

Etanercept – juvenile patient declaration form

Please read this declaration carefully and print information neatly in block letters. This form must be signed by the patient, or the patient's legal guardian and the prescriber in the presence of a witness (over 18 years of age). The completed declaration must be sent to HealthPAC along with the relevant Special Authority application. These forms are available from PHARMAC's website (www.pharmac.govt.nz) or by contacting PHARMAC on 0800 66 00 50.

Patient or legal guardian declaration

I acknowledge that continued PHARMAC subsidised treatment with etanercept for Juvenile Idiopathic Arthritis (JIA) will cease if subsequent testing demonstrates that:

- an initial response after 16 weeks of treatment demonstrating an improvement of 50% or greater in total active joint count and physicians global assessment from baseline is not achieved;
- continuation of at least 30% improvement in active joint count and continued improvement in physician's global assessment from baseline is not achieved.

I acknowledge that PHARMAC may, from time to time, review funding of and criteria for access to etanercept.

I consent to the use of all information relating to my/my dependent minor's treatment and contained in and relating to the application for Special Authority for subsidised treatment with etanercept, by medical specialists permitted by PHARMAC to prescribe etanercept for the purpose of monitoring treatment with etanercept.

I understand that:

- all information relating to the patient's treatment, and contained in and relating to the application for Special Authority for subsidised treatment with etanercept, will be held at a secure central registry by the President of the New Zealand Rheumatology Association (NZRA);
- the patient has the right to access all information held in the central registry by the NZRA about him or her relating to subsidised treatment with etanercept;
- the patient has the right to correct any information held in the central registry by the NZRA about him or her, on request to: the President c/- Hutt Valley DHB High Street, Private Bag 310907, Lower Hutt.

I acknowledge that although I am not required to by law, if I do not consent to the collection and use of the information outlined above, my application for subsidised treatment with etanercept for JIA will not be considered.

Patient details

Family name: First name:

Date of birth:/...../..... Male Female NHI Number:

...../...../.....
Signature of patient or legal guardian if patient is under 18 years Date

Prescribers declaration

I have explained the circumstances governing the continuation of PHARMAC's subsidised treatment with etanercept and the nature of the ongoing monitoring and testing required in order to demonstrate adequate and sustained response to therapy. To the best of my knowledge I believe these to be understood and accepted by the patient/patients legal guardian.

Signature of prescriber:

Prescriber's name: Date:/...../.....

Witness

Signature of witness:

Witnessed by: Date:/...../.....