Il application — Hidradenitis suppurativa lications only from a dermatologist. Approvals equisites(tick boxes where appropriate)	valid for 4 months.	
	Patient has hidradenitis suppurativ	a Hurley Stage II or Hurley Stage III lesions in distinc	et anatomic areas
	Patient has tried, but had an inade has contraindications for systemic and	quate response to at least a 90 day trial of systemic a antibiotics	antibiotics or has demonstrated intolerance to or
	Patient has 3 or more active lesion	s	
	The patient has a DLQI of 10 or m	ore and the assessment is no more than 1 month old	at time of application
Rene	ewal — Hidradenitis suppurativa		
Appli	ent approval Number (if known): cations from any relevant practitioner. Approvequisites(tick boxes where appropriate)		
	The patient has a reduction in activand  The patient has a DLQI improvement	ve lesions (e.g. inflammatory nodules, abscesses, drent of 4 or more from baseline	aining fistulae) of 25% or more from baseline

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Reg No:	First Names:	. First Names:
Name:	Surname:	. Surname:
Address:	DOB:	. Address:
	Address:	
Initial application — Plaque psoriasis - s Applications only from a dermatologist or a Prerequisites(tick boxes where appropriate	my relevant practitioner on the recommendation of a derm	atologist. Approvals valid for 4 months.
and Patient has exp	citial Special Authority approval for etanercept for severe controllerable side effects relived insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for expected insufficient benefit to meet the renewal criteria for the renewal criteria for expected insufficient benefit to meet the renewal criteria for	
or Patient has see have been present for at least 6 m than 10	nole body" severe chronic plaque psoriasis with a PASI sc east 6 months from the time of initial diagnosis were chronic plaque psoriasis of the face, or palm of a han sent for at least 6 months from the time of initial diagnosis were chronic localised genital or flexural plaque psoriasis were time of initial diagnosis, and with a Derman	d or sole of a foot, where the plaque or plaques where the plaques or lesions have been present
following (at maximum and A PASI assessment of	had an inadequate response to, or has experienced intolern tolerated doses unless contraindicated): phototherapy, or DLQI assessment has been completed for at least the regreessation of each prior treatment course and is no more	methotrexate, ciclosporin, or acitretin nost recent prior treatment course but no longer

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APPLICANT (stamp or sticker acceptable)				stick	er acceptable)	PATIENT NHI:	REFERRER Reg No:		
Reg No:						First Names:	First Names:		
Name:						Surname:	Surname:		
Addres	s:					DOB:	Address:		
						Address:			
Fax Nu	ımbeı	r:					Fax Number:		
Adali	mun	nab (	Am	gevi	ta) - continued				
Rene	wal –	– Plaq	ue p	soria	sis - severe chronic				
Curre	nt apı	oroval l	Num	ber (i	f known):				
Applic	ation	s from	any	releva	ant practitioner. Appro	ovals valid for 2 years.			
Prere	quisi	tes(tic	k bo	xes w	here appropriate)				
		Г	_	Datia					
		and ,		Patiei	nt had "whole body" s	evere chronic plaque psoriasis at the start of treatme	nt		
						rienced a 75% or more reduction in PASI score, or is	sustained at this level, when compared with		
			or	_	the pre-treatment bas	eline value  QI improvement of 5 or more, when compared with the pre-treatment baseline value			
				Ш	The patient has a DL				
	or						- 1		
		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	Ш		rienced reduction in the PASI symptom subscores fo stained at this level, as compared to the treatment co			
		C			-	•			
					Ш	to the pre treatment to	rienced reduction of 75% or more in the skin area aff paseline value	ected, or sustained at this level, as compared	
	or	L							
	-	Г		Patie	nt had severe chronic	localised genital or flexural plaque psoriasis at the st	art of treatment		
		and		_					
				Ш	The patient has expet to the pre-treatment be	rienced a reduction of 75% or more in the skin area a	affected, or sustained at this level, as compared		
			or		·				
				Ш	commencing adalimu	cology Quality of Life Index (DLQI) improvement of 5 imab	or more, as compared to baseline DLQI prior to		
L		L							
Initial	anni	ication		nvod	erma gangrenosum				
Appli	cation	ns only	fror	n a de	ermatologist. Approval	s valid without further renewal unless notified.			
Prere	quisi	tes(tic	k bo	xes w	here appropriate)				
	[	Pa	atier	t has	pyoderma gangrenos	um*			
	and [	_ թ.	ation	ıt hac	received three months	s of conventional therapy including a minimum of thre	an pharmacouticals (a.g. prednisopo ciclosporio		
	L					d has not received an adequate response	priamiaceulicais (e.g. preumsone, ciclosponn,		
Note:	India	ations	mar	kad w	vith * are unapproved i	ndications			

# 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:
Adalimumab (Amgevita) - continued		
Initial application — Crohn's disease - adults Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)	vals valid for 6 months.	
Patient has active Crohn's disease	•	
	greater than or equal to 300, or HBI score of greater	than or equal to 10
Patient has extensive small i	intestine disease affecting more than 50 cm of the sm	nall intestine
Patient has evidence of shor	rt gut syndrome or would be at risk of short gut syndr	ome with further bowel resection
	colostomy and has intestinal inflammation	
Patient has tried but had an inaded and corticosteroids	quate response to, or has experienced intolerable sid	e effects from, prior therapy with immunomodulators
Renewal — Crohn's disease - adults		
Current approval Number (if known):		
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick boxes where appropriate)		
CDAI score has reduced by 100 po on adalimumab	pints from the CDAI score, or HBI score has reduced	by 3 points, from when the patient was initiated
CDAI score is 150 or less, or HBI is	s 4 or less	
The patient has demonstrated an a	adequate response to treatment, but CDAI score and	or HBI score cannot be assessed
Initial application. Outline's discoon, shild control		
Initial application — Crohn's disease - children Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)		
Paediatric patient has active Crohr	n's disease	
Patient has a PCDAI score of	of greater than or equal to 30	
Patient has extensive small i	intestine disease	
and Patient has tried but had an inaded and corticosteroids	quate response to, or has experienced intolerable sid	e effects from, prior therapy with immunomodulators

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 6 Form SA2400 July 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 (Amgevita) - continued		
Renewal — Crohn's disease - children		
Current approval Number (if known):		
Applications from any relevant practitioner. Approv	als valid for 2 years.	
Prerequisites(tick boxes where appropriate)		
PCDAI score has reduced by 10 pc	oints from the PCDAI score when the patient was initiated	ated on adalimumab
PCDAI score is 15 or less		
The patient has demonstrated an a	adequate response to treatment but PCDAI score car	nnot be assessed
Initial application — Crohn's disease - fistulisin Applications from any relevant practitioner. Appro-		
Prerequisites(tick boxes where appropriate)		
Patient has confirmed Crohn's dise	ease	
Patient has one or more com	nplex externally draining enterocutaneous fistula(e)	
Patient has one or more rect	ovaginal fistula(e)	
Patient has complex peri-ana	al fistula	
and A Baseline Fistula Assessment has	s been completed and is no more than 1 month old a	t the time of application
Renewal — Crohn's disease - fistulising		
Current approval Number (if known):		
Applications from any relevant practitioner. Approv		
Prerequisites(tick boxes where appropriate)	,	
· · ·	ae have decreased from baseline by at least 50%	
There has been a marked reduction score, together with less induration	n in drainage of all fistula(e) from baseline as demon a and patient-reported pain	strated by a reduction in the Fistula Assessment

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APPLICANT (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 Number:			
Initia App	al app	olication ons from	— Ocu any rele	rita) - continued  lar inflammation - che evant practitioner. Apprevante appropriate)	r <b>onic</b> ovals valid for 4 months.				
	or	The	e patien	t has had an initial Spe	ecial Authority approval for infliximab for chronic ocular	rinflammation			
	Ŭ.	and	Patie	ent has severe uveitis u	uncontrolled with treatment of steroids and other immu	nosuppressants with a severe risk of vision loss			
			or	Patient is 18 years o	r older and treatment with at least two other immunom	odulatory agents has proven ineffective			
				Patient is under 18 y	ears and treatment with methotrexate has proven ineff	ective or is not tolerated at a therapeutic dose			
			or		ears and treatment with steroids or methotrexate has p disease requires control to prevent irreversible vision l				
		L		methotrexate					
Rene	ewal -	— Ocula	r inflam	nmation - chronic					
	-	-		(if known):vant practitioner. Appro	ovals valid for 2 years.				
			-	where appropriate)	· · · · · · · · · · · · · · · · · · ·				
	or	The	e patien	t has had a good clinic	al response following 12 weeks' initial treatment				
	· ·	No	menclat	ture (SUN) criteria < ½	period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic				
	or			cular oedema)	paying the nations has a questioned storaid appring office				
					period, the patient has a sustained steroid sparing effe vice daily if under 18 years old	ect, allowing reduction in prednisone to < 10mg			
App	licatio	ns from	any rele	lar inflammation - servant practitioner. Approvhere appropriate)	vere ovals valid for 4 months.				
	or	Pa	ient has	s had an initial Special	Authority approval for infliximab for severe ocular infla	mmation			
		and	Patie	ent has severe, vision-t	hreatening ocular inflammation requiring rapid control				
				Treatment with high-ineffective at controll	dose steroids (intravenous methylprednisolone) followe	ed by high dose oral steroids has proven			
			or		ew inflammatory symptoms while receiving high dose s	steroids			
			or	· 	r 8 years and treatment with high dose oral steroids a				

# 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:					
Adalimumab (Amgevita) - continued  Renewal — Ocular inflammation - severe							
Current approval Number (if known):							
Applications from any relevant practitioner. Approv							
or Following each 2 year treatment p Nomenclature (SUN) criteria < ½+ cystoid macular oedema)  Following each 2 year treatment pe	Following each 2 year 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 uveit cystoid macular oedema)						
and  The patient has experi	ecial Authority approval for etanercept for ankylosing ienced intolerable side effects						
or							
Patient has a confirmed diag and Patient has low back pain an	nosis of ankylosing spondylitis for more than six more described at tiffness that is relieved by exercise but not by rest tis demonstrated by radiology imaging						
	dequately to treatment with two or more NSAIDs, whor ankylosing spondylitis	ile patient was undergoing at least 3 months of					
Patient has limitation of BASMI measures: a n than or equal to 10 cm	of motion of the lumbar spine in the sagittal and the fundified Schober's test of less than or equal to 4 cm (mean of left and right)  of chest expansion by at least 2.5 cm below the average.	and lumbar side flexion measurement of less					
	0-10 scale completed after the 3 month exercise trial, an 1 month old at the time of application	but prior to ceasing any previous pharmacological					

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APPLICANT (stamp or sticker acceptable)			PATIENT NHI: REFERRER Reg No:						
Reg N	No:		First Names:	First Names:					
Name	e:		Surname:	Surname:					
Addre	ss:		DOB:	Address:					
			Address:						
				Fax Number:					
		nab (Amgevita) - continued							
Rene	ewal –	- ankylosing spondylitis							
Curr	ent ap	proval Number (if known):							
		s from any relevant practitioner. Approv tes(tick box where appropriate)	/als valid for 2 years.						
1	_	,	DAODAL of A consequence of the form of the form						
l		reatment has resulted in an improveme ASDAI of 50%, whichever is less	nt in BASDAI of 4 or more points from pre-treatment I	paseline on a 10 point scale, or an improvement in					
App	licatio	ication — Arthritis - oligoarticular cons only from a named specialist or rheutes(tick boxes where appropriate)	ourse juvenile idiopathic matologist. Approvals valid for 6 months.						
		The patient has had an initial Special Authority approval for etanercept for oligoarticular course juvenile idiopathic arthriti							
		and	a openiar rationly approval to otalioroopt to oligoar	and the second of parents and the second of					
		Patient has experienc	ed intolerable side effects						
			nsufficient benefit to meet the renewal criteria for oligo	particular course JIA					
	or			,					
			methotrexate therapy or monotherapy where use of r	nethotrexate is limited by toxicity or intolerance					
		and Patient has had oligoarticula	ar course JIA for 6 months duration or longer						
		and							
		maximum tolerated do	s with limited range of motion, pain or tenderness afte ose)	r a 3-month trial of methotrexate (at the					
			ase activity (cJADAS10 score greater than 1.5) with p	poor prognostic features after a 3-month trial of					
		methotrexate (at the n	naximum tolerated dose)						
Rene	ewal –	- Arthritis - oligoarticular course juv	enile idiopathic						
Curre	ent ap	proval Number (if known):							
		s from any relevant practitioner. Approx	vals valid for 2 years.						
Pren	equisi	tes(tick boxes where appropriate)							
	or [	Following initial treatment, the pati assessment from baseline	ent has at least a 50% decrease in active joint count	and an improvement in physician's global					
	j. [	On subsequent reapplications, the improvement in physician's global	patient demonstrates at least a continuing 30% imprassessment from baseline	ovement in active joint count and continued					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)					r acceptable)		PATIENT NHI: REFERRER Reg No:		
Reg No:							First Names:	First Names:	
Name:							Surname:	Surname:	
Addre	ess:						DOB:	Address:	
							Address:		
								Fax Number:	
Initia App	al app licatio	lication	from	arthrit a nan es wh	ned specialist ere appropria	ular cou or rheude te)	ourse juvenile idiopathic Imatologist. Approvals valid for 6 months.		
	and Patient has experience or Patient has received			Patient has ex Patient has re used as an ad	perience ceived in	pecial Authority approval for etanercept for polyartics and intolerable side effects insufficient benefit to meet the renewal criteria for polyartics and intolerable side effects insufficient benefit to meet the renewal criteria for polyartics and intolerable side effects.	olyarticular course JIA		
		and	or [		At least 5 acti methotrexate of Moderate or h	ve joints at the migh dise	s and at least 3 joints with limited range of motion, maximum tolerated dose) ease activity (cJADAS10 score of at least 2.5) after cJADAS10 score between 1.1 and 2.5) after a 6-motion	a 3-month trial of methotrexate (at the maximum	
Rene	ewal -	— Arthr	itis -	polya	articular cou	se juve	enile idiopathic		
Appli	icatior	rs from a	any r	elevar	,	Approv	vals valid for 2 years.		
	or assessment from baseline					ons, the	ient has at least a 50% decrease in active joint course patient demonstrates at least a continuing 30% im		

# 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 Num	ber:					Fax Number:
Adalim	um	ab (	٩m	gevita) - continued		
Applica	uisit	s only	fror	The patient has experi	ecial Authority approval for etanercept or secukinumal enced intolerable side effects ed insufficient benefit from to meet the renewal criter atic arthritis for six months duration or longer ponded to at least three months of methotrexate at a ponded to at least three months of sulfasalazine or lessymptoms of poorly controlled and active disease in deither shoulder or hip el greater than 15 mg/L measured no more than one leater than 25 mm per hour assured as patient is currently receiving prednisone the	maximum tolerated dose (unless contraindicated) efflunomide at maximum tolerated doses (unless at least 15 swollen joints at least four joints from the following: wrist,
Renewa	al —	Arth	itis	- psoriatic		
Applicat	tions	from es(ticles) Fore re	any k bo ollov spo	nse in the opinion of the phys	rals valid for 2 years.  ent has at least a 50% decrease in swollen joint counsician  ntinuing 30% improvement in swollen joint count from	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)					er acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:						First Names:	First Names:	
Name:						Surname:	Surname:	
Addre	ss:					DOB:	Address:	
						Address:		
Fax N	umbei	r:					Fax Number:	
Adal	imun	nab (	An	ngevit	(a) - continued			
App	lication	ns only	fro	m a rhe		al Special Authority approval for etanercept for rheum-	atoid arthritis	
				Ш	The patient has receive	red insufficient benefit from etanercept to meet the re	newal criteria for rheumatoid arthritis	
Patient he months de and  Treatmer intolerand and  Patient he sulphate and  or  and  Patient he sulphate and be also and also also also also also also also also		nent is to be used as a ance  It has tried and not result has persistent patient has persistent	arthritis (either confirmed by radiology imaging, or the an adjunct to methotrexate therapy or monotherapy with a ponded to at least three months of methotrexate at a sponded to at least three months of methotrexate in conted doses (unless contraindicated)  not responded to at least three months of methotrexate and responded to at least three months of methotrexate and responded to at least three months of therapy at the single with methotrexate and responded to at least three months of therapy at the single with methotrexate and responded to a single property and active disease in a symptoms of poorly controlled and active disease in a symptoms of poorly controlled and active disease in and either shoulder or hip	here use of methotrexate is limited by toxicity or maximum tolerated dose (unless contraindicated) ombination with sulfasalazine and hydroxychloroquin te in combination with the maximum tolerated the maximum tolerated dose of leflunomide at least 15 swollen joints				
Curre	ent app	proval s from ites(tic	Nur any k bo	mber (if y releva oxes wh	nt practitioner. Approvere appropriate)		from baseline and a clinically significant	
	or [	re	spo	onse to	treatment in the opinion	• •	, ,	
	[					patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a atment in the opinion of the physician		

# 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:					
Adal	Adalimumab (Amgevita) - continued								
App	licatio	lication — Still's disease - adult-onse ns only from a rheumatologist. Approva ites(tick boxes where appropriate)	et (AOSD)  Ils valid without further renewal unless notified.						
		The patient has had an initial Special Authority approval for etanercept and/or tocilizumab for AOSD  Patient has experienced intolerable side effects from etanercept and/or tocilizumab  or							
	or	Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab							
		Patient diagnosed with AOSD according to the Yamaguchi criteria  Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, NSAIDs and methotrexate  Patient has persistent symptoms of disabling poorly controlled and active disease							
Initial application — ulcerative colitis Applications from any relevant practitioner. Approvals valid for 3 months.  Prerequisites(tick boxes where appropriate)									
	and	Patient has active ulcerative colitis							
		Patient's SCCAI score is gre	eater than or equal to 4						
		Patient's PUCAI score is gre	Patient's PUCAI score is greater than or equal to 20						
	and	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from prior therapy with immunomodulators and systemic corticosteroids  Surgery (or further surgery) is considered to be clinically inappropriate							
		Surgery (or further surgery) is con	sidered to be clinically mappropriate						
Rene	Renewal — ulcerative colitis								
Current approval Number (if known):									
		The SCCAI score has reduced by	2 points or more from the SCCAI score when the patient was initiated on biologic therapy						
	or 	The PUCAI score has reduced by	10 points or more from the PUCAI score when the pa	tient was initiation on biologic therapy					

# 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:					
Adalimumab (Amgevita) - continued							
Initial application — undifferentiated spondyloarthritis Applications only from a rheumatologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)							
	Patient has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip						
Patient has tried and not responded to at least three months of each of methotrexate, sulfasalazine and leflunomide, at maximum tolerated doses (unless contraindicated)  and							
	Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application						
	than 25 mm per hour measured no more than one month prior to the date of this application						
	ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months						
Note: Indications marked with * are unapproved in	ndications						
Renewal — undifferentiated spondyloarthritis							
Current approval Number (if known): Applications from any relevant practitioner. Appro							
Prerequisites(tick boxes where appropriate)	·						
Following initial treatment, the pat response to treatment in the opini	ent has at least a 50% decrease in active joint count from baseline and a clinically significant n of the physician						
	a continuing 30% improvement in active joint count fician	rom baseline and a clinically significant response					
Initial application — inflammatory bowel arthritis – axial Applications only from a rheumatologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)							
Patient has a diagnosis of active u	ulcerative colitis or active Crohn's disease						
and Patient has axial inflammatory pai	in for six months or more						
and Patient is unable to take NSAIDs							
and	a description of the modified sized in a size of MDI						
and	s demonstrated by radiological imaging or MRI						
Patient has not responded adequate physiotherapist and	ately to prior treatment consisting of at least 3 months	s of an exercise regime supervised by a					
	scale completed after the 3 month exercise trial, but	prior to ceasing any previous pharmacological					

# 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:					
Adalimumab (Amgevita) - continued							
Renewal — inflammatory bowel arthritis – ax	al						
Current approval Number (if known):							
Applications from any relevant practitioner. Appr							
Prerequisites(tick box where appropriate)	•						
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 Patient has active arthritis in at less ternoclavicular  Patient has tried and not experie (unless contraindicated)  and Patient has tried and not experie contraindicated)  and Patient has a CRP level gror Patient has an ESR greate or	vals valid for 6 months.  ulcerative colitis or active Crohn's disease east four joints from the following: hip, knee, ankle, sulfaced a response to at least three months of methotrex niced a response to at least three months of sulfasalaze eater than 15 mg/L measured no more than one month or than 25 mm per hour measured no more than one more ed as patient is currently receiving prednisone therapy	ate, or azathioprine at a maximum tolerated dose ine at a maximum tolerated dose (unless h prior to the date of this application nonth prior to the date of this application					
Renewal — inflammatory bowel arthritis – peripheral  Current approval Number (if known):							
treatment in the opinion of the ph	t has at least a 50% decrease in active joint count fror sysician	n baseline and a clinically significant response to					
Patient has experienced at least physician	a continuing 30% improvement in active joint count fro	om baseline in the opinion of the treating					