SA2525 - Adalimumab (Amgevita)

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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)					
Initial application — Behcet's disease - severe Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)	vals valid without further renewal unless notified.				
The patient has severe Behcet's di	sease* that is significantly impacting the patient's qua	ality of life			
	ar, neurological, and/or vasculitic symptoms and has the particular symptom(s)	not responded adequately to one or more			
The patient has severe gastr	ointestinal, rheumatological, and/or mucocutaneous opropriate for the particular symptom(s)	symptoms and has not responded adequately			
Note: Indications marked with * are unapproved in	dications.				
Initial application — Hidradenitis suppurativa Applications only from a dermatologist. Approvals Prerequisites(tick boxes where appropriate)	valid for 4 months.				
Patient has hidradenitis suppurative	a Hurley Stage II or Hurley Stage III lesions in distinc	et anatomic areas			
Patient has tried, but had an inader has contraindications for systemic	quate response to at least a 90 day trial of systemic a	antibiotics or has demonstrated intolerance to or			
Patient has 3 or more active lesion	s				
The patient has a DLQI of 10 or mo	ore and the assessment is no more than 1 month old	at time of application			
Renewal — Hidradenitis suppurativa					
Current approval Number (if known):					
Applications from any relevant practitioner. Approvement of the properties of the pr	rals valid for 2 years.				
The patient has a reduction in active	re lesions (e.g. inflammatory nodules, abscesses, dr	aining fistulae) of 25% or more from baseline			
The patient has a DLQI improvement of 4 or more from baseline					

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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:	
			gevita) - continued		Fax Number:
Application	ns only	fror	Plaque psoriasis - severe on a dermatologist or any relevances where appropriate)	chronic vant practitioner on the recommendation of a dermate	ologist. Approvals valid for 4 months.
and Patient has experience or		Patient has experience	ecial Authority approval for etanercept for severe chro ed intolerable side effects nsufficient benefit to meet the renewal criteria for etar		
or Patient has severe chronic plaque have been present for at least 6 in Patient has severe chronic localise. Patient has severe chronic localise.		present for at least 6 n Patient has severe chr have been present for Patient has severe chr for at least 6 months for	dy" severe chronic plaque psoriasis with a PASI score nonths from the time of initial diagnosis ronic plaque psoriasis of the face, or palm of a hand of at least 6 months from the time of initial diagnosis ronic localised genital or flexural plaque psoriasis who rom the time of initial diagnosis, and with a Dermatole	or sole of a foot, where the plaque or plaques ere the plaques or lesions have been present	
following (at maximum tolera and A PASI assessment or DLQI			following (at maximum tolera A PASI assessment or DLQI	inadequate response to, or has experienced intolerated doses unless contraindicated): phototherapy, me assessment has been completed for at least the mo ation of each prior treatment course and is no more the	ethotrexate, ciclosporin, or acitretin st recent prior treatment course but no longer

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APPLICAN	NT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:			
Reg No:		First Names:	First Names:			
Name:		Surname:	Surname:			
Address: .		DOB:	Address:			
		Address:				
Fax Number	er:		Fax Number:			
Adalimu	ımab (Amgevita) - continued					
Renewal	— Plaque psoriasis - severe chronic					
Current	pproval Number (if known):					
	ons from any relevant practitioner. Appro					
	sites(tick boxes where appropriate)	vais valid for 2 years.				
	Patient had "whole body" se	evere chronic plaque psoriasis at the start of treatmen	t			
		rienced a 75% or more reduction in PASI score, or is	sustained at this level, when compared with			
	the pre-treatment bas					
		QI improvement of 5 or more, when compared with th	e pre-treatment baseline value			
or						
	Patient had severe chronic to	plaque psoriasis of the face, or palm of a hand or sole	of a foot at the start of treatment			
	and	stayue poortasis of the face, of paint of a finite of soil	of a lost at the start of treatment			
		rienced reduction in the PASI symptom subscores for tained at this level, as compared to the treatment cou				
	or	•				
	to the pre treatment b	rienced reduction of 75% or more in the skin area affe aseline value	cted, or sustained at this level, as compared			
or						
	Patient had severe chronic I	ocalised genital or flexural plaque psoriasis at the sta	rt of treatment			
	and					
	The patient has expert to the pre-treatment b	rienced a reduction of 75% or more in the skin area a aseline value	ffected, or sustained at this level, as compared			
	or	ology Quality of Life Index (DLQI) improvement of 5 o	r more, as compared to baseline DLOI prior to			
	commencing adalimu		i more, as compared to baseline DEQI phor to			
Initial ap	plication — pyoderma gangrenosum					
Application	ons only from a dermatologist. Approval	s valid without further renewal unless notified.				
Prerequis	sites(tick boxes where appropriate)					
	Patient has pyoderma gangrenosu	ım*				
and		of conventional therapy including a minimum of three	e pharmaceuticals (e.g. prednisone, ciclosporin,			
	azathioprine, or methotrexate) and	I has not received an adequate response	, , , , , , , , , , , , , , , , , , , ,			
Note: Ind	Note: Indications marked with * are unapproved indications.					

