

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER**

Name: First Names: Name:
Address: Surname: Address:
..... DOB:
..... Address:
Fax Number: Fax Number:
NZMC No: NZMC No:

Adalimumab

INITIAL APPLICATION

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

Prerequisites (tick boxes where appropriate)

- Patient is an adult who has had severe and active erosive Rheumatoid Arthritis for six months duration or longer
and
 Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance
and
 Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose
and
 Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with at least two of the following (triple therapy): sulphasalazine, prednisone at a dose of at least 7.5 mg per day, azathioprine, intramuscular gold, or hydroxychloroquine sulphate (at maximum tolerated doses)
and
 Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of Cyclosporin alone or in combination with another agent
or
 Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of Leflunomide alone or in combination with another agent
and
 Patient has persistent symptoms of poorly-controlled and active disease in at least 20 active, swollen, tender joints
or
 Patient has persistent symptoms of poorly-controlled and active disease in at least four active joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
and
 Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application
or
 C-reactive protein levels 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
and
 The patient consents to details of their treatment being held on a central registry and has signed a consent form outlining the conditions of ongoing treatment

Note:

A patient declaration form http://www.pharmac.govt.nz/special_authority_forms/SA0812-declaration.pdf must be signed by the legal guardian of the patient and the prescriber in the presence of a witness (over 18 years of age).

Applicants are requested to register the treatment with the New Zealand Rheumatology Association by completing the forms and questionnaire http://www.pharmac.govt.nz/special_authority_forms/SA0812-survey.pdf.

Use next page for: Renewal

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

Signed: Date:

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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Adalimumab - continued

RENEWAL

Current approval Number:.....

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

Prerequisites (tick boxes where appropriate)

Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance
and

- Following 4 months initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
or
 On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

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 Payments, Agreements and Compliance (HealthPAC), Private Bag 3015, Wanganui - Fax: 0800 100 131