Statewide High Cost Medicines Formulary

Infliximab

Infliximab for adult's patients with severe **biopsy proven pulmonary, cardiac or ocular sarcoidosis** who are refractory to standard treatment including at least 0.5mg/kg of prednisolone (or equivalent) with the addition of at least ONE (preferably two) immunosuppressive steroid sparing agent for at least three months at target dose.

The dose of infliximab is 3 mg/kg at weeks 0, 2, 6 and 12 weeks for 12 months.

The following information is required to be provided by the **prescriber** prior to dispensing of the high cost medicine:

Hospital:

Patient UR number:

Prescriber eligibility for infliximab: (both criteria must be ticked)

1. ☐ **Respiratory physician OR immunologist**

   AND

2. ☐ **Prescriber agrees to forward the following outcome measures to the SAMEP executive officer :**
   - Pulmonary sarcoidosis: Pulmonary function test (PFT) at baseline (prior to commencing infliximab) and PFT at 6 months post initiating infliximab treatment.
     OR
     Positron emission tomography (PET) scan at baseline (prior to commencing infliximab) and PET at 6 months post initiating infliximab treatment.
   - Cardiac Sarcoidosis: Cardiac magnetic resonance imaging (MRI) at baseline (prior to commencing infliximab) and at 6 months post initiating infliximab treatment.
     OR
     Positron emission tomography (PET) scan at baseline (prior to commencing infliximab) and PET at 6 months post initiating infliximab treatment.
     OR
     Ejection fraction measured on echocardiography at baseline (prior to commencing infliximab) and at 6 months post initiating infliximab treatment.

Patient eligibility for infliximab: (at least 3 criteria must be ticked)

1. ☐ **Biopsy-proven pulmonary, cardiac or ocular sarcoidosis** (*all other sarcoidosis subtypes require an IPU application)*.
   - Date of biopsy:
   - For pulmonary sarcoidosis:

     Predicted FEV % and Date
     Date of PET scan
   - For cardiac sarcoidosis: Date of MRI or PET scan

   ☐ **Patient has been discussed at Respiratory MDT**

AND

2. ☐ **Patient is experiencing disease progression despite high dose corticosteroid (despite at least 0.5mg/kg prednisolone or equivalent for ≥ 3 months).** *Please specify below:*

Corticosteroid	From	To	Dose	Minimum dose
Prednisolone (or equivalent)	/ /	/ /		0.5mg/kg

OR

3. ☐ **Patient is corticosteroid dependent (unable to taper corticosteroid to less than 10 mg/day) to maintain disease control.** *Please specify current dose below:*

Corticosteroid	From	Current dose
Prednisolone (or equivalent)	/ /	

OR

4. ☐ **Patient is experiencing corticosteroid related side effects (including true psychosis, uncontrolled diabetes or uncontrolled blood pressure).**

AND

5. ☐ **Patient has tried at least ONE (preferably two) or more immunosuppressive corticosteroid sparing agents for a <u>minimum</u> of 3 months.** *Please specify below:*

	Immunosuppressive	From	To	Dose	Target dose
☐	Methotrexate	/ /	/ /		15-20mg/week
☐	Azathioprine	/ /	/ /		2mg/kg (max 200mg/day)
☐	Mycophenolate	/ /	/ /		1.5 – 3g/day (max 2g/day in chronic renal failure)
☐	Leflunomide	/ /	/ /		20mg/day

If the patient is intolerant to immunosuppressive therapy, please provide a detailed reason below:

_____

I certify that the above information is correct: _____
(Prescribers signature)

Date:

Name:

Position:

Department:

Contact/pager number:

Government of South Australia
SA Health

Information for pharmacy

This form should be retained in the pharmacy department and a copy forwarded to:

✉ The Executive Officer
South Australian Medicines Evaluation Panel
Medicines and Technology Policy and Programs
Level 1, 101 Grenfell St
Adelaide 5000

☎ (08) 7117 9805

💻 SAMEP@sa.gov.au

For more information:
http://www.sahealth.sa.gov.au/samep

Government of South Australia
SA Health

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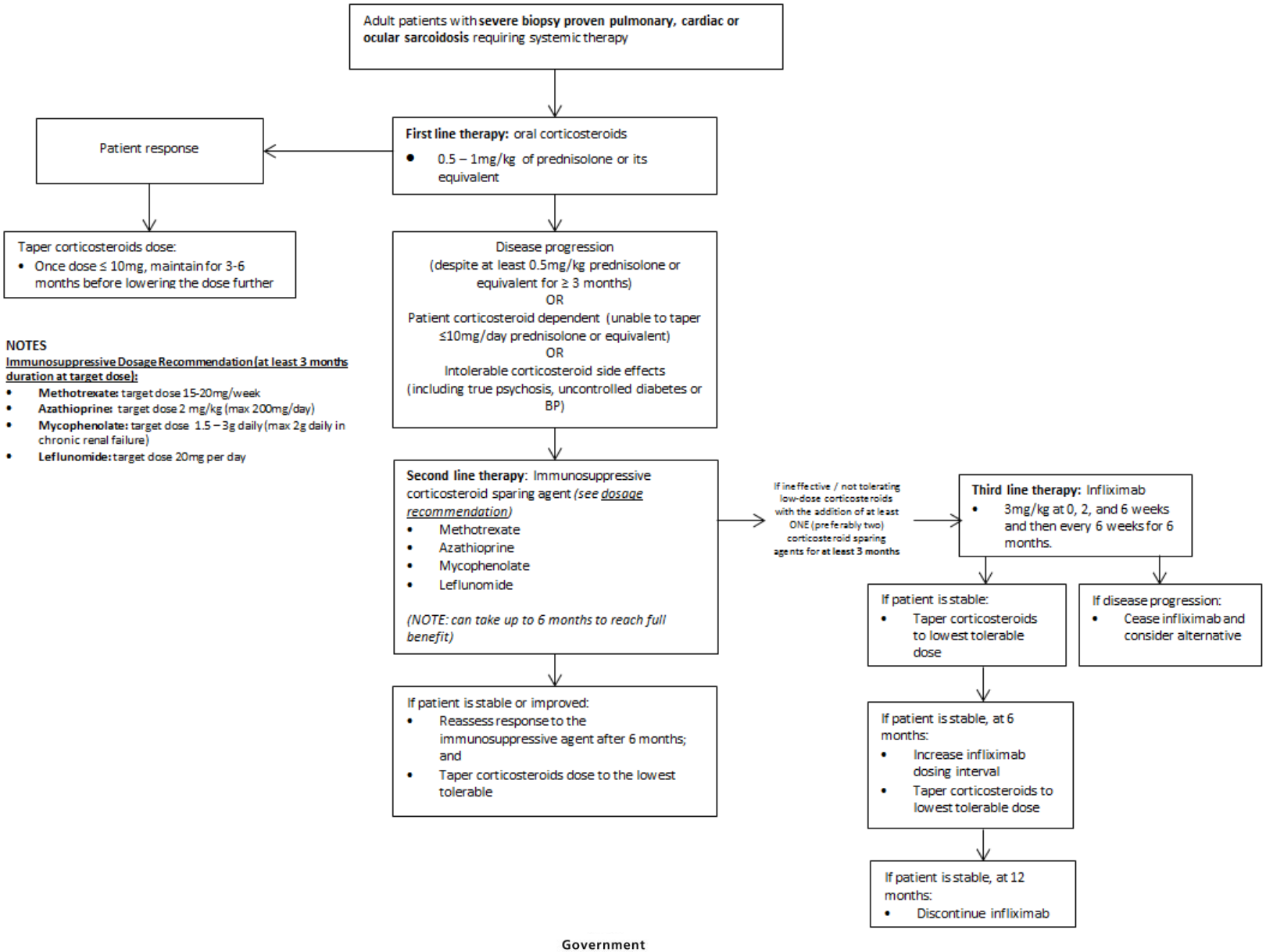
Clinical pathway for infliximab for use in conjunction with eligibility checklist



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