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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			
or	greater than or equal to 300, or HBI score of greater intestine disease affecting more than 50 cm of the sm		
Patient has evidence of showing or	rt gut syndrome or would be at risk of short gut syndr	ome with further bowel resection	
Patient has an ileostomy or	colostomy and has intestinal inflammation		
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	
Renewal — Crohn's disease - adults			
Current approval Number (if known):			
Applications from any relevant practitioner. Approx Prerequisites (tick boxes where appropriate)			
CDAI score has reduced by 100 poor	oints 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 i	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 — Crohn's disease - children Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)			
Paediatric patient has active Crohi	n's disease		
Patient has a PCDAI score of	of greater than or equal to 30		
Patient has extensive small	intestine disease		
Patient has tried but had an inaded and corticosteroids	quate response to, or has experienced intolerable sid	e effects from, prior therapy with immunomodulators	

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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 — 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 initial	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 been completed and is no more than 1 month old at 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)		sticker acceptable)	PATIENT NHI:	REFERRER Reg No:		
Reg No:					First Names:	First Names:
Name:					Surname:	Surname:
Addre	ss: .				DOB:	Address:
					Address:	
Fax N	umbe	ər:				Fax Number:
Adal	imu	mab (A mg	gevita) - continued		
Appl	lication	ons from	any ı	Ocular inflammation - chrorelevant practitioner. Appropriate)		
	or	Th	ie pat	tient has had an initial Spec	cial Authority approval for infliximab for chronic ocular	inflammation
		and	P	Patient has severe uveitis ur	ncontrolled with treatment of steroids and other immu	nosuppressants with a severe risk of vision loss
			or [Patient is 18 years or	older and treatment with at least two other immunom	odulatory agents has proven ineffective
			or [Patient is under 18 ye	ars and treatment with methotrexate has proven ineff	ective or is not tolerated at a therapeutic dose
			[ars and treatment with steroids or methotrexate has p isease requires control to prevent irreversible vision l	
Rene	ewal	— Ocul	ar inf	lammation - chronic		
Curre	ent ai	oproval I	Jumb	er (if known):		
		•		elevant practitioner. Approv		
Prere	equis	sites(ticl	boxe	es where appropriate)		
		Tr	ie pai	tient has had a good clinica	l response following 12 weeks' initial treatment	
	or	No	omen	clature (SUN) criteria < 1/2+	period, the patient has had a sustained reduction in in anterior chamber or vitreous cells, absence of active	
	or	_ ^		macular oedema)		
					eriod, the patient has a sustained steroid sparing effe ice daily if under 18 years old	ect, allowing reduction in prednisone to < 10mg
Appl	Initial application — Ocular inflammation - severe Applications from any relevant practitioner. Approvals valid for 4 months. Prerequisites(tick boxes where appropriate)					
	or	☐ Pa	atient	has had an initial Special A	Authority approval for infliximab for severe ocular infla	mmation
		and] P	atient has severe, vision-th	reatening ocular inflammation requiring rapid control	
			or [Treatment with high-d ineffective at controllir	ose steroids (intravenous methylprednisolone) followe	ed by high dose oral steroids has proven
			[Patient developed nev	v inflammatory symptoms while receiving high dose s	steroids
			or [Patient is aged under ineffective at controllir	8 years and treatment with high dose oral steroids and symptoms	nd other immunosuppressants has proven

