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1 PRODUCT NAME

COSENTYX® 150 mg Powder for Injection
COSENTYX® 150 mg/mL Solution for Injection

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Active ingredient:	Secukinumab
Chemical name:	Recombinant human monoclonal anti-human Interleukin-17A (IL-17A, IL-17) antibody of the IgG1/kappa isotype
CAS Numbers:	875356-43-7 (heavy chain), 875356-44-8 (light chain)
Molecular formula:	C ₆₅₈₄ H ₁₀₁₃₄ N ₁₇₅₄ O ₂₀₄₂ S ₄₄
Molecular weight:	Approximately 148 kDa
Structure:	The amino acid sequences of the light chain (215 amino acids) and the heavy chain (457 amino acids) respectively.

Secukinumab is a recombinant fully human monoclonal antibody selective for interleukin-17A. Secukinumab is of the IgG1/κ-class produced in Chinese Hamster Ovary (CHO) cells.

3 PHARMACEUTICAL FORM

Powder for injection

Each vial of powder for injection contains 150 mg of secukinumab as a lyophilized cake in glass vials.

Solution for injection

Solution for injection in a single-use, pre-filled syringe and/or pen (auto-injector). The solution is clear and colourless to slightly yellow.

Prefilled syringe: Each single-use pre-filled syringe contains 150 mg/mL of secukinumab.

Pen: Each single-use prefilled pen contains 150 mg/mL of secukinumab.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Plaque psoriasis

COSENTYX is indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy.

Psoriatic arthritis

COSENTYX is indicated for the treatment of adult patients with active psoriatic arthritis when the response to previous disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate.

Ankylosing spondylitis

COSENTYX is indicated for the treatment of adult patients with active ankylosing spondylitis.

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4.2 Dose and method of administration

Dosage

Plaque psoriasis

The recommended dose is 300 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3, and 4 followed by the same dose every month.

Each 300 mg dose is given as two subcutaneous injections of 150 mg. When administering two 150 mg doses (i.e., 300 mg dose), two injection sites should be used. New injection sites should be used for each set of injections.

Psoriatic arthritis

The recommended dose is 150 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2, 3, and 4 followed by the same dose every month. Based on clinical response, the dose can be increased to 300 mg.

For patients who are anti-TNF-alpha inadequate responders (IR) or patients with concomitant moderate to severe plaque psoriasis, the recommended dose is 300 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2, 3, and 4 followed by the same dose every month. Each 300 mg dose is given as two subcutaneous injections of 150 mg.

COSENTYX may be administered with or without methotrexate.

Ankylosing spondylitis

The recommended dose is 150 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2, 3, and 4 followed by the same dose every month. Based on clinical response, the dose can be increased to 300 mg. Each 300 mg dose is given as two subcutaneous injections of 150 mg.

Assessment Prior to Initiation of COSENTYX

Evaluate patients for tuberculosis (TB) infection prior to initiating treatment with COSENTYX (see section 4.4)

Special populations

Patients with renal or hepatic impairment

COSENTYX has not been specifically studied in these patient populations. No dose recommendations can be made.

Paediatric and adolescent patients

Safety and effectiveness in patients below the age of 18 years have not yet been established.

Elderly patients (≥ 65 years of age)

No dose adjustment is needed for elderly patients.

Administration

The product is for single use in one patient only. Discard any residue.

Powder for injection

COSENTYX is administered by subcutaneous injection. Each vial of COSENTYX must be reconstituted with 1 mL of sterile water for injections to obtain a 150 mg/mL solution. The powder for injection should be administered by healthcare professionals only.

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Prefilled syringe and pre-filled pen

COSENTYX is administered by subcutaneous injection. If possible, areas of the skin that show psoriasis should be avoided as injection sites.

Before injection, secukinumab may be allowed to reach room temperature (20 minutes) without removing the needle cap during this time.

Prior to administration, the liquid must be checked whether it is clear and colourless. The solution should not be used if discoloured, or cloudy, or if foreign particles are present.

After proper training in subcutaneous injection technique, patients or appropriate care giver may self-inject COSENTYX if a physician determines that it is appropriate. However, the physician should ensure appropriate follow-up of patients. Patients should be instructed to inject the full amount of COSENTYX according to the instructions provided in the package leaflet. Comprehensive instructions for administration are given in the package leaflet.

4.3 Contraindications

Severe hypersensitivity reactions to the active substance or to any of the excipients (see sections 2, 4.4, and 6.1).

Clinically important, active infections (see section 4.4).

4.4 Special warnings and precautions for use

Infections

COSENTYX has the potential to increase the risk of infections. In clinical studies, infections have been observed in patients receiving COSENTYX (see section 4.8). Most of these were mild or moderate.

Related to the mechanism of action of COSENTYX, non-serious mucocutaneous candida infections were more frequently reported for secukinumab than placebo in the psoriasis clinical studies (3.55 per 100 patient years for secukinumab 300 mg versus 1.00 per 100 patient years for placebo) (see section 4.8). A similar increase in risk of infection was seen in placebo-controlled trials in patients with psoriatic arthritis and ankylosing spondylitis. The incidence of some types of infections appeared to be dose-dependent in clinical studies (see section 4.8).

Caution should be exercised when considering the use of COSENTYX in patients with a chronic infection or a history of recurrent infection.

Patients should be instructed to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, the patient should be closely monitored and COSENTYX should not be administered until the infection resolves.

No increased susceptibility to tuberculosis was reported from clinical studies. However, COSENTYX should not be given to patients with active tuberculosis. Anti-tuberculosis therapy should be considered prior to initiation of COSENTYX in patients with latent tuberculosis.

Crohn's disease

Caution should be exercised, when prescribing COSENTYX to patients with inflammatory bowel disease. Exacerbations, in some cases serious, occurred in COSENTYX treated patients during clinical trials in plaque psoriasis, psoriatic arthritis, and ankylosing spondylitis. In addition, new onset inflammatory bowel disease cases occurred in clinical trials with COSENTYX.

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Patients who are treated with COSENTYX should be monitored for signs and symptoms of inflammatory bowel disease.

Hypersensitivity reactions

In clinical studies, rare cases of anaphylactic reactions have been observed in patients receiving COSENTYX. If an anaphylactic or other serious allergic reaction occurs, administration of COSENTYX should be discontinued immediately and appropriate therapy initiated.

Latex-sensitive individuals – prefilled-syringe/pen only

The removable cap of the COSENTYX pre-filled syringe/pen contains a derivative of natural rubber latex. Although no natural rubber latex is detected in the cap, the safe use of COSENTYX pre-filled syringe/pen in latex-sensitive individuals has not been studied.

Vaccinations

Live vaccines should not be given concurrently with COSENTYX (see section 4.5).

Patients treated with COSENTYX may receive vaccinations, except for live vaccines. In a study, after *meningococcal* and inactivated *influenza* vaccinations, a similar proportion of COSENTYX-treated and placebo-treated patients were able to mount an adequate immune response of at least a 4-fold increase in antibody titres to *meningococcal* or *influenza vaccines*. The data suggest that COSENTYX does not suppress the humoral immune response to the meningococcal and influenza vaccines.

Patients receiving COSENTYX may receive concurrent inactivated or non-live vaccinations.

Use in Patients with Hepatic or Renal Impairment

No data are available in patients with hepatic or renal impairment.

Paediatric Use

Safety and effectiveness in patients below the age of 18 years have not yet been established.

Use in the Elderly

Based on population PK analysis, clearance in patients aged 65 and older (n=230) and patients less than 65 years of age was similar.

Carcinogenicity

Secukinumab has not been evaluated for carcinogenic potential.

Genotoxicity

COSENTYX has not been evaluated for genotoxic potential.

Effect on laboratory tests

There is no known interference between COSENTYX and routine laboratory tests.

4.5 Interaction with other medicines and other forms of interaction

Live vaccines should not be given concurrently with COSENTYX (see also section 4.4).

In a study in subjects with plaque psoriasis, no clinically relevant pharmacokinetic interaction was observed between secukinumab and midazolam (CYP 3A4 substrate). Following initiation or discontinuation and during ongoing use of secukinumab in patients being treated with CYP450

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substrates, particularly those with a narrow therapeutic index, consider monitoring for therapeutic effect or drug concentration and consider dosage adjustment as needed.

No interaction was seen when COSENTYX was administered concomitantly with methotrexate (MTX) and/or corticosteroids in arthritis studies (including in patients with psoriatic arthritis and ankylosing spondylitis).

4.6 Fertility, pregnancy and lactation

Fertility

There are no special recommendations for females of reproductive potential

The effect of COSENTYX on human fertility has not been evaluated. Animal studies do not indicate direct or indirect harmful effects with respect to fertility.

Fertility was unaffected in mice treated with an anti-murine IL17-A antibody.

Use in Pregnancy (Category C)

There are no adequate data from the use of COSENTYX in pregnant women. Secukinumab was shown to cross the placenta in monkeys. Use of secukinumab during pregnancy may compromise the immunity of the fetus and neonate.

In an embryofetal development study in cynomolgus monkeys, secukinumab showed no maternal toxicity, embryofetal toxicity or teratogenicity when administered throughout organogenesis and late gestation at up to 150mg/kg/week.

COSENTYX should be used in pregnancy only if the benefits clearly outweigh the potential risks.

If secukinumab has been used during pregnancy, administration of live vaccines to newborns/ infants for 16 weeks after the mother's last dose of secukinumab is generally not recommended.

Use in Lactation

It is not known whether secukinumab is excreted in human milk. Because immunoglobulins are excreted in human milk, caution should be exercised when COSENTYX is administered to a woman who is breast-feeding and a decision on whether to discontinue breast-feeding during treatment should be made.

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use of machines have been performed.

4.8 Undesirable effects

Summary of the safety profile

A total of 17,942 patients have been treated with COSENTYX in blinded and open-label clinical studies in various indications (plaque psoriasis and other autoimmune conditions) representing 29,978 patient years of exposure. Of these, over 11,752 patients were exposed to COSENTYX for at least one year.

Adverse reactions in plaque psoriasis

Four placebo-controlled phase III studies in plaque psoriasis were pooled to evaluate the safety of COSENTYX in comparison to placebo up to 12 weeks after treatment initiation. In total, 2,076 patients

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were evaluated (692 patients on 150 mg, 690 patients on 300 mg and 694 patients on placebo).

The most frequently reported adverse drug reactions (ADRs) were upper respiratory tract infections (most frequently nasopharyngitis, rhinitis). Most of the events were mild or moderate in severity.

In the placebo-controlled period of plaque psoriasis phase III studies the proportion of patients who discontinued treatment due to adverse events was approximately 1.2 % in the COSENTYX arm and 1.2 % in the placebo arm.

The adverse reactions from clinical studies (Table 1) are listed by MedDRA system organ class. Within each system organ class, the ADRs are ranked by frequency. Within each frequency grouping, adverse drug reactions are presented in order of decreasing seriousness. In addition, the corresponding frequency category for each adverse drug reaction is based on the following convention: very common (> 1/10); common (> 1/100, ≤ 1/10); uncommon (> 1/1,000, ≤ 1/100); rare (≥ 1/10,000, ≤ 1/1,000) very rare (< 1/10,000).

Table 1 Percentage of patients with adverse drug reactions in psoriasis clinical studies¹

Adverse drug reactions	Secukinumab		Placebo (N=694) n (%)	Frequency category ²
	300 mg (N=690) n (%)	150 mg (N=692) n (%)		
Infections and infestations				
Upper respiratory tract infections				
• Nasopharyngitis	117 (17.0)	129 (18.6)	72 (10.4)	Very common
• Upper respiratory tract infection	79 (11.4)	85 (12.3)	60 (8.6)	Very common
• Rhinitis	17 (2.5)	22 (3.2)	5 (0.7)	Common
• Pharyngitis	10 (1.4)	10 (1.4)	5 (0.7)	Common
• Sinusitis	8 (1.2)	7 (1.0)	0 (0)	Common
• Tonsillitis	3 (0.4)	6 (0.9)	1(0.1)	Uncommon
	4 (0.6)	4 (0.6)	3(0.4)	Uncommon
Oral herpes	9 (1.3)	1 (0.1)	2 (0.3)	Common
Oral candidiasis	4 (0.6)	1 (0.1)	1 (0.1)	Uncommon
Tinea pedis	5 (0.7)	5 (0.7)	0 (0)	Uncommon
Blood and lymphatic system disorders				
Neutropenia	2 (0.3)	1 (0.1)	0 (0)	Uncommon
Eye disorders				
Conjunctivitis	5 (0.7)	2 (0.3)	1 (0.1)	Uncommon
Respiratory, thoracic and mediastinal disorders				
Rhinorrhoea	8 (1.2)	2 (0.3)	1 (0.1)	Common
Gastrointestinal disorders				
Diarrhoea	28 (4.1)	18 (2.6)	10 (1.4)	Common
Skin and subcutaneous tissue disorders				
Urticaria	4 (0.6)	8 (1.2)	1 (0.1)	Common

1) placebo-controlled clinical studies (phase III) in plaque psoriasis patients exposed to 300 mg, 150 mg or placebo up to 12-weeks treatment duration

2) ADR frequencies are based upon the highest percentage rate seen in any of the secukinumab groups

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Adverse drug reactions from spontaneous reports and literature cases (frequency not known)

The following adverse drug reactions have been derived from post-marketing experience with COSENTYX via spontaneous case reports and literature cases. Because these reactions are reported voluntarily from a population of uncertain size, it is not possible to reliably estimate their frequency which is therefore categorized as not known. Adverse drug reactions are listed according to system organ classes in MedDRA. Within each system organ class, ADRs are presented in order of decreasing seriousness.

Table 2 Adverse drug reactions from spontaneous reports and literature (frequency not known)

Infections and infestations Mucosal and cutaneous candidiasis

Infections

In the placebo-controlled period of clinical studies in plaque psoriasis (a total of 1,382 patients treated with COSENTYX and 694 patients treated with placebo for up to 12 weeks), infections were reported in 28.7 % of patients treated with COSENTYX compared with 18.9 % of patients treated with placebo. Most of these were mild or moderate. Serious infections occurred in 0.14 % of patients treated with COSENTYX and in 0.3 % of patients treated with placebo (see section 4.4).

Over the entire treatment period (a total of 3,430 patients treated with COSENTYX for up to 52 weeks for the majority of patients), infections were reported in 47.5 % of patients treated with COSENTYX (0.9 per patient-year of follow-up). Serious infections were reported in 1.2 % of patients treated with COSENTYX (0.015 per patient-year of follow-up).

There was an increase in mucosal or cutaneous candidiasis, related to the mechanism of action. The cases were mild or moderate in severity, non-serious, responsive to standard treatment and did not necessitate treatment discontinuation. Frequency of candida infection was 1.2% (secukinumab 300 mg) vs 0.3% (placebo and etanercept arms) in the induction period.

Infection rates as observed in psoriatic arthritis and ankylosing spondylitis clinical studies were similar to what was observed in the psoriasis studies.

Neutropenia

In psoriasis phase 3 clinical studies, neutropenia was more frequently observed with secukinumab than with placebo, but most cases were mild, transient and reversible. Neutropenia $<1.0-0.5 \times 10^9/L$ (CTCAE Grade 3) was reported in 18 out of 3,430 (0.5%) patients on secukinumab, with no dose dependence and no temporal relationship to infections in 15 out of 18 cases. There were no reported cases of more severe neutropenia. Non-serious infections with usual response to standard care and not requiring discontinuation of COSENTYX were reported in the remaining 3 cases.

The frequency of neutropenia in psoriatic arthritis and ankylosing spondylitis is similar to psoriasis. Rare cases of neutropenia $<0.5 \times 10^9/L$ (CTCAE Grade 4) were reported.

Hypersensitivity reactions

In clinical studies, urticaria and one case of anaphylactic reaction to COSENTYX were observed.

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Immunogenicity

In psoriasis, psoriatic arthritis and ankylosing spondylitis clinical studies less than 1% of patients treated with COSENTYX developed antibodies to secukinumab up to 52 weeks of treatment. About half of the treatment emergent anti-drug antibodies were neutralizing, but this was not associated with loss of efficacy or PK abnormalities.

Reproductive system related adverse events

In the induction period of clinical studies, mild and moderate reproductive system adverse events were reported in females, including: dysmenorrhoea (secukinumab 300 mg, 1.9%; placebo, 0.5%; etanercept, 1.1%), menorrhagia (secukinumab 300 mg, 0.9%; placebo, 0%; etanercept, 0%) and metrorrhagia (including menometrorrhagia) (secukinumab 300 mg, 1.4%; placebo, 0%; etanercept, 0%). Women of child-bearing potential were included in studies only if using adequate contraception.

Major adverse cardiovascular events (MACE)

In the secukinumab clinical trials, MACE events were observed in patients receiving secukinumab. In the Phase 3 studies in psoriasis, PsA and AS, the exposure adjusted incidence rates of adjudication-confirmed MACE cases per 100 patient-years was 0.49 (19/3911.6 patient-years, 95% CI 0.29, 0.76) for secukinumab versus 0.00 (0/351.3 patient-years, 95% CI 0.00, 1.05) for placebo. In the overall secukinumab program, the exposure adjusted incidence rates of adjudication-confirmed cases per 100 patient-years for secukinumab was 0.40 (25/6259.8 patient-years, 95% CI 0.26, 0.59) versus 0.39 (2/515.1 patient-years, 95% CI 0.05, 1.40) for placebo.

Adverse reactions in psoriatic arthritis

COSENTYX was studied in five placebo-controlled psoriatic arthritis trials with 2,754 patients (1,871 patients on COSENTYX and 883 patients on placebo) for a total exposure of 4,478 patient-years of study exposure on COSENTYX. The adverse events that occurred at a proportion of at least 2% and at a higher proportion in the COSENTYX groups than the placebo groups during the 16-week placebo-controlled period were nasopharyngitis, upper respiratory tract infection, headache, urinary tract infection, and hypercholesterolemia. The safety profile observed in patients with psoriatic arthritis treated with COSENTYX is consistent with the safety profile in psoriasis.

The proportion of patients with infections in the COSENTYX groups (28.5%) is similar to the placebo group (28.1%) (see section 4.4).

There were cases of Crohn's disease and ulcerative colitis that include patients who experienced either exacerbations or the development of new disease. In the psoriatic arthritis program with 2,536 patients exposed to COSENTYX there were 17 cases of inflammatory bowel disease during the entire treatment period (0.4 per 100 patient-years). During the placebo-controlled period 16 week period, there were seven cases of inflammatory bowel disease, of which five patients received secukinumab and two received placebo (see section 4.4).

Cholesterol and triglycerides

Elevations of blood cholesterol and triglyceride levels were reported in patients receiving either secukinumab or placebo in psoriatic arthritis clinical trials. The elevations of cholesterol levels were limited primarily to CTCAE Grade 1 (28.7% vs. 19.1%, respectively) and Grade 2 (1.6% vs. 0.5%, respectively). No cases of CTCAE Grade 3 and Grade 4 cholesterol levels were observed in either secukinumab or placebo groups during the placebo controlled period.

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An increase in blood triglycerides levels was also observed in psoriatic arthritic patients receiving secukinumab compared to placebo (CTCAE Grade 1: 26.7% vs. 19.1%, Grade 2: 4.6% vs. 3.5%, Grade 3: 1.0% vs. 0.7% and Grade 4: 0.2% vs. 0.1%, respectively) up to Week 16.

Elevations (mainly CTCAE Grade 1 and Grade 2) in cholesterol and triglycerides were also observed during long-term treatment with secukinumab.

Hepatic transaminases

During the placebo-controlled period, increased incidence of elevated hepatic transaminases was observed in psoriatic arthritis patients treated with secukinumab compared to placebo. The elevations in hepatic transaminases were seen primarily in CTCAE Grade 1 (ALT: 17.1% vs 14.8%; AST: 12.5% vs. 10.1%, respectively). No difference in the incidence of elevated ALT and AST was seen between secukinumab and placebo in CTCAE Grade 2, Grade 3, and Grade 4. No cases of CTCAE Grade 4 were observed for AST.

Elevations (mainly CTCAE Grade 1 and grade 2) in ALT and AST was also observed during long-term treatment with secukinumab.

Adverse reactions in ankylosing spondylitis

COSENTYX was studied in three placebo-controlled ankylosing spondylitis trials with 816 patients (544 patients on COSENTYX and 272 patients on placebo). The median duration of exposure for secukinumab-treated patients was 469 days in AS1 Study, 460 days in AS2 Study, and 1,142 days in AS3 Study. During the 16-week placebo-controlled period of the trials in patients with ankylosing spondylitis, the overall proportion of patients with adverse events was higher in the secukinumab groups than the placebo-treatment groups (60% and 55%, respectively).

The overall safety profile of COSENTYX in AS3 Study remained in line with the safety profile established in the pivotal AS1 and AS2 studies, which are summarised in the next paragraphs.

The adverse events that occurred at a proportion of at least 2% and at a higher proportion in the COSENTYX groups than the placebo groups during the 16-week placebo-controlled period were nasopharyngitis, nausea, and upper respiratory tract infection. The safety profile observed in patients with ankylosing spondylitis treated with COSENTYX is consistent with the safety profile in psoriasis.

Similar to clinical trials in patients with psoriasis, there was an increased proportion of patients with infections in the COSENTYX groups (31%) compared to the placebo group (18%) (see section 4.4).

In the ankylosing spondylitis program, with 571 patients exposed to COSENTYX there were 8 cases of inflammatory bowel disease during the entire treatment period (5 Crohn's (0.7 per 100 patient-years) and 3 ulcerative colitis (0.4 per 100 patient-years)). During the placebo-controlled 16-week period, there were 2 Crohn's disease exacerbations and 1 new onset ulcerative colitis case that was a serious adverse event in patients treated with COSENTYX compared to none of the patients treated with placebo. During the remainder of the study when all patients received COSENTYX, 1 patient developed Crohn's disease, 2 patients had Crohn's exacerbations, 1 patient developed ulcerative colitis, and 1 patient had an ulcerative colitis exacerbation (see section 4.4).

Cholesterol and triglycerides

Elevations of blood cholesterol and triglyceride levels were reported in patients receiving either secukinumab or placebo in ankylosing spondylitis clinical trials.

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The elevations of cholesterol levels were limited primarily to CTCAE Grade 1 (20.0% vs. 19.8%, respectively) without any clinically meaningful impact on patients. Increase in CTCAE Grade 2 cholesterol levels was uncommon (0.8% vs. 0.0%, respectively) and no cases of CTCAE Grade 3 and Grade 4 cholesterol levels were observed in both secukinumab and placebo groups during the placebo controlled period.

An increase in blood triglycerides levels was also observed in ankylosing spondylitis patients receiving secukinumab or placebo (CTCAE Grade 1: 17.8% vs. 17.1%, Grade 2: 2.7% vs. 2.7%, and Grade 3: 0.8% vs. 0.5%, respectively). No cases of CTCAE Grade 4 triglyceride levels were reported during the placebo-controlled period.

Hepatic transaminases

During the placebo-controlled period, increased incidence of elevated hepatic transaminases was observed in ankylosing spondylitis patients treated with secukinumab compared to placebo. The elevations in hepatic transaminases were seen primarily in CTCAE Grade 1 (ALT: 16.6% vs 7.1%; AST: 11.3% vs. 7.0%, respectively) without any clinically meaningful impact on patients. Increase in CTCAE Grade 2 and Grade 3 hepatic transaminase levels was uncommon in both secukinumab and placebo groups (Grade 2 ALT: 1.0% vs. 0.5%, AST: 0.5% vs. 0.0%; Grade 3 ALT: 0.8% vs. 0.0%, AST: 0.8% vs.1.6%, respectively). One case of CTCAE Grade 4 ALT levels was reported in the placebo group and no cases of CTCAE Grade 4 ALT and AST levels were reported in the secukinumab group.

Similar pattern in ALT and AST was also observed during the long-term treatment with secukinumab.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions <https://nzphvc.otago.ac.nz/reporting/>.

4.9 Overdose

No case of overdose has been reported in clinical studies.

Doses up to 30 mg/kg (i.e. approximately 2,000 mg to 3,000 mg) have been administered intravenously in clinical studies without dose-limiting toxicity.

In the event of overdose, it is recommended that the patient be monitored for any signs or symptoms of adverse reactions and appropriate symptomatic treatment be instituted immediately.

For advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: interleukin inhibitors; ATC Code: L04AC10

Mechanism of action

Secukinumab is a fully human IgG1 antibody that selectively binds to and neutralizes the proinflammatory cytokine interleukin-17A (IL-17A). IL-17A is a naturally occurring cytokine that is involved in normal inflammatory and immune responses. IL-17A plays a key role in the pathogenesis

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of plaque psoriasis and immunity against infections. Increased numbers of IL-17A producing lymphocytes and innate immune cells and increased levels of IL-17A have been found in the blood and affected skin of patients with plaque psoriasis. IL-17A is highly up-regulated in lesional skin in contrast to non-lesional skin of plaque psoriasis patients. Higher frequency of IL-17- producing cells was detected in the synovial fluid of patients with psoriatic arthritis and in the subchondral bone marrow of facet joints from patients with ankylosing spondylitis. IL-17A also promotes tissue inflammation, neutrophil infiltration, bone and tissue destruction, and tissue remodelling including angiogenesis and fibrosis.

Secukinumab works by targeting IL-17A and inhibiting its interaction with the IL-17 receptor, which is expressed on various cell types including keratinocytes. As a result, secukinumab inhibits the release of proinflammatory cytokines, chemokines and mediators of tissue damage and reduces IL-17A-mediated contributions to autoimmune and inflammatory diseases. Clinically relevant levels of secukinumab reach the skin and reduce local inflammatory markers. As a direct consequence, treatment with secukinumab reduces erythema, induration, and desquamation present in plaque psoriasis lesions.

Serum levels of total IL-17A (free and secukinumab-bound IL-17A) are increased due to reduced clearance of secukinumab-bound IL-17A within 2 to 7 days in patients receiving secukinumab, indicating that secukinumab selectively captures free IL-17A which plays a key role in the pathogenesis of plaque psoriasis.

In a study with secukinumab, infiltrating epidermal neutrophils and various neutrophil associated markers that are increased in lesional skin of plaque psoriasis patients were significantly reduced after one to two weeks of treatment.

Clinical efficacy and safety

Plaque psoriasis

The safety and efficacy of COSENTYX were evaluated versus placebo or etanercept in four randomized, double-blind, placebo-controlled phase 3 studies in adult patients with moderate to severe chronic plaque-type psoriasis poorly controlled by topical treatments and / or phototherapy and / or previous systemic therapy (ERASURE, FIXTURE, FEATURE, and JUNCTURE). The safety and efficacy of COSENTYX were evaluated versus placebo or etanercept in four randomized, double-blind, placebo-controlled phase 3 studies in patients with moderate to severe plaque psoriasis who were candidates for phototherapy or systemic therapy (ERASURE, FIXTURE, FEATURE, and JUNCTURE). In addition, one study assessed a chronic treatment regimen versus a 'retreatment as needed' regimen (SCULPTURE). The co-primary endpoints in the placebo and active controlled studies were the proportion of patients who achieved a PASI 75 response and IGA mod 2011 'clear' or 'almost clear' response versus placebo at Week 12.

Key exclusion criteria across pivotal trials were: forms of psoriasis other than chronic plaque-type; drug-induced psoriasis; ongoing use of certain psoriasis treatments, e.g. topical or systemic corticosteroids or UV therapy; patients with active, ongoing inflammatory disease; patients with active, ongoing, chronic or recurrent infectious disease; evidence of tuberculosis infection (enrolment was allowed for patients with latent tuberculosis if appropriate treatment was initiated and maintained according to the local treatment guideline); history of HIV, hepatitis B or hepatitis C; underlying immunocompromising conditions; presence of lymphoproliferative disease, malignancy or history of malignancy within the past 5 years; significant medical problems including uncontrolled hypertension and congestive heart failure (NYHA Class III and IV); patients with serum creatinine >176.8 micromol/L or with white blood cell count <2,500 /microL, platelets <100,000/microL,

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neutrophils <1,500/microL or haemoglobin <8.5 g/dL; pregnant or nursing women; and women of child-bearing potential not using effective contraception during the study.

Of the 2,403 patients who were included in the placebo-controlled studies, 79 % were biologic-naïve, 45 % were non-biologic failures, 8 % were biologic failures, 6 % were anti-TNF failures, and 2 % were anti-p40 failures. Baseline disease characteristics were generally consistent across all treatment groups with a median baseline Psoriasis Area Severity Index (PASI) score from 19 to 20, IGA mod 2011 baseline score ranged from “moderate” (62 %) to “severe” (38 %), median baseline Body Surface Area (BSA) ≥ 27 and median Dermatology Life Quality Index (DLQI) score from 10 to 12. Approximately 15 to 25 % of patients in phase III studies had psoriatic arthritis (PsA) at baseline.

ERASURE Study (A2302)

This trial evaluated 738 patients. Patients were randomised to COSENTYX received 150 mg or 300 mg doses at weeks 0, 1, 2, 3, and 4 followed by the same dose every month. Patients were randomized to receive placebo who were non-responders at week 12 were then crossed over to receive COSENTYX (either 150 mg or 300 mg) at weeks 12, 13, 14, and 15, followed by the same dose every month starting at week 16. All patients were followed for up to 52 weeks following first administration of study treatment.

FIXTURE Study (A2303)

This trial evaluated 1,306 patients. Patients were randomised to COSENTYX received 150 mg or 300 mg doses at weeks 0, 1, 2, 3, and 4 followed by the same dose every month. Patients were randomized to etanercept received 50 mg doses twice per week for 12 weeks followed by 50 mg every week. Patients were randomised to receive placebo who were non-responders at week 12 then crossed over to receive COSENTYX (either 150 mg or 300 mg) at weeks 12, 13, 14, and 15, followed by the same dose every month starting at week 16. All patients were followed for up to 52 weeks following first administration of study treatment.

FEATURE Study (A2308)

This trial evaluated 177 patients using a pre-filled syringe compared with placebo after 12 weeks of treatment to assess the safety, tolerability, and usability of COSENTYX self-administration via the pre-filled syringe. Patients randomised to COSENTYX received 150 mg or 300 mg doses at weeks 0, 1, 2, 3, and 4 followed by the same dose every month. Patients were also randomized to receive placebo at weeks 0, 1, 2, 3, and 4 followed by the same dose every month.

JUNCTURE Study (A2309)

This trial evaluated 182 patients using a pre-filled pen compared with placebo after 12 weeks of treatment to assess the safety, tolerability, and usability of COSENTYX self-administration via the pre-filled pen. Patients were randomised to COSENTYX received 150 mg or 300 mg doses at weeks 0, 1, 2, and 3, followed by the same dose every month starting at week 4. Patients were also randomized to receive placebo at weeks 0, 1, 2, and 3, followed by the same dose every month starting at week 4.

SCULPTURE Study (A2304)

This trial evaluated 966 patients. All patients received COSENTYX 150 mg or 300 mg doses at weeks 0, 1, 2, 3, 4, 8 and 12 and then were randomised to receive either a maintenance regimen of the same dose every month starting at Week 12 or a “retreatment as needed” regimen of the same dose.

Results

The 300 mg dose provided improved skin clearance across efficacy endpoints of PASI 75/90/100, and IGA mod 2011 ‘clear’ or ‘almost clear’ responses across all studies with peak effects seen at week 16 (see to Table 3 and Table 4). Therefore the 300 mg dose is recommended.

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COSENTYX was efficacious in biologic-naive, biologic/anti-TNF-exposed and biologic/anti-TNF-failure patients.

COSENTYX was associated with a fast onset of efficacy as shown in Figure 1 with a 50 % reduction in mean PASI by week 3 for 300 mg.

Figure 1 Time course of percentage change from baseline of mean PASI score in ERASURE trial (m = number of patients evaluable)

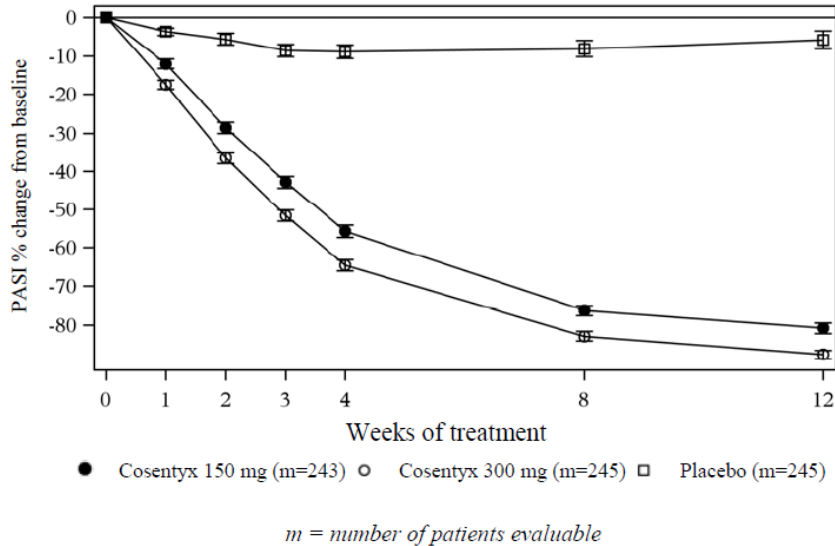


Table 3 Summary of clinical response in ERASURE, FEATURE and JUNCTURE trials

	Week 12			Week 16		Week 52	
	Placebo	150 mg	300 mg	150 mg	300 mg	150 mg	300 mg
ERASURE							
Number of patients	246	244	245	244	245	244	245
PASI 50 response n (%)	22 (8.9%)	203 (83.5%)	222 (90.6%)	212 (87.2%)	224 (91.4%)	187 (77%)	207 (84.5%)
PASI 75 response n (%)	11 (4.5%)	174 (71.6%)**	200 (81.6%)**	188 (77.4%)	211 (86.1%)	146 (60.1%)	182 (74.3%)
PASI 90 response n (%)	3 (1.2%)	95 (39.1%)**	145 (59.2%)**	130 (53.5%)	171 (69.8%)	88 (36.2%)	147 (60.0%)
PASI 100 response n (%)	2 (0.8%)	31 (12.8%)	70 (28.6%)	51 (21.0%)	102 (41.6%)	49 (20.2%)	96 (39.2%)
IGA mod 2011 "clear" or "almost clear" response n (%)	6 (2.40%)	125 (51.2%)**	160 (65.3%)**	142 (58.2%)	180 (73.5%)	101 (41.4%)	148 (60.4%)

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	Week 12			Week 16		Week 52	
	Placebo	150 mg	300 mg	150 mg	300 mg	150 mg	300 mg
FEATURE							
Number of patients	59	59	58	-	-	-	-
PASI 50 response n (%)	3 (5.1%)	51 (86.4%)	51 (87.9%)	-	-	-	-
PASI 75 response n (%)	0 (0.0%)	41 (69.5%)**	44 (75.9%)**	-	-	-	-
PASI 90 response n (%)	0 (0.0%)	27 (45.8%)	35 (60.3%)	-	-	-	-
PASI 100 response n (%)	0 (0.0%)	5 (8.5%)	25 (43.1%)	-	-	-	-
IGA mod 2011 "clear" or "almost clear" response n (%)	0 (0.0%)	31 (52.5%)**	40 (69.0%)**	-	-	-	-
JUNCTURE							
Number of patients	61	60	60	-	-	-	-
PASI 50 response n (%)	5 (8.2%)	48 (80.0%)	58 (96.7%)	-	-	-	-
PASI 75 response n (%)	2 (3.3%)	43 (71.7%)**	52 (86.7%)**	-	-	-	-
PASI 90 response n (%)	0 (0.0%)	24 (40.0%)	33 (55.0%)	-	-	-	-
PASI 100 response n (%)	0 (0.0%)	10 (16.7%)	16 (26.7%)	-	-	-	-
IGA mod 2011 "clear" or "almost clear" response n (%)	0 (0.0%)	32 (53.3%)**	44 (73.3%)**	-	-	-	-

*The IGA mod 2011 is a 5-category scale including "0 = clear", "1 = almost clear", "2 = mild", "3 = moderate" or "4 = severe", indicating the physician's overall assessment of the psoriasis severity focusing on induration, erythema and scaling. Treatment success of "clear" or "almost clear" consisted of no signs of psoriasis or normal to pink coloration of lesions, no thickening of the plaque and none to minimal focal scaling.

** p values versus placebo and adjusted for multiplicity: p<0.0001

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Table 4 Summary of clinical response in FIXTURE trial

	Placebo	Week 12			Week 16			Week 52		
		150 mg	300 mg	Etanercept	150 mg	300 mg	Etanercept	150 mg	300 mg	Etanercept
Number of patients	324	327	323	323	327	323	323	327	323	323
PASI 50 response n (%)	49 (15.1%)	266 (81.3%)	296 (91.6%)	226 (70.0%)	290 (88.7%)	302 (93.5%)	257 (79.6%)	249 (76.1%)	274 (84.8%)	234 (72.4%)
PASI 75 response n (%)	16 (4.9%)	219 (67.0%) **	249 (77.1%) **	142 (44.0%)	247 (75.5%)	280 (86.7%)	189 (58.5%)	215 (65.7%)	254 (78.6%)	179 (55.4%)
PASI 90 response n (%)	5 (1.5%)	137 (41.9%)	175 (54.2%)	67 (20.7%)	176 (53.8%)	234 (72.4%)	101 (31.3%)	147 (45.0%)	210 (65.0%)	108 (33.4%)
PASI 100 response n (%)	0 (0%)	47 (14.4%)	78 (24.1%)	14 (4.3%)	84 (25.7%)	119 (36.8%)	24 (7.4%)	65 (19.9%)	117 (36.2%)	32 (9.9%)
IGA mod 2011 “clear” or “almost clear” response n (%)	9 (2.8%)	167 (51.1%) **	202 (62.5%) **	88 (27.2%)	200 (61.2%)	244 (75.5%)	127 (39.3%)	168 (51.4%)	219 (67.8%)	120 (37.2%)

** p values versus etanercept: p=0.0250

An additional psoriasis study (CLEAR) evaluated 676 patients. Secukinumab 300 mg met the primary and secondary endpoints by showing superiority to ustekinumab based on PASI 90 response at Week 16 and speed of onset of PASI 75 response at Week 4, and long term PASI 90 response at Week 52. Greater efficacy of secukinumab compared to ustekinumab for the endpoints PASI 75/90/100 and IGA mod 2011 0 or 1 response (“clear” or “almost clear”) was observed early and continued through Week 52.

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Table 5 Summary of clinical response on CLEAR Study

	Week 4		Week 16		Week 52	
	Secukinumab 300 mg	Ustekinumab*	Secukinumab 300 mg	Ustekinumab*	Secukinumab 300 mg	Ustekinumab*
Number of patients	334	335	334	335	334	335
PASI 75 response n (%)	167 (50.0%)**	69 (20.6%)	311 (93.1%)	277 (82.7%)	306 (91.6%)	262 (78.2%)
PASI 90 response n (%)	70 (21.0%)	18 (5.4%)	264 (79.0%)**	193 (57.6%)	250 (74.9%)***	203 (60.6%)
PASI 100 response n (%)	14 (4.2%)	3 (0.9%)	148 (44.3%)	95 (28.4%)	150 (44.9%)	123 (36.7%)
IGA mod 2011 “clear” or “almost clear” response n (%)	126 (37.7%)	41 (12.2%)	277 (82.9%)	226 (67.5%)	261 (78.1%)	213 (63.6%)

* Patients treated with secukinumab received 300 mg doses at Weeks 0, 1, 2, 3, and 4 followed by the same dose at Weeks 8 and 12. Patients treated with ustekinumab received 45 mg or 90 mg at Weeks 0 and 4 (dosed by weight as per approved posology)

** p values versus ustekinumab: p<0.0001 for primary endpoint PASI 90 at Week 16 and secondary endpoint PASI 75 at Week 4

*** p value versus ustekinumab: p = 0.0001 for secondary endpoint of PASI 90 at Week 52

All plaque psoriasis phase III studies included approximately 15 to 25% of patients with concurrent psoriatic arthritis at baseline. Improvements in PASI 75 in this patient population were similar to those in the overall plaque psoriasis population.

In the subset of psoriatic arthritis patients in the ERASURE and FIXTURE studies, physical function was assessed using the HAQ Disability Index (HAQ-DI). In these studies, patients treated with 150 mg or 300 mg COSENTYX showed greater improvement from baseline in the HAQ-DI score (mean decreases of -27.5% and -50.2% at week 12) compared to placebo (-8.9%). This improvement was maintained up to week 52.

Patients in the SCULPTURE study that were randomized after week 12 to a “retreatment as needed” maintenance regimen did not achieve adequate maintenance of response to either dose used. After 52 weeks of treatment patients with 300 mg “retreatment as needed” regimen achieved a PASI 75 of 41.0% and a PASI 90 of 13.8%, whereas patients with a monthly maintenance regimen of 300 mg achieved a PASI 75 of 78.2% and a PASI 90 of 59.7%. Similarly, patients with 150 mg “retreatment as needed” regimen achieved a PASI 75 of 35.0% and a PASI 90 of 11.2%, whereas patients with a monthly maintenance regimen of 150 mg achieved a PASI 75 of 62.1% and a PASI 90 of 45.8% after 52 weeks of treatment. Therefore a fixed monthly maintenance regimen is recommended.

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Specific locations/forms of plaque psoriasis

In two additional placebo-controlled studies, improvement was seen in both nail psoriasis (TRANSFIGURE, 198 patients) and palmoplantar plaque psoriasis (GESTURE, 205 patients). In the TRANSFIGURE study, secukinumab was superior to placebo at Week 16 (46.1% for 300 mg, 38.4% for 150 mg and 11.7% for placebo) as assessed by significant improvement from baseline in the Nail Psoriasis Severity Index (NAPSI %) for patients with moderate to severe plaque psoriasis with nail involvement. In the GESTURE study, secukinumab was superior to placebo at Week 16 (33.3% for 300 mg, 22.1% for 150 mg, and 1.5% for placebo) as assessed by significant improvement of the Palmoplantar Investigator's Global Assessment (ppIGA) 0 or 1 response ("clear" or "almost clear") for patients with moderate to severe palmoplantar plaque psoriasis.

The placebo-controlled SCALP study evaluated 102 patients with moderate to severe scalp psoriasis, defined as having a Psoriasis Scalp Severity Index (PSSI) score of ≥ 12 , an IGA mod 2011 scalp only score of 3 or greater, and at least 30% of the scalp affected. In this study, 62% of patients had at least 50% or more of scalp surface area affected. Secukinumab 300 mg was superior to placebo at Week 12 as assessed by significant improvement from baseline in both the PSSI 90 response (52.9% vs. 2.0%) and IGA mod 2011 0 or 1 scalp only response (56.9% vs. 5.9%). Greater efficacy of secukinumab 300 mg over placebo for both endpoints was observed by Week 3. Improvement in both endpoints was sustained for secukinumab patients who continued treatment through Week 24 (PSSI 90 response 58.8% and IGA mod 2011 0 or 1 scalp only response 62.7%).

Quality of Life / Patient reported outcomes

Statistically significant improvements at week 12 (Studies 1-4) from baseline compared to placebo were demonstrated in the DLQI (Dermatology Life Quality Index), these improvements were maintained for 52 weeks (Studies 1 and 2).

Statistically significant improvements at week 12 from baseline compared to placebo (ERASURE and FIXTURE Studies) in patient reported signs and symptoms of itching, pain and scaling were demonstrated in the validated Psoriasis Symptom Diary.

Statistically significant improvements at Week 4 from baseline in patients treated with secukinumab compared to patients treated with ustekinumab (CLEAR) were demonstrated in the DLQI (Dermatology Life Quality Index), and these improvements were maintained for up to 52 weeks. The Work Productivity and Activity Impairment Questionnaire-Psoriasis outcomes (WPAI-PSO) showed greater improvement in patients treated with secukinumab compared to patients treated with ustekinumab.

Statistically significant improvements in patient reported signs and symptoms of itching, pain and scaling at Week 16 and Week 52 (CLEAR) were demonstrated in the Psoriasis Symptom Diary in patients treated with secukinumab compared to patients treated with ustekinumab.

Statistically significant improvements at Week 12 from baseline compared to placebo (SCALP) were demonstrated in the HRQoL (Health Related Quality of Life Index) as measured by Scalpdex. These improvements were observed starting at Week 4 and were maintained through 24 weeks.

Statistically significant improvements (decreases) at week 12 from baseline (SCALP) were demonstrated in patient reported signs and symptoms of scalp itching (-59.4%), pain (-45.9%), and scaling (-69.5%), whereas placebo treated patients demonstrated worsening (increases) in scalp itching (7.7%) and pain (38.5%), and less improvement in scalp scaling (-4.7%).

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Psoriatic Arthritis

The safety and efficacy of COSENTYX were assessed in 1,999 patients in three randomised, double-blind, placebo-controlled phase III studies in patients with active psoriatic arthritis (≥ 3 swollen and ≥ 3 tender joints) despite non-steroidal anti-inflammatory drug (NSAID), corticosteroids or disease-modifying anti-rheumatic drug (DMARD) therapy. Patients with each subtype of PsA were enrolled in these studies, including polyarticular arthritis with no evidence of rheumatoid nodules, spondylitis with peripheral arthritis, asymmetric peripheral arthritis, distal interphalangeal involvement and arthritis mutilans. Patients in these studies had a diagnosis of PsA for a median of 3.9 to 5.3 years. The majority of patients also have active psoriasis skin lesions or a documented history of psoriasis. Approximately half of all enrolled patients had at least 3% BSA involvement with skin psoriasis at baseline. Over 61% and 42% of the PsA patients had enthesitis and dactylitis at baseline, respectively.

