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N&WICS - TA445 - Certolizumab - Psoriatic arthritis after inadequate response to DMARDs		
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:	**Consultant Making Request:**	**Practice Postcode:**
Patient's Initials and DoB:		**Practice Code:**
Notification Email Address: (@NHS.net account ONLY)		**Contact name & number:**
Start date of requested treatment:	**Provider:** ☐ Private ☐ NHS **Supplier:** ☐ Homecare ☐ Hospital	**Sub-Type:** N/A **(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. Certolizumab pegol alone, or in combination with methotrexate, is recommended as an option for treating active psoriatic arthritis in adults only if: • 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. • the person has had a tumour necrosis factor (TNF)-alpha inhibitor but their disease has stopped responding after the first 12 weeks. • Certolizumab pegol is only recommended if the company provides it as agreed in the patient access scheme.	☐ Yes ☐ No
2. Assess the response to certolizumab pegol after 12 weeks of treatment. • Only continue treatment if there is clear evidence of response, defined as an improvement in at least 2 of the 4 Psoriatic Arthritis Response Criteria (PsARC), 1 of which must be joint tenderness or swelling score, with no worsening in any of the 4 criteria. • People whose disease has a Psoriasis Area and Severity Index (PASI) 75 response but whose PsARC response does not justify continuing treatment should be assessed by a dermatologist, to determine whether continuing treatment is appropriate based on skin response (as described in the NICE technology appraisal guidance on etanercept, infliximab and adalimumab for the treatment of psoriatic arthritis, recommendation 1.3).	☐ Yes ☐ No
3. 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.	☐ Yes ☐ No
4. 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. 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.	☐ Yes ☐ No
5. The product is being used as described by local commissioning position.	☐ Yes ☐ No

I confirm that the patient meets the criteria for treatment	
Name of person completing:	Contact Details:
Designation of person completing:	Date:

Trust Authorising Pharmacist

Name:

Date: