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N&WICS - TA375 - Abatacept in combination with methotrexate - Rheumatoid arthritis not previously treated with DMARDs or after conventional DMARDs only have failed

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. Adalimumab, etanercept, infliximab, certolizumab pegol, golimumab, tocilizumab and abatacept, all in combination with methotrexate, are recommended as options for treating rheumatoid arthritis, only if: • disease is severe, that is, a disease activity score (DAS28) greater than 5.1 and • disease has not responded to intensive therapy with a combination of conventional disease-modifying antirheumatic drugs (DMARDs) and • the companies provide certolizumab pegol, golimumab, abatacept and tocilizumab as agreed in their patient access schemes.	☐ Yes ☐ No
2. Adalimumab, etanercept, certolizumab pegol or tocilizumab can be used as monotherapy for people who cannot take methotrexate because it is contraindicated or because of intolerance, when the criteria in section 1.1 are met.	☐ Yes ☐ No
3. Continue treatment only if there is a moderate response measured using European League Against Rheumatism (EULAR) criteria at 6 months after starting therapy.	☐ Yes ☐ No
4. After initial response within 6 months, withdraw treatment if a moderate EULAR response is not maintained.	☐ Yes ☐ No
5. Start treatment with the least expensive drug (taking into account administration costs, dose needed and product price per dose). This may need to be varied for some people because of differences in the mode of administration and treatment schedules.	☐ Yes ☐ No
6. Take into account any physical, sensory or learning disabilities, or communication difficulties that could affect the responses to the DAS28 and make any appropriate adjustments.	☐ Yes ☐ No
7. 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
I confirm that the patient meets the criteria for treatment Name of person completing: Designation of person completing:	Contact Details: Date:
Trust Authorising Pharmacist Name: Date:	