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**N&WICS - TA419 - Apremilast - Treating moderate to severe plaque psoriasis**

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. ☐

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

For support regarding the criteria listed below, please contact: [norfolknontariff@nhs.net](mailto:norfolknontariff@nhs.net)

<b>Please indicate whether patient meets the following NICE criteria:</b>	<b>Please tick</b>
1. Apremilast is recommended as an option for treating chronic plaque psoriasis in adults whose disease has not responded to other systemic therapies, including ciclosporin, methotrexate and PUVA (psoralen and ultraviolet-A light), or when these treatments are contraindicated or not tolerated, only if: <ul style="list-style-type: none"> <li>the disease is severe, as defined by a total Psoriasis Area Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10</li> <li>the company provides apremilast with the discount agreed in the patient access scheme.</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Apremilast treatment should be stopped in people whose psoriasis has not responded adequately at 16 weeks. Further treatment cycles are not recommended in these people. An adequate response is defined as either: <ul style="list-style-type: none"> <li>a 75% reduction in the PASI score (PASI 75) from when treatment started or</li> <li>a 50% reduction in the PASI score (PASI 50) and a 5-point reduction in DLQI from start of treatment</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. When using the DLQI, healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties, that could affect the responses to the DLQI and make any adjustments they consider appropriate.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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: