Please complete or attach patient sticker:

Name:

Hosp. No.:

NHS/CHI:

DoB:

Gender: ☐ **Male** ☐ **Female**

Address:

BADBIR ID: ☐☐☐☐☐☐☐☐☐☐

BAD Biologics and Immunomodulators Register Baseline Clinical Questionnaire

Today's Date:_____ **Date of Consent:**_____ **Sent to BADBIR?** ☐

Date Entered on to Database:_____

Psoriasis

1. Does the patient have a <u>past history</u> of the following?

	No
Erythrodermic psoriasis	☐
Generalised pustular psoriasis	☐

2. What type of psoriasis does the patient <u>currently</u> have?

	Yes	No	
Chronic plaque psoriasis	☐	☐	→ **Small** (≤3cm diam) ☐ **Large** (>3cm diam) ☐
Flexural/intertriginous	☐	☐	
Seborrhoeic psoriasis	☐	☐	
Scalp	☐	☐	
Palms/soles (non pustular)	☐	☐	
Nails	☐	☐	→ Indicate number of nails affected ☐
Guttate psoriasis	☐	☐	
Unstable psoriasis	☐	☐	
Erythrodermic	☐	☐	
Generalised pustular psoriasis	☐	☐	
Localised pustular psoriasis	☐	☐	→ Acrodermatitis Hallopeau ☐☐ Palmoplantar pustulosis ☐☐
Other (please specify below)	☐	☐	

☐

3. Please complete the following details:

Year of diagnosis (best approximation) ☐☐☐☐ Year first seen by a dermatologist ☐☐☐☐

4. Does the patient have a family history of psoriasis? (i.e. first-degree relative such as parent, sibling or child)

Yes ☐
No ☐
Don't know ☐

Disease Severity

5. Does the patient have diagnosis by a rheumatologist of psoriatic arthritis?

Please add details of any other inflammatory arthritis conditions to comorbidities

Yes ☐ → ☐☐☐☐ Year of Diagnosis
No ☐

6. Please document all recent PASIs & PGAs including the <u>pre-BADBIR</u> registration treatment PASI:

PASI	Date	Psoriasis Global Assessment	Patient Completed PGA

Psoriasis Global Assessment:
- Severe
- Moderate to severe
- Moderate
- Mild
- Almost clear
- Clear

If patient has **pustular psoriasis** please document BSA:

BSA	Date

Current Drug Therapy

7. Is the patient currently on any of the following topical treatments?

Topical pimecrolimus Yes ☐ No ☐ **Topical tacrolimus** Yes ☐ No ☐

8. Please list all the patient's current therapy for any *indication (Please note topical treatments apart from the two listed above are not required)*

DRUG	Date Started (d d m m y y)	DRUG	Date Started (d d m m y y)

Psoriasis Treatment

9. Is the patient currently receiving biologic treatment for their psoriasis? **Yes** ☐ **No** ☐

- ☐ **Amgevita (adalimumab)**
- ☐ **Benepali (etanercept)**
- ☐ **Cimzia (certolizumab pegol)**
- ☐ **Cosentyx (secukinumab)**
- ☐ **Erelzi (etanercept)**
- ☐ **Hyrimoz (adalimumab)**
- ☐ **Ilumetri (tildrakizumab)**
- ☐ **Imraldi (adalimumab)**
- ☐ **Kyntheum (brodalumab)**
- ☐ **Skyrizi (risankizumab)**
- ☐ **Taltz (ixekizumab)**
- ☐ **Tremfya (guselkumab)**
- ☐ **Zessly (infliximab)**

Commencement date of this episode of biologic therapy: d d m m y y ☐☐☐☐☐☐

Is this the patient's first exposure to a biologic agent: Yes ☐ No ☐

***If applicable*: Was the recommended opening schedule followed?**

Yes ☐ No* ☐ Currently unknown ☐

Dose: ☐

Frequency: ☐

***If 'No'**, please provide details of deviation from schedule:

ILUMETRI/SKYRIZI/ZESSLY ONLY: Provide administration dates

d d m m y y	Batch number

RECOMMENDED OPENING SCHEDULES:

Amgevita: 80mg week 0, 40mg fortnightly from week 1
Cimzia: 400 mg at weeks 0, 2 and 4
Cosentyx: 300mg at weeks 0, 1, 2, 3 & 4
Hyrimoz: 80mg week 0, 40mg fortnightly from week 1
Ilumetri: 100mg at weeks 0 & 4. 12 weekly thereafter
Imraldi: 80mg week 0, 40mg fortnightly from week 1
Kyntheum: 210 mg at weeks 0, 1 and 2
Skyrizi: 150mg at weeks 0 & 4. 12 weekly thereafter
Taltz: 160mg at week0, 80mg at weeks 2, 4, 6, 8, 10, and 12
Tremfya: 100mg at week 0, 100mg at week 4

10. Is the patient currently receiving a small molecule immunomodulator therapy for their psoriasis? **Yes** ☐ **No** ☐

DRUG	(Please Tick)	Dose (mg)	Frequency	Date Started (d d m m y y)
Skilarance (dimethyl fumarate)	☐	☐	*Average Daily Dose*	☐☐☐☐☐☐

11. Is the patient currently receiving conventional therapy for their psoriasis? **Yes** ☐ **No** ☐

DRUG	(Please Tick)	J/cm² or mg	Frequency	Date Started (d d m m y y)
Oral PUVA	☐	☐	☐	☐☐☐☐☐☐
Methotrexate	☐	☐	☐	☐☐☐☐☐☐
Ciclosporin	☐	☐	*Average Daily Dose*	☐☐☐☐☐☐
Acitretin	☐	☐	☐	☐☐☐☐☐☐
Fumaderm	☐	☐	*Average Daily Dose*	☐☐☐☐☐☐
Hydroxycarbamide	☐	☐	☐	☐☐☐☐☐☐

MTX Only: Oral ☐ Sub-Cut ☐

Previous Therapy

12. Please list <u>all previous</u> systemic anti-psoriatic therapy: **If none please tick** ☐

Drug	Start date	Stop date	Stop reason*

***Stop reasons:** Adverse Events, Clinical Trial, Contraindication, Death, Financial Consideration, Inefficacy, Inefficacy and Adverse Events, Other (please provide details), Patient Choice, Patient Non-Compliance, Remission, Titration*

Co-morbidities

13. Has the patient <u>ever</u> had (i.e. <u>required treatment for</u>) any of the following illnesses?

(please tick <u>all</u> that apply) **If none please tick** ☐

Hypertension	Yes	Year of Onset
Hypertension		

Cardiovascular Disease	Yes	Year of Onset
Angina		
Myocardial Infarction		
Stroke / Cerebrovascular Disease		
Peripheral Vascular Disease		
Dyslipidaemia		

Diabetes	Yes	Year of Onset
Type 1		
Type 2		

Autoimmune Disorders	Yes	Year of Onset
Thyroid Disease		
Alopecia Areata		
Vitiligo		
Psoriatic Arthritis		

Thrombosis	Yes	Year of Onset
Deep vein thrombosis		
Pulmonary embolism		
Asthma		
COPD (including chronic bronchitis, emphysema)		

Liver Disease	Yes	Year of Onset
NAFLD (non-alcoholic fatty liver disease, including fatty liver and NASH)		
Alcoholic Liver Disease		
Viral Hepatitis		
Autoimmune Hepatitis		
Inherited Liver Disease (inc. haemochromatosis)		

Kidney Disease	Yes	Year of Onset
Chronic Kidney Disease		
Glomerular Disease		
Renovascular Kidney Disease		
Inherited Renal Disease (polycystic kidney disease)		

Peptic Ulcer	Yes	Year of Onset
Peptic Ulcer		

Demyelination	Yes	Year of Onset
Optic Neuritis		
Multiple Sclerosis		
Transverse Myelitis		
Chronic Inflammatory De-myelinating Polyneuropathy		
Guillain-Barre Syndrome		

Epilepsy	Yes	Year of Onset
Epilepsy		

Peptic Ulcer	Yes	Year of Onset
Peptic Ulcer		

Non-Skin Cancer	Yes	Year of Onset
Please specify type / site:		

Psychiatric	Yes	Year of Onset
Depression		
Anxiety		

Inflammatory Bowel	Yes	Year of Onset
Crohns		
Ulcerative Colitis		

Other (please specify)	Yes	Year of Onset

Skin

Skin Cancer risk factors:

14a) Please indicate Fitzpatrick skin type in box below

Description	Fitzpatrick Skin Type	Please tick
Burns easily, never tans	**1**	
Burns easily, tans minimally	**2**	
Burns moderately, tans gradually	**3**	
Burns minimally, tans well	**4**	
Rarely burns, tans profusely	**5**	
Never burns, deeply pigmented	**6**	

14b) History of prior neoplastic or pre-cancerous lesions? Yes ☐ No ☐

(Please indicate number) and site below)

Type	Site	Number
SCC		
BCC		
Melanoma		
Melanoma in situ		
Actinic keratosis		
Bowen's disease		
Keratoacanthoma		

UV Therapy

15. Has the patient ever had UV therapy? Yes ☐ No ☐ **If YES, please complete the following:**

UV Therapy Details	Yes	No. of Courses	No. of Treatments	Cumulative Dose (J/cm^2)	Data Known to be Accurate?
Broadband UVB					
Narrowband UVB					
TOTAL BODY PUVA					
Oral PUVA					
Topical PUVA					
HAND AND FOOT PUVA					
Oral PUVA					
Topical PUVA					

Lab Values

16. Please complete the following laboratory values (recent i.e. within last 6 months):

LABORATORY VALUES	Result	Date
Haemoglobin count (g/dL)		
White cell count (x10^9/L)		
Platelet count (x10^9/L)		
Creatinine (µmol/L)		
Transaminase ALT (U/L)		
Cholesterol (mmol/L)		
Triglyceride (mmol/L)		
HDL (mmol/L)		

Additional Information

17. What is the patient's current (i.e. at the time that the biologic/systemic agent was started) blood pressure?

Systolic ☐☐☐ mm

Diastolic ☐☐☐ mm

15. What is the patient's current (i.e. at the time that the biologic/systemic agent was started) height, weight and waist circumference?

Height ☐☐☐ cm

Weight ☐☐☐ kg

Waist circumference ☐☐☐ cm

PBQ & QoL Questionnaires

The following patient questionnaires should also be completed:

PBQ ☐
(1)DLQI ☐
EuroQol ☐

CAGE ☐
(2)HAQ ☐
HADS ☐

If paediatric patient:

cDLQI ☐
EQ-5D-y ☐

PBQ ☐
(2)cHAQ ☐

(1) It is not essential but a DLQI taken prior to drug commencement is preferred
(2) (Only if patient has a rheumatologist's diagnosis of inflammatory arthritis)

Signature

Please sign and date below:

Name: _____ **Signature:** _____ **Date:** _____