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N&WICS - TA199 - Infliximab - Psoriatic arthritis

Before providing patient identifiable data on this form, please confirm that the patient (or in the case of a minor or vulnerable adult with the parent/legal guardian/carer) has given appropriate explicit consent for sensitive personal information on this form to be passed to the CCG and/or CSU for processing this funding request and validating subsequent invoices. Consent given: ☐

If there is more than one NICE-approved treatment available, a discussion between the responsible clinician and the patient has taken place about the advantages and disadvantages of the treatments available. This has taken into consideration therapeutic need and whether or not the patient is likely to adhere to treatment. The most appropriate, least expensive, will be chosen (taking into account administration costs, dosage and price per dose) unless an order of preference is stated in the TAs. ☐

Patient NHS No:	Trust:	Practice Name:
Patient Hospital No: <input type="text"/>	Consultant Making Request: <input type="text"/>	Practice Postcode:
Patient's Initials and DoB:		Practice Code:
Notification Email Address: <input type="text"/> (@NHS.net account ONLY)		Contact name & number: <input type="text"/>
Start date of requested treatment: <input type="text"/>	Provider: <input type="checkbox"/> Private <input type="checkbox"/> NHS Supplier: <input type="checkbox"/> Homecare <input type="checkbox"/> Hospital	Sub-Type: <input type="text"/> N/A <input type="checkbox"/> (if applicable)

By completing this form, you confirm that you intend to use the requested medicinal product described below as agreed in the local commissioning statement. Any requests which fall outside of this use will require an individual funding request (IFR).

For support regarding IFRs, please contact: norfolkicd@nhs.net

For support regarding the criteria listed below, please contact: norfolknontariff@nhs.net

Please indicate whether patient meets the following NICE criteria:	Please tick
1. Infliximab is recommended for the treatment of adults with active and progressive psoriatic arthritis when the following criteria are met. <ul style="list-style-type: none"> The person has peripheral arthritis with three or more tender joints and three or more swollen joints, and The psoriatic arthritis has not responded to adequate trials of at least two standard disease-modifying antirheumatic drugs (DMARDs), administered either individually or in combination. 	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Treatment as described in 1 should normally be started with the least expensive drug (taking into account drug administration costs, required dose and product price per dose). This may need to be varied for individual patients because of differences in the method of administration and treatment schedules.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Infliximab treatment should be discontinued in people whose psoriatic arthritis has not shown an adequate response using the Psoriatic Arthritis Response Criteria (PsARC) at 12 weeks. An adequate response is defined as: <ul style="list-style-type: none"> an improvement in at least two of the four PsARC criteria, (one of which has to be joint tenderness or swelling score) with no worsening in any of the four criteria. People whose disease has a Psoriasis Area and Severity Index (PASI) 75 response at 12 weeks but whose PsARC response does not justify continuation of treatment should be assessed by a dermatologist to determine whether continuing treatment is appropriate on the basis of skin response (see [NICE TA103, TA134 & TA146]) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. When using the PsARC healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect a person's responses to components of the PsARC and make any adjustments they consider appropriate.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. As per NICE guidance, treatment should normally be started with the least expensive drug (considering the dose required, price per dose and any additional administration costs).	

Please confirm that the choice of drug is considered the most cost-effective treatment for this individual

patient, noting that alternative treatment options recommended by NICE may be lower in cost, including the use of biosimilar medications if applicable.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Where an alternative lower cost treatment is available and has not been tried by the patient, please confirm that the clinical rationale for prescribing has been included in the patients' medical record for the purpose of auditing.	
6. The product is being used as described by local commissioning position.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I confirm that the patient meets the criteria for treatment	
Name of person completing: <input type="text"/>	Contact Details: <input type="text"/>
Designation of person completing: <input type="text"/>	Date: <input type="text"/>
Trust Authorising Pharmacist	
Name: <input type="text"/>	
Date: <input type="text"/>	