## SA2742 - Adalimumab (Humira - Alternative brand)


Arthritis - polyarticular course juvenile idiopathic - Initial application ..... 10
Arthritis - polyarticular course juvenile idiopathic - Renewal ..... 10
Arthritis - psoriatic - Initial application ..... 11
Arthritis - psoriatic - Renewal ..... 11
Arthritis – oligoarticular course juvenile idiopathic - Initial application ..... 10
Arthritis – oligoarticular course juvenile idiopathic - Renewal ..... 10
Arthritis – rheumatoid - Initial application ..... 11
Arthritis – rheumatoid - Renewal ..... 12
Behcet's disease – severe - Initial application ..... 2
Behcet's disease – severe - Renewal ..... 2
Crohn's disease - adult - Initial application ..... 5
Crohn's disease - adult - Renewal ..... 5
Crohn's disease - children - Initial application ..... 6
Crohn's disease - children - Renewal ..... 6
Crohn's disease - fistulising - Initial application ..... 6
Crohn's disease - fistulising - Renewal ..... 7
Hidradenitis suppurativa - Initial application ..... 2
Hidradenitis suppurativa - Renewal ..... 3
Ocular inflammation – chronic - Initial application ..... 7
Ocular inflammation – chronic - Renewal ..... 8
Ocular inflammation – severe - Initial application ..... 8
Ocular inflammation – severe - Renewal ..... 9
Psoriasis - severe chronic plaque - Initial application ..... 3
Psoriasis - severe chronic plaque - Renewal ..... 4
Pyoderma gangrenosum - Initial application ..... 4
Pyoderma gangrenosum - Renewal ..... 5
Still's disease – adult-onset (AOSD) - Initial application ..... 12
Still's disease – adult-onset (AOSD) - Renewal ..... 12
Ankylosing spondylitis - Initial application ..... 9
Ankylosing spondylitis - Renewal ..... 9

| **APPLICANT** (stamp or sticker acceptable) | **PATIENT** NHI: ..... | **REFERRER** Reg No: ..... |
|---|---|---|
| Reg No: ..... | First Names: ..... | First Names: ..... |
| Name: ..... | Surname: ..... | Surname: ..... |
| Address: ..... | DOB: ..... | Address: ..... |
| ..... | Address: ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

## Adalimumab (Humira - Alternative brand)

**Initial application — Behcet's disease – severe**
Applications from any relevant practitioner. Approvals valid for 6 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment
- **or**
- ☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**
☐ Patient has received a maximum of 6 months treatment with Amgevita
**and**
☐ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication
**and**
☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**Renewal — Behcet's disease – severe**

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 6 months.
**Prerequisites**(tick boxes where appropriate)

☐ The patient has had a good clinical response to treatment with measurably improved quality of life
**and**
☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**Initial application — Hidradenitis suppurativa**
Applications only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment
- **or**
- ☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**
☐ Patient has received a maximum of 6 months treatment with Amgevita
**and**
☐ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication
**and**
☐ Adalimumab to be administered at doses no greater than 40 mg every 7 days. Fortnightly dosing has been considered

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....
**Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz**

| **APPLICANT** (stamp or sticker acceptable) | **PATIENT** NHI: ..... | **REFERRER** Reg No: ..... |
|---|---|---|
| Reg No: ..... | First Names: ..... | First Names: ..... |
| Name: ..... | Surname: ..... | Surname: ..... |
| Address: ..... | DOB: ..... | Address: ..... |
| ..... | Address: ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

## Adalimumab (Humira - Alternative brand) *- continued*

**Renewal — Hidradenitis suppurativa**

Current approval Number (if known):.....

Applications only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has a reduction in active lesions (e.g. inflammatory nodules, abscesses, draining fistulae) of 25% or more from baseline

**or**

- ☐ The patient has a DLQI 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 plaque**

Applications only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

- ☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

- ☐ Patient has received a maximum of 6 months treatment with Amgevita

**and**

- ☐ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

**Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz**

| **APPLICANT** (stamp or sticker acceptable) | **PATIENT** NHI: ..... | **REFERRER** Reg No: ..... |
|---|---|---|
| Reg No: ..... | First Names: ..... | First Names: ..... |
| Name: ..... | Surname: ..... | Surname: ..... |
| Address: ..... | DOB: ..... | Address: ..... |
| ..... | Address: ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

## Adalimumab (Humira - Alternative brand) *- continued*

**Renewal — Psoriasis - severe chronic plaque**

Current approval Number (if known):.....

Applications only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient had "whole body" severe chronic plaque psoriasis at the start of treatment

**and**

- ☐ Following each prior adalimumab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-adalimumab treatment baseline value

**or**

- ☐ Following each prior adalimumab treatment course the patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, when compared with the pre-treatment baseline value

**or**

- ☐ 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**

- ☐ Following each prior adalimumab treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values

**or**

- ☐ Following each prior adalimumab treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-adalimumab treatment baseline value

**and**

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**Initial application — Pyoderma gangrenosum**

Applications only from a dermatologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

- ☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

- ☐ Patient has received a maximum of 6 months treatment with Amgevita

**and**

- ☐ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ☐ A maximum of 8 doses

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

**Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz**

**APPLICANT** (stamp or sticker acceptable)

Reg No: .....

Name: .....

Address: .....

.....

.....

.....

**PATIENT** NHI: .....

First Names: .....

Surname: .....

DOB: .....

Address: .....

.....

.....

.....

**REFERRER** Reg No: .....

First Names: .....

Surname: .....

Address: .....

.....

.....

.....

## Adalimumab (Humira - Alternative brand) *- continued*

**Renewal — Pyoderma gangrenosum**

Current approval Number (if known):.....

Applications only from a dermatologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has demonstrated clinical improvement and continues to require treatment

**and**

- ☐ A maximum of 8 doses

**Initial application — Crohn's disease - adult**

Applications only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevitat

**or**

- ☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen

**or**

- ☐ Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment

**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

**Renewal — Crohn's disease - adult**

Current approval Number (if known):.....

Applications only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ CDAI score has reduced by 100 points from the CDAI score when the patient was initiated on adalimumab

**or**

- ☐ CDAI score is 150 or less

**or**

- ☐ The patient has demonstrated an adequate response to treatment, but CDAI score cannot be assessed

**and**

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

**Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz**

| **APPLICANT** (stamp or sticker acceptable) | **PATIENT** NHI: ..... | **REFERRER** Reg No: ..... |
|---|---|---|
| Reg No: ..... | First Names: ..... | First Names: ..... |
| Name: ..... | Surname: ..... | Surname: ..... |
| Address: ..... | DOB: ..... | Address: ..... |
| ..... | Address: ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

## Adalimumab (Humira - Alternative brand) *- continued*

**Initial application — Crohn's disease - children**
Applications only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita

**or**

- ☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen

**or**

- ☐ Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment

**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

**Renewal — Crohn's disease - children**

Current approval Number (if known):.....

Applications only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on adalimumab

**or**

- ☐ PCDAI score is 15 or less

**or**

- ☐ The patient has demonstrated an adequate response to treatment, but PCDAI score cannot be assessed

**and**

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**Initial application — Crohn's disease - fistulising**
Applications only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita

**or**

- ☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen

**or**

- ☐ Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment

**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

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....
**Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz**

| **APPLICANT** (stamp or sticker acceptable) | **PATIENT** NHI: ..... | **REFERRER** Reg No: ..... |
|---|---|---|
| Reg No: ..... | First Names: ..... | First Names: ..... |
| Name: ..... | Surname: ..... | Surname: ..... |
| Address: ..... | DOB: ..... | Address: ..... |
| ..... | Address: ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

## Adalimumab (Humira - Alternative brand) *- continued*

**Renewal — Crohn's disease - fistulising**

Current approval Number (if known):.....

Applications only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The number of open draining fistulae have decreased from baseline by at least 50%

**or**

- ☐ There has been a marked reduction in drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula Assessment score, together with less induration and patient-reported pain

**and**

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**Initial application — Ocular inflammation – chronic**

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita

**or**

- ☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with Amgevita, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen

**or**

- ☐ Patient has uveitis and is considered to be at risk of vision loss if they were to change treatment

**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

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

**Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz**

| **APPLICANT** (stamp or sticker acceptable) | **PATIENT** NHI: ..... | **REFERRER** Reg No: ..... |
|---|---|---|
| Reg No: ..... | First Names: ..... | First Names: ..... |
| Name: ..... | Surname: ..... | Surname: ..... |
| Address: ..... | DOB: ..... | Address: ..... |
| ..... | Address: ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

## Adalimumab (Humira - Alternative brand) *- continued*

**Renewal — Ocular inflammation – chronic**

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has had a good clinical response following 12 weeks' initial treatment

**or**

- ☐ Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)

**or**

- ☐ Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

**and**

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**Initial application — Ocular inflammation – severe**

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita

**or**

- ☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with Amgevita, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen

**or**

- ☐ Patient has uveitis and is considered to be at risk of vision loss if they were to change treatment

**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

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

**Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz**

| **APPLICANT** (stamp or sticker acceptable) | **PATIENT** NHI: ..... | **REFERRER** Reg No: ..... |
|---|---|---|
| Reg No: ..... | First Names: ..... | First Names: ..... |
| Name: ..... | Surname: ..... | Surname: ..... |
| Address: ..... | DOB: ..... | Address: ..... |
| ..... | Address: ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

## Adalimumab (Humira - Alternative brand) *- continued*

**Renewal — Ocular inflammation – severe**

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has had a good clinical response following 3 initial doses

**or**

- ☐ Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)

**or**

- ☐ Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

**and**

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**Initial application — ankylosing spondylitis**

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

- ☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita)

**and**

- ☐ Patient has received a maximum of 6 months treatment with Amgevita

**and**

- ☐ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**Renewal — ankylosing spondylitis**

Current approval Number (if known):.....

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes 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**

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

**Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz**

| **APPLICANT** (stamp or sticker acceptable) | **PATIENT** NHI: ..... | **REFERRER** Reg No: ..... |
|---|---|---|
| Reg No: ..... | First Names: ..... | First Names: ..... |
| Name: ..... | Surname: ..... | Surname: ..... |
| Address: ..... | DOB: ..... | Address: ..... |
| ..... | Address: ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

## Adalimumab (Humira - Alternative brand) *- continued*

**Initial application — Arthritis – oligoarticular course juvenile idiopathic**
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 boxes where appropriate)

☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

☐ Patient has received a maximum of 6 months treatment with Amgevita

**and**

☐ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**Renewal — Arthritis – oligoarticular 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)

☐ The patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

**Initial application — Arthritis - polyarticular course juvenile idiopathic**
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 boxes where appropriate)

☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

☐ Patient has received a maximum of 6 months treatment with Amgevita

**and**

☐ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**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)

☐ The patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

**Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz**

**APPLICANT** (stamp or sticker acceptable)

Reg No: .....

Name: .....

Address: .....

.....

.....

.....

**PATIENT** NHI: .....

First Names: .....

Surname: .....

DOB: .....

Address: .....

.....

.....

.....

**REFERRER** Reg No: .....

First Names: .....

Surname: .....

Address: .....

.....

.....

.....

## Adalimumab (Humira - Alternative brand) *- continued*

**Initial application — Arthritis - psoriatic**

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 boxes where appropriate)

- ☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

- ☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

☐ Patient has received a maximum of 6 months treatment with Amgevita

**and**

☐ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**Renewal — Arthritis - psoriatic**

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 boxes where appropriate)

☐ The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior adalimumab treatment in the opinion of the treating physician

**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 Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

- ☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

☐ Patient has received a maximum of 6 months treatment with Amgevita

**and**

☐ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**and**

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**or**

- ☐ Patient cannot take concomitant methotrexate and requires doses of adalimumab higher than 40 mg every 14 days to maintain an adequate response

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

**Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz**

**APPLICANT** (stamp or sticker acceptable)

Reg No: .....

Name: .....

Address: .....

.....

.....

.....

**PATIENT** NHI: .....

First Names: .....

Surname: .....

DOB: .....

Address: .....

.....

.....

.....

**REFERRER** Reg No: .....

First Names: .....

Surname: .....

Address: .....

.....

.....

.....

## Adalimumab (Humira - Alternative brand) *- continued*

**Renewal — Arthritis – rheumatoid**

Current approval Number (if known):.....

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

☐ The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior adalimumab treatment in the opinion of the treating physician

**and**

☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

**or**

☐ Patient cannot take concomitant methotrexate and requires doses of adalimumab higher than 40 mg every 14 days to maintain an adequate response

**Initial application — Still's disease – adult-onset (AOSD)**

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

☐ The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment

**or**

☐ Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

**and**

☐ Patient has received a maximum of 6 months treatment with Amgevita

**and**

☐ Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

**Renewal — Still's disease – adult-onset (AOSD)**

Current approval Number (if known):.....

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

**Prerequisites**(tick box where appropriate)

☐ The patient has demonstrated a sustained improvement in inflammatory markers and functional status

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

**Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz**