SA Health

Streamline Non-Formulary Request: Anakinra 100mg/0.67mL Subcutaneous Injection for Recurrent Idiopathic Pericarditis

Anakinra 100mg/0.67mL Subcutaneous Injection is not listed on the South Australian Medicines Formulary for recurrent idiopathic pericarditis, however, is accessible via the Streamline Non Formulary Request approval pathway. This is an off-label indication, please ensure the patient has provided informed consent.

This Streamline approval is valid for a maximum of 6 months at the treatment dose plus 6 months at a tapering dose (total of 12 months). Requests for treatment doses for longer than 6 months due to recurrence of pericarditis require an individual patient use (IPU) application. SAFC will review the outcomes of this approval in 12 months' time.

The following information is required to be provided by the prescriber prior to dispensing.

Patient details:

Name:		
UR #:	Date of birth:	Gender:
Patient location (site/hospital):		

Prescriber eligibility for Anakinra 100mg/0.67mL Subcutaneous Injection:

☐ Rheumatologist OR ☐ Immunologist OR ☐ Cardiologist AND

☐ Prescriber/Home Team agrees to provide treatment outcomes before and 12 months after anakinra treatment

If another medical officer is completing this form, provide:

Consultant name _____ Position _____

Patient eligibility for Anakinra 100mg/0.67mL Subcutaneous Injection:

☐ Treatment with anakinra for recurrent* idiopathic pericarditis after three recurrences AND

☐ Used in combination with colchicine AND

☐ Where previous treatment has been trialled including colchicine in combination with NSAID and/or aspirin and/or prednisolone, where appropriate AND

☐ Treatment dosing will be prescribed for 6 months' duration AND

Government of South Australia
SA Health

☐ Tapering (weaning) dosing will be prescribed over a further 6 months' duration AND

☐ Written informed patient consent has been obtained for the off-label use of this medication

Previously trialled treatments for pericarditis before consideration of anakinra:

	First recurrence	**Second recurrence**	**Third recurrence**
Medications Prescribed	☐ Colchicine ☐ Ibuprofen or indomethacin ☐ Aspirin ☐ Prednisolone	☐ Colchicine ☐ Ibuprofen or indomethacin ☐ Aspirin ☐ Prednisolone	☐ Colchicine ☐ Ibuprofen or indomethacin ☐ Aspirin ☐ Prednisolone
Treatment Duration	From: To:	From: To:	From: To:
Response (e.g. why did treatment fail?)			
Side Effects (if any)			
Comments (if any, include details about contraindications to other therapies prior to anakinra)			

*Recurrence of pericarditis is defined as:
A recurrence of pericarditic chest pain >4 weeks after symptom cessation of the previous episode OR persistence of pericarditic chest pain for >4 weeks after initiation of treatment for the episode,
PLUS one or more of the following signs:

- Fever
- Pericardial friction rubs
- Electrocardiographic (ECG) changes
- New or worsening pericardial effusion
- C-reactive protein (CRP) elevation

Outcome assessment at 12 months after treatment**:**

Government of South Australia
SA Health

Complete the following section after 12 months of treatment:

Did the patient have any pericarditis episodes in the first 6 months of treatment with anakinra?

If yes, how many episodes?

When did they occur?

Was hospital admission required?

How was this treated?

Did the patient experience any side effects from treatment with anakinra?

What was the tapering schedule prescribed?

Prescriber details:

I certify that the above information is correct Date: Prescriber Name: Position:
Clinical unit, hospital:
Telephone No: Pager No:

Forward this form to your clinical pharmacist or Pharmacy Department.

PHARMACY USE INFORMATION

Entered in iPharmacy	Yes ☐ No ☐	Signature:
Entered in database	Yes ☐ No ☐	Date:
Treatment end date		
Weaning end date		

Government of South Australia
SA Health