SA2525 - Adalimumab (Amgevita)

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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. Approvals valid without further renewal unless notified. Prerequisites(tick boxes where appropriate) The patient has severe Behcet's disease* that is significantly impacting the patient's quality of life The patient has severe ocular, neurological, and/or vasculitic symptoms and has not responded adequately to one or more treatment(s) appropriate for the particular symptom(s) The patient has severe gastrointestinal, rheumatological, and/or mucocutaneous symptoms and has not responded adequately to two or more treatments appropriate for the particular symptom(s)					
Initial application — Hidradenitis suppurativa Applications only from a dermatologist. Approvals Prerequisites(tick boxes where appropriate)	s valid for 4 months.				
Patient has tried, but had an inade has contraindications for systemic and Patient has 3 or more active lesion and		antibiotics or has demonstrated intolerance to or			
Renewal — Hidradenitis suppurativa					
Current approval Number (if known):		aining fistulae) of 25% or more from baseline			
The patient has a DLQI improvement of 4 or more from baseline					

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Reg N	Reg No:				First Names:	First Names:
Name	:				Surname:	Surname:
Addre	ss:				DOB:	Address:
					Address:	
Fax N	umbe	r:				Fax Number:
Adali	imur	nab (An	ngevita) - continued		
Appl	icatio	ns only	fro	Patient has had an initial Sp	ecial Authority approval for etanercept for severe chro	
	or		01	Patient has received in	nsufficient benefit to meet the renewal criteria for etar	nercept for severe chronic plaque psoriasis
Patient has "whole body" severe chronic plaque psoriasis with a PASI score of greater than 10, where I present for at least 6 months from the time of initial diagnosis Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the place have been present for at least 6 months from the time of initial diagnosis Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions here of at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQ than 10)		or sole of a foot, where the plaque or plaques ere the plaques or lesions have been present				
		and [and		following (at maximum tolera A PASI assessment or DLQ	inadequate response to, or has experienced intoleral ted doses unless contraindicated): phototherapy, me assessment has been completed for at least the mo ation of each prior treatment course and is no more to	ethotrexate, ciclosporin, or acitretin st recent prior treatment course but no longer

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Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Renewal — Plaque psoriasis - severe chronic Current approval Number (if known): Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)		
or The patient has experiment base or The patient has a DL or Patient had severe chronic pand The patient has experiment has experiment base or The patient has experiment has experiment base or The patient has experiment base or The patient has experiment base or The patient has experiment base or or The patient has experiment base or or The patient has experiment base or	QI improvement of 5 or more, when compared with the plaque psoriasis of the face, or palm of a hand or sole rienced reduction in the PASI symptom subscores for tained at this level, as compared to the treatment courienced reduction of 75% or more in the skin area affectaseline value	e pre-treatment baseline value e of a foot at the start of treatment all 3 of erythema, thickness and scaling, to use baseline values ected, or sustained at this level, as compared art of treatment ffected, or sustained at this level, as compared
Initial application — pyoderma gangrenosum Applications only from a dermatologist. Approvale Prerequisites(tick boxes where appropriate)	s valid without further renewal unless notified.	
	s of conventional therapy including a minimum of three d has not received an adequate response	e pharmaceuticals (e.g. prednisone, ciclosporin,

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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. Appl Prerequisites(tick boxes where appropriate)	rovals valid for 6 months.	
Patient has active Crohn's diseas	se	
	of greater than or equal to 300, or HBI score of gre	eater than or equal to 10
Patient has extensive small	Il intestine disease affecting more than 50 cm of the	ne small intestine
Patient has evidence of sh	ort gut syndrome or would be at risk of short gut s	syndrome with further bowel resection
	r colostomy and has intestinal inflammation	
Patient has tried but had an inadand corticosteroids	equate response to, or has experienced intolerabl	e side effects from, prior therapy with immunomodulators
Renewal — Crohn's disease - adults		
Owner to a second Number ("Classes")		
Current approval Number (if known): Applications from any relevant practitioner. Appro		
Prerequisites(tick boxes where appropriate)	5.a.oa.ao. 2 y oa.o.	
CDAI score has reduced by 100 on adalimumab	points from the CDAI score, or HBI score has redu	uced by 3 points, from when the patient was initiated
CDAI score is 150 or less, or HB	l is 4 or less	
The patient has demonstrated ar	n adequate response to treatment, but CDAI score	and/or HBI score cannot be assessed
Initial confliction Control discourse shill do		
Initial application — Crohn's disease - childre Applications from any relevant practitioner. Appl Prerequisites(tick boxes where appropriate)		
Paediatric patient has active Cro	hn's disease	
	of greater than or equal to 30	
Patient has extensive small	Il intestine disease	
Patient has tried but had an inadand corticosteroids	equate response to, or has experienced intolerabl	e side 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. Appro	vals valid for 2 years.					
Prerequisites(tick boxes where appropriate)						
PCDAI score has reduced by 10 p	points from the PCDAI score when the patient was init	iated on adalimumab				
PCDAI score is 15 or less						
The patient has demonstrated an	adequate response to treatment but PCDAI score car	nnot be assessed				
Initial application — Crohn's disease - fistulisi Applications from any relevant practitioner. Appro						
Prerequisites(tick boxes where appropriate)	ovais valid for 6 months.					
Patient has confirmed Crohn's dis	ease					
	mplex externally draining enterocutaneous fistula(e)					
or Patient has one or more rec	stovaginal fistula(e)					
or Patient has complex peri-ar						
and	iai iistuia					
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. Appro Prerequisites (tick boxes where appropriate)	vals valid for 2 years.					
		7				
The number of open draining fistu	lae have decreased from baseline by at least 50%					
There has been a marked reduction score, together with less induration	on in drainage of all fistula(e) from baseline as demor n and patient-reported pain	strated by a reduction in the Fistula Assessment				

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APPLICANT (stamp or sticker acceptable)			amp o	r sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg N	lo:				First Names:	First Names:	
Name	:				Surname:	Surname:	
Addre	ss:				DOB:	Address:	
					Address:		
Fax N	umbe	er:				Fax Number:	
Adali	imu	mab	(Am	gevita) - continued			
Appl	icatio	ons fro	m any	Ocular inflammation - chro relevant practitioner. Approxes where appropriate)			
	or		The p	atient has had an initial Spec	cial Authority approval for infliximab for chronic ocular	inflammation	
	or	and		Patient has severe uveitis un	ncontrolled with treatment of steroids and other immu	nosuppressants with a severe risk of vision loss	
		and		Patient is 18 years or	older and treatment with at least two other immunome	odulatory agents has proven ineffective	
			or	Patient is under 18 ve	ears and treatment with methotrexate has proven ineffe	ective or is not tolerated at a therapeutic dose	
			or			.	
					ars and treatment with steroids or methotrexate has proven ineffective or is not tolerated at a isease requires control to prevent irreversible vision loss prior to achieving a therapeutic dose of		
				monorato			
Rene	wal -	— Ос	ular iı	nflammation - chronic			
Curre	ant ar	oprove	al Nium	nber (if known):			
		•		relevant practitioner. Appro-			
Prere	equis	sites(t	ick bo	xes where appropriate)			
			The p	atient has had a good clinica	al response following 12 weeks' initial treatment		
	or		Follov	ving each 2 year treatment p	period, the patient has had a sustained reduction in in	flammation (Standardisation of Uveitis	
				nclature (SUN) criteria < ½+ d macular oedema)	anterior chamber or vitreous cells, absence of active	vitreous or retinal lesions, or resolution of uveitic	
	or				period, the patient has a sustained steroid sparing effe	ct, allowing reduction in prednisone to < 10mg	
			daily,	or steroid drops less than tw	ice daily if under 18 years old		
Appl	Initial application — Ocular inflammation - severe Applications from any relevant practitioner. Approvals valid for 4 months. Prerequisites(tick boxes where appropriate)						
	0.5		Patier	nt has had an initial Special A	Authority approval for infliximab for severe ocular inflat	mmation	
	or	and		Patient has severe, vision-th	nreatening ocular inflammation requiring rapid control		
		ant		Treatment with high-d ineffective at controlling	lose steroids (intravenous methylprednisolone) followeng symptoms	ed by high dose oral steroids has proven	
			or		w inflammatory symptoms while receiving high dose s	teroids	
			or		8 years and treatment with high dose oral steroids ar		

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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)			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 initia	al Special Authority approval for etanercept for oligoar	ticular course juvenile idiopathic arthritis (JIA)
		and	a openiar rationly approval to calloroopt 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)			PATIENT NHI:	REFERRER Reg No:
Reg No:			First Names:	First Names:
Name:	:		Surname:	Surname:
Addres	ss:		DOB:	Address:
			Address:	
				Fax Number:
Patient has experienced or Patient has received ins To be used as an adjunct to mand Patient has had polyarticular of and At least 5 active joints a methotrexate (at the mand or Moderate or high disease tolerated dose)				yarticular course JIA methotrexate is limited by toxicity or intolerance ain or tenderness after a 3-month trial of 3-month trial of methotrexate (at the maximum
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)			mp o	r sticker 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	lications on	on — ly froi	Arthritis - psoriatic m a rheumatologist. Appropriate)	vals valid for 6 months.	
		and		Patient has had an initial	Special Authority approval for etanercept or secukinum	nab for psoriatic arthritis
			or	The patient has exp	erienced intolerable side effects	
	or			The patient has rec	eived insufficient benefit from to meet the renewal crite	eria for psoriatic arthritis
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 and Patient has tried and not responded to at least three months of sulfasalazin contraindicated) and Patient has persistent symptoms of poorly controlled and active disease or Patient has persistent symptoms of poorly controlled and active disease elbow, knee, ankle, and either shoulder or hip			Patient has tried and not recontraindicated) Patient has persisted Patient has persisted elbow, knee, ankle,	esponded to at least three months of methotrexate at esponded to at least three months of sulfasalazine or nt symptoms of poorly controlled and active disease in the symptoms of poorly controlled and active disease in	leflunomide at maximum tolerated doses (unless n at least 15 swollen joints n at least four joints from the following: wrist,	
			or		greater than 25 mm per hour	
					neasured as patient is currently receiving prednisone more than three months	therapy at a dose of greater than 5 mg per day
Rene	ewal –	– Art	hritis	- psoriatic		
Appli	ication	s fror	n any	nber (if known): r relevant practitioner. App oxes where appropriate)	rovals valid for 2 years.	
	0,			wing initial treatment, the p	atient has at least a 50% decrease in swollen joint counysician	unt from baseline and a clinically significant
	or 			nt demonstrates at least a pinion of the treating physic	continuing 30% improvement in swollen joint count fro cian	m baseline and a clinically significant response in

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APPLICANT (stamp or sticker acceptable)			or stick	er acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:					First Names:	First Names:	
Name:					Surname:	Surname:	
Addres	ss:					DOB:	Address:
						Address:	
Fax N	umbei	r:					Fax Number:
Adali	imun	nab	(An	ngevi	ita) - continued		
Appl	ication	ns onl	y fro	m a rh	ritis - rheumatoid leumatologist. Approva lhere appropriate) patient has had an initia	als valid for 6 months. al Special Authority approval for etanercept for rheum	natoid arthritis
		and	or		The patient has expen	rienced intolerable side effects ved insufficient benefit from etanercept to meet the re	
Patient has had rheumatoid arthritis (either confirmed by radiology image months duration or longer and Treatment is to be used as an adjunct to methotrexate therapy or monor intolerance and Patient has tried and not responded to at least three months of methotre sulphate at maximum tolerated doses (unless contraindicated) Patient has tried and not responded to at least three months of methotre sulphate at maximum tolerated doses (unless contraindicated) Patient has tried and not responded to at least three months of methotre dose of ciclosporin (unless contraindicated) Patient has tried and not responded to at least three months of the (unless contraindicated) alone or in combination with methotrexate and Patient has persistent symptoms of poorly controlled and active or elbow, knee, ankle, and either shoulder or hip			ment is to be used as a crance and not resent has tried and dose of ciclosporin (unless contraindicate and the patient has tried and the patient has persistent patient has persistent patient has persistent patient has persistent the patient the patient has persistent the patient	an adjunct to methotrexate therapy or monotherapy we sponded 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 methotrexaness contraindicated) not responded to at least three months of therapy at the dollar and active disease in a symptoms of poorly controlled and active disease in a symptoms of poorly controlled and active disease in	where use of methotrexate is limited by toxicity or a maximum tolerated dose (unless contraindicated) combination with sulfasalazine and hydroxychloroquinate in combination with the maximum tolerated the maximum tolerated dose of leflunomide at least 15 swollen joints		
Curre Appli	ent apposation	proval s from i tes (tio	Nur ang k be	mber (i y relev oxes w wing ir	ant practitioner. Appro here appropriate)	ient has at least a 50% decrease in active joint count	from baseline and a clinically significant
	Ĺ					e patient demonstrates at least a continuing 30% imprestment in the opinion of the physician	rovement in active joint count from baseline and a

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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 initial Special Authority approval for etanercept and/or tocilizumab for AOSD and						
		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 gre	ater than or equal to 20					
	and [d 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								
Current approval Number (if known):								
Applications from any relevant practitioner. Approvals valid for 2 years. Prerequisites(tick boxes where appropriate)								
	[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 spondylo Applications only from a rheumatologist. Approva 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 and Patient has tried and not responded to at least three months of each of methotrexate, sulfasalazine and leflunomide, at maximum						
tolerated doses (unless contraindi						
Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this application						
ESR and CRP not measure done so for more than three	ed as patient is currently receiving prednisone therapy e months	at a dose of greater than 5 mg per day and has				
Note: Indications marked with * are unapproved in	ndications					
Renewal — undifferentiated spondyloarthritis						
Current approval Number (if known):						
Current approval Number (if known):						
	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					
	least a continuing 30% improvement in active joint count from baseline and a clinically significant response physician					
Initial application — inflammatory bowel arthritis – axial Applications only from a rheumatologist. Approvals valid for 6 months. Prerequisites(tick boxes where appropriate)						
	ulcerative colitis or active Crohn's disease					
Patient has axial inflammatory pa	in for six months or more					
Patient is unable to take NSAIDs						
·	s demonstrated by radiological imaging or MRI					
physiotherapist	ately to prior treatment consisting of at least 3 month	s of an exercise regime supervised by a				
A BASDAI of at least 6 on a 0-10 treatment	scale completed after the 3 month exercise trial, but	prior to ceasing any previous pharmacological				

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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 – axial							
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					