SA Health

Eligibility Checklist:

Tocilizumab 162mg/0.9mL Subcutaneous Injection

Tocilizumab 162mg/0.9mL subcutaneous injection is listed on the South Australian Medicines Formulary for selected patients who have received Pharmaceutical Benefits Scheme (PBS)-funded therapy for this injection for giant cell arteritis (GCA) for 52 weeks and require an additional 52 weeks of treatment (non-PBS). The Formulary allows a maximum treatment duration of 2 years with tocilizumab 162mg/0.9mL subcutaneous injection for GCA for selected patients (includes PBS and non-PBS supply).

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 tocilizumab 162mg/0.9mL subcutaneous injection:

☐ Rheumatology consultant or medical officer working under Rheumatology consultant

Patient eligibility for tocilizumab 162mg/0.9mL subcutaneous injection:

☐ Has experienced disease relapse with cranial symptoms at cessation of tocilizumab after 52 weeks **OR**

☐ Has experienced partial remission of cranial symptoms at cessation of tocilizumab after 52 weeks

AND ALSO

☐ Has biopsy/radiologically proven GCA and qualified and received treatment with PBS-subsidised tocilizumab 162mg/0.9mL subcutaneous injection in previous 52 weeks

AND

☐ Has experienced or are at very high risk of unacceptable glucocorticoid related complications (i.e., unstable diabetes, osteoporotic fractures, etc.) **AND**

☐ Are unsuitable or intolerant of alternative immunosuppressive agents e.g. methotrexate

Reason:

AND

☐ Has been informed by prescriber that they will be eligible for a maximum 52 weeks of additional tocilizumab to treat GCA relapse and they need to have this dispensed via the hospital pharmacy (non-PBS)

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Outcome assessment:

Prescriber agrees to provide the following objective measures of outcome at 3 months after treatment (or earlier if applicable) to local hospital Drug and Therapeutics Committee (DTC): Dose of tocilizumab prescribed: Response after additional tocilizumab prescribed: Change in cumulative corticosteroid use:

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 for forwarding to the local DTC.

PHARMACY USE INFORMATION

Entered in iPharmacy	Yes ☐ No ☐	Signature:
Entered in database	Yes ☐ No ☐	Date:
Expiry		

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