

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**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: .....

## Etanercept

### INITIAL APPLICATION

Applications only from a named specialist or rheumatologist. Approvals valid for 4 months.

#### Prerequisites (tick boxes where appropriate)

- To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance
- and
- Patient diagnosed with Juvenile Idiopathic Arthritis (JIA)
- and
- Patient has had severe active polyarticular course JIA for 6 months duration or longer
- and
- Patient has tried and not responded to at least three months of oral or parenteral methotrexate (at a dose of 10-20mg/m<sup>2</sup> weekly or at the maximum tolerated dose) in combination with oral corticosteroids (prednisone 0.25 mg/kg or at the maximum tolerated dose)
- and
- Patient has tried and not responded to at least three months of oral or parenteral methotrexate (at a dose of 10-15mg/m<sup>2</sup> weekly or at the maximum tolerated dose) in combination with one other disease-modifying agent

- 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, shoulder, cervical spine, hip

and  
 Physician's global assessment indicating severe disease

- and  
 The patient or their legal guardian consents to details of their treatment being held on a central registry and has signed a consent form outlining conditions of ongoing treatment

Note:

A patient declaration form [http://www.pharmac.govt.nz/special\\_authority\\_forms/SA0667-declaration.pdf](http://www.pharmac.govt.nz/special_authority_forms/SA0667-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)

### RENEWAL

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

Applications only from a named specialist or rheumatologist. Approvals valid for 6 months.

#### Prerequisites (tick boxes where appropriate)

- Subsidised 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 and an improvement in physician's global assessment from baseline

or  
 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

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

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

Post application to Ministry of Health, Private Bag 3015, Wanganui – Fax: 0800 100 131