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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	er:			Fax Number:	
Adalimu	mab (A	mgevita) - continued			
Renewal	— Ocula	r inflammation - severe			
Current ap	pproval N	umber (if known):			
		ny relevant practitioner. Appro	ovals valid for 2 years.		
Prerequis	sites(tick	boxes where appropriate)			
	The	e patient has had a good clinic	al response following 3 initial doses		
or	Fol	lowing each 2 year treatment	period, the patient has had a sustained reduction in in	nflammation (Standardisation of Uveitis	
		menclature (SUN) criteria < ½- toid macular oedema)	anterior chamber or vitreous cells, absence of active	e vitreous or retinal lesions, or resolution of uveitic	
or			period, the patient has a sustained steroid sparing effe	ect, allowing reduction in prednisone to < 10mg	
	dail	ly, or steroid drops less than tw	vice daily if under 18 years old		
		— ankylosing spondylitis			
	-	rom a rheumatologist. Approva boxes where appropriate)	als valid for 6 months.		
		,			
	and	Patient has had an initial Sp	pecial Authority approval for etanercept for ankylosing	spondylitis	
		The patient has expe	rienced intolerable side effects		
		or	ived insufficient benefit to meet the renewal criteria for	ankylosing spondylitis	
		The patient has recei	wed insulicient benefit to meet the renewal enteria for	annylosing spondynus	
or				aut.	
	and	- 7	ignosis of ankylosing spondylitis for more than six mor		
	and	Patient has low back pain a	and stiffness that is relieved by exercise but not by rest	t	
	and	Patient has bilateral sacroili	iitis demonstrated by radiology imaging		
		Patient has not responded a regular exercise regimen	adequately to treatment with two or more NSAIDs, wh	ile patient was undergoing at least 3 months of	
	and	a regular exercise regimen	for ankylosing spondynus		
		BASMI measures: a than or equal to 10 cr	of motion of the lumbar spine in the sagittal and the fr modified Schober's test of less than or equal to 4 cm m (mean of left and right)		
		Patient has limitation gender	of chest expansion by at least 2.5 cm below the aver-	age normal values corrected for age and	
	and		a 0-10 scale completed after the 3 month exercise trial, nan 1 month old at the time of application	but prior to ceasing any previous pharmacological	
			1 1		

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APPLICANT (stamp or sticker acceptable)			or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:				First Names:	First Names:	
Name):			Surname:	Surname:	
Addre	ess:			DOB:	Address:	
				Address:		
Fax N	lumbei	r:			Fax Number:	
Adal	imun	nab (An	ngevita) - continued			
Rene	ewal –	– ankylos	ing spondylitis			
Curre	ent api	oroval Nur	nber (if known):			
			relevant practitioner. Approv			
Prer	equisi	ites(tick bo	ox where appropriate)			
[nas resulted in an improvements 50%, whichever is less	nt in BASDAI of 4 or more points from pre-treatment I	baseline on a 10 point scale, or an improvement in	
Initis	al anni	lication —	- Arthritis - oligoarticular co	urse iuvenile idionathic		
App	lication	ns only fro	m a named specialist or rheu	matologist. Approvals valid for 6 months.		
Prer	equisi	ites(tick bo	oxes where appropriate)			
			The patient has had an initia	Il Special Authority approval for etanercept for oligoar	rticular course juvenile idiopathic arthritis (JIA)	
		and				
		or	Patient has experience	ed intolerable side effects		
			Patient has received in	nsufficient benefit to meet the renewal criteria for oligi	oarticular course JIA	
	or					
		and	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	r course JIA for 6 months duration or longer		
		and	At 12 2 4 0 2 2 4 5 12 12 12 12 12 12 12 12 12 12 12 12 12	with limited and a second fraction and a second second	u o O manakh kirini af mankh akununka (ak kha	
		or	maximum tolerated do	s with limited range of motion, pain or tenderness afte use)	er a 3-month that of methotrexate (at the	
			Moderate or high dise	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	s - oligoarticular course juv	enile idiopathic		
Curre	ent ap _l	proval Nur	mber (if known):			
		-	relevant practitioner. Approv	vals valid for 2 years.		
Prer	equisi	ites(tick bo	oxes where appropriate)			
	or [wing initial treatment, the pati	ent has at least a 50% decrease in active joint count	and an improvement in physician's global	
	On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline					

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APPLICANT (stamp or sticker acceptable)			PATIENT NHI:	REFERRER Reg No:		
Reg No:			First Names:	First Names:		
Name:			Surname:	Surname:		
Addres	ss:		DOB:	Address:		
			Address:			
				Fax Number:		
Adalimumab (Amgevita) - continued Initial application — Arthritis - polyarticular course juvenile idiopathic Applications only from a named specialist or rheumatologist. Approvals valid for 6 months. Prerequisites(tick boxes where appropriate) Patient has had an initial Special Authority approval for etanercept for polyarticular course juvenile idiopathic arthritis (JIA) Patient has experienced intolerable side effects or Patient has received insufficient benefit to meet the renewal criteria for polyarticular course JIA or To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance and Patient has had polyarticular course JIA for 6 months duration or longer At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose) or Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose) or Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate						
Curre Applie	ent app	— Arthritis - polyarticular course juve proval Number (if known): as from any relevant practitioner. Appro ites(tick boxes where appropriate)				
	Following initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline					

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APPLICANT (stamp or sticker acceptable)			or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:				First Names:	First Names:	
Name:				Surname:	Surname:	
Addre	ss:			DOB:	Address:	
				Address:		
Fax N	lumbei	r:			Fax Number:	
Adal	imun	nab (Ar	ngevita) - continued			
App	lication	ns only fro	Arthritis - psoriatic om a rheumatologist. Approva	als valid for 6 months.		
		and	Patient has had an initial Sp	pecial Authority approval for etanercept or secukinuma	ab for psoriatic arthritis	
			The patient has expe	rienced intolerable side effects		
		o	r _	ved insufficient benefit from to meet the renewal criter	ia for psoriatic arthritis	
					ia ioi poolitatio aramitio	
Patient has had active psoriatic arthritis for six months duration or longer and Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contrain and Patient has tried and not responded to at least three months of sulfasalazine or leflunomide at maximum tolerated doses (contraindicated) and 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 at least four joints from the following: wrielbow, knee, ankle, and either shoulder or hip and Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application or Patient has an ESR greater than 25 mm per hour ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per and has done so for more than three months					at least 15 swollen joints at least four joints from the following: wrist, month prior to the date of this application	
116116	- vvai	Aiuiili	s - psoriatic			
Appli	ication	s from ar	mber (if known):			
	[owing initial treatment, the pat onse in the opinion of the phy	ient has at least a 50% decrease in swollen joint cour sician	nt from baseline and a clinically significant	
	or Patient demonstrates at least a continuing 30% improvement in swollen joint count from baseline and a clinically significant respons the opinion of the treating physician					

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APPLICANT (stamp or sticker acceptable)			ker acceptable)	PATIENT NHI:		REFERRER Reg No:		
Reg No:				First Names:		First Names:		
Name:				Surname:		Surname:		
Addres	s:					. DOB:		Address:
						Address:		
Fax Nu	ımber	·:						Fax Number:
Adaliı	mun	nab (An	ıgev	/ita) - continued			
Appli	cation	ns only	fro	m a r	where appropriate)	vals valid for 6 months.	r etanercept for rheum	atoid arthritis
			or		1	erienced intolerable side effects	nercept to meet the re	enewal criteria for rheumatoid arthritis
	Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is CCP antibody positive) for six months duration or longer Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity intolerance Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated) Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychle sulphate at maximum tolerated doses (unless contraindicated) Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin (unless contraindicated) Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide (unless contraindicated) alone or in combination with methotrexate and 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 at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip				where use of methotrexate is limited by toxicity or maximum tolerated dose (unless contraindicated) ombination with sulfasalazine and hydroxychloroquinate in combination with the maximum tolerated the maximum tolerated dose of leflunomide at least 15 swollen joints			
Currer Applic Prere	nt app	oroval s from tes(tic	Nur any k bo	nber rele exes wing onse	vant practitioner. Appr where appropriate) initial treatment, the pa to treatment in the opin quent reapplications, the	atient has at least a 50% decreas nion of the physician ne patient demonstrates at least	a continuing 30% impr	from baseline and a clinically significant rovement in active joint count from baseline and a
	clinically significant response to treatment in the opinion of the physician							

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APPLICANT (stamp or sticker acceptable)			PATIENT NHI:	REFERRER Reg No:				
Reg No:			First Names:	First Names:				
Name:			Surname:	Surname:				
Addre	ess:		DOB:	Address:				
			Address:					
Fax N	lumbe	<u></u>		Fax Number:				
Adal	Adalimumab (Amgevita) - continued							
Initial application — Still's disease - adult-onset (AOSD) Applications only from a rheumatologist. Approvals valid without further renewal unless notified. Prerequisites(tick boxes where appropriate)								
		The patient has had an initia	l Special Authority approval for etanercept and/or too	ilizumab for AOSD				
		Patient has experienced intolerable side effects from etanercept and/or tocilizumab						
		Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab						
	or							
		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 and						
		Patient has persistent sympt	toms of disabling poorly controlled and active disease	3				
Initial application — ulcerative colitis Applications from any relevant practitioner. Approvals valid for 3 months.								
Piei	equisi	tes(tick boxes where appropriate)						
	and	Patient has active ulcerative colitis						
		Patient's SCCAI score is gre	eater than or equal to 4					
		or 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						
	and [Surgery (or further surgery) is con	sidered to be clinically inappropriate					
Renewal — ulcerative colitis								
Curr	Current approval Number (if known):							
Current approval Number (if known):								
	[The SCCAI score has reduced by	2 points or more from the SCCAI score when the pati	ient was initiated on biologic therapy				
	or [The PUCAI score has reduced by	10 points or more from the PUCAI score when the pa	atient was initiation on biologic therapy				

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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						
	atient has tried and not responded to at least three months of each of methotrexate, sulfasalazine and leflunomide, at maximum plerated doses (unless contraindicated)						
	Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application						
	or Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this application						
or 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	dications						
Renewal — undifferentiated spondyloarthritis							
Current approval Number (if known):							
Prerequisites(tick boxes where appropriate)	rais valid for 2 years.						
	Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant esponse to treatment in the opinion of the physician						
	The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response in the opinion of the treating physician						
Initial application — inflammatory bowel arthritis – axial Applications only from a rheumatologist. Approvals valid for 6 months. Prerequisites(tick boxes where appropriate)							
	Icerative colitis or active Crohn's disease						
and Patient has axial inflammatory pair	n for six months or more						
and Patient is unable to take NSAIDs							
and Patient has unequivocal sacroiliitis	itis demonstrated by radiological imaging or MRI						
and	Patient has not responded adequately to prior treatment consisting of at least 3 months of an exercise regime supervised by a physiotherapist						
	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 N	lo:	First Names:	First Names:					
Name	:	Surname:	Surname:					
Address:		DOB:	Address:					
		Address:						
Fax Number:			Fax Number:					
Adal	Adalimumab (Amgevita) - continued							
Renewal — inflammatory bowel arthritis – axial								
Curre	ent approval Number (if known):							
	cations from any relevant practitioner. Approv	als valid for 2 years.						
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								
App	Patient has active arthritis in at lead sternoclavicular and Patient has tried and not experience (unless contraindicated) and Patient has tried and not experience contraindicated) and Patient has a CRP level great or Patient has an ESR greater to	Icerative colitis or active Crohn's disease st four joints from the following: hip, knee, ankle, subsed a response to at least three months of methotrexacted a response to at least three months of sulfasalazing the subsection of the sulfasalazing that subsection of the subsection	ne at a maximum tolerated dose ne at a maximum tolerated dose (unless n prior to the date of this application onth prior to the date of this application					
Rene	ewal — inflammatory bowel arthritis – perip	pheral						
	ent approval Number (if known):							
Applications from any relevant practitioner. Approvals valid for 2 years. Prerequisites(tick boxes where appropriate)								
	Following initial treatment, patient I treatment in the opinion of the physics	nas at least a 50% decrease in active joint count from sician continuing 30% improvement in active joint count from						