In FUTURE 1 Study (PsA1 Study), FUTURE 2 Study (PsA2 Study), and FUTURE 5 Study (PSA3 Study), 29%, 35%, and 30% of patients, respectively, were previously treated with an anti-TNF-alpha agent and discontinued the anti-TNF-alpha agent for either lack of efficacy or intolerance (anti-TNF-alpha-IR patients). For FUTURE 1 and FUTURE 2, the primary endpoint was American College of Rheumatology (ACR) 20 response at Week 24. The primary endpoint for FUTURE 5 was ACR20 response at Week 16, and the key secondary endpoint was the change from baseline in modified Total Sharp Score (mTSS) at Week 24.

Key exclusion criteria across pivotal trials were: use of high potency opioid analgesics; ongoing use of certain psoriasis treatments, e.g. topical or systemic corticosteroids or UV therapy; previous exposure to secukinumab or any other biologic drugs for psoriasis and PsA except for those targeting TNF α , patients with active, ongoing inflammatory disease other than PsA; patients with active, ongoing, chronic or recurrent infectious disease; evidence of tuberculosis infection (enrolment was allowed for patients with latent tuberculosis if appropriate treatment was initiated and maintained according to the local treatment guideline); history of HIV, hepatitis B or hepatitis C; underlying immunocompromising conditions; presence of lymphoproliferative disease, malignancy or history of malignancy within the past 5 years; significant medical problems including uncontrolled hypertension and congestive heart failure (NYHA Class III and IV); patients with serum creatinine >132.6 micromol/L or with white blood cell count $<3,000$ /microL, platelets $<100,000$ /microL, neutrophils $<1,500$ /microL or haemoglobin <8.5 g/dL; pregnant or nursing women; and women of child-bearing potential not using effective contraception during the study.

FUTURE 1 Study (F2306)

PsA1 Study evaluated 606 patients, of whom 60.7% had concomitant MTX. Patients randomised to receive placebo who were non-responders at Week 16 (early rescue) and other placebo patients at Week 24 were crossed over to receive COSENTYX (either 75 mg or 150 mg) at Week 16 followed by the same dose every month.

FUTURE 2 Study (F2312)

PsA2 Study evaluated 397 patients, of whom 46.6% had concomitant MTX. Patients randomised to COSENTYX received 75 mg, 150 mg or 300 mg s.c. at Weeks 0, 1, 2, 3, and 4 followed by the same dose every month. Patients randomised to receive placebo who were non-responders at Week 16 (early rescue) were then crossed over to receive COSENTYX (either 150 mg or 300 mg, s.c.) at Week 16 followed by the same dose every month. Patients randomised to receive placebo who were responders at Week 16 were crossed over to receive COSENTYX (either 150 mg or 300 mg) at Week 24 followed by the same dose every month.

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FUTURE 5 Study (F2342)

PsA3 Study evaluated 996 patients, of whom 50.1% had concomitant MTX treatment. Patients were randomised to receive COSENTYX 150 mg, 300 mg, or placebo s.c. at Weeks 0, 1, 2, 3 and 4 followed by the same dose every month, or a once monthly injection of COSENTYX 150 mg (without loading). Patients randomised to receive placebo who were non-responders at Week 16 were then crossed over to receive COSENTYX (either 150 mg or 300 mg, s.c.) at Week 16 followed by the same dose every month. Patients randomised to receive placebo who were responders at Week 16 were crossed over to receive COSENTYX (either 150 mg or 300 mg) at Week 24 followed by the same dose every month. The total combined duration of treatment for PsA3 Study is 2 years.

Signs and symptoms

Treatment with COSENTYX resulted in significant improvement in the measure of disease activity compared to placebo at Weeks 16 and 24 (see Table 6).

Table 6 Clinical response in PsA2 and PSA3 Studies at Week 16 and Week 24

	PsA2			PsA3		
	Placebo	150 mg ¹	300 mg ¹	Placebo	150 mg ¹	300 mg ¹
Number of patients randomised	98	100	100	332	220	222
ACR 20 response n (%)						
Week 16				91 ^o (27.4%)	122 ^o (55.5%***)	139 ^o (62.6%***)
Week 24	15 ^o (15.3%)	51 ^o (51.0%***)	54 ^o (54.0%***)			
ACR 50 response n (%)						
Week 16				27 (8.1%)	79 (35.9%*)	88 (39.6%*)
Week 24	7 (7.1%)	35 (35.0%)	35 (35.0%**)			
ACR 70 response n (%)						
Week 16				14 (4.2%)	40 (18.2%)	45 (20.3%)
Week 24	1 (1.0%)	21 (21.0%)	20 (20.0%)			
DAS28-CRP						
Week 16				-0.63	-1.29*	-1.49*
Week 24	-0.96	-1.58**	-1.61**			
Number of patients with ≥ 3% BSA psoriasis skin involvement at baseline	43 (43.9%)	58 (58.0%)	41 (41.0%)	162 (48.8%)	125 (56.8%)	110 (49.5%)
PASI 75 response n (%)						
Week 16				20 (12.3%)	75 (60.0%*)	77 (70.0%*)
Week 24	7 (16.3%)	28 (48.3%**)	26 (63.4%***)			
PASI 90 response n (%)						
Week 16				15 (9.3%)	46 (36.8%*)	59 (53.6%*)
Week 24	4 (9.3%)	19 (32.8%**)	20 (48.8%***)			
Dactylitis Resolution n (%) †						

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Week 16				40 (32.3%)	46 (57.5%*)	54 (65.9%*)
Week 24	4 (14.8%)	16 (50.0%)	26 (56.5%)			
Enthesitis Resolution n (%) ‡						
Week 16				68 (35.4%)	77 (54.6%*)	78 (55.7%*)
Week 24	14 (21.5%)	27 (42.2%)	27 (48.2%)			

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$; versus placebo

All p-values are adjusted for multiplicity of testing based on pre-defined hierarchy at Week 24 for PsA Study 2, except for all endpoints at Week 16. ACR70, Dactylitis and Enthesitis, were exploratory endpoints.

All p-values are adjusted for multiplicity of testing based on pre-defined hierarchy at Week 16 for PsA Study 3. ACR70 was an exploratory endpoint.

Non-responder imputation used for missing binary endpoint.

NA: Not Available; ACR: American College of Rheumatology; PASI: Psoriasis Area and Severity Index; DAS: Disease Activity Score; BSA: Body Surface Area

°Primary Endpoint

¹Cosentyx 150 mg or 300 mg s.c. at Weeks 0, 1, 2, 3, and 4 followed by the same dose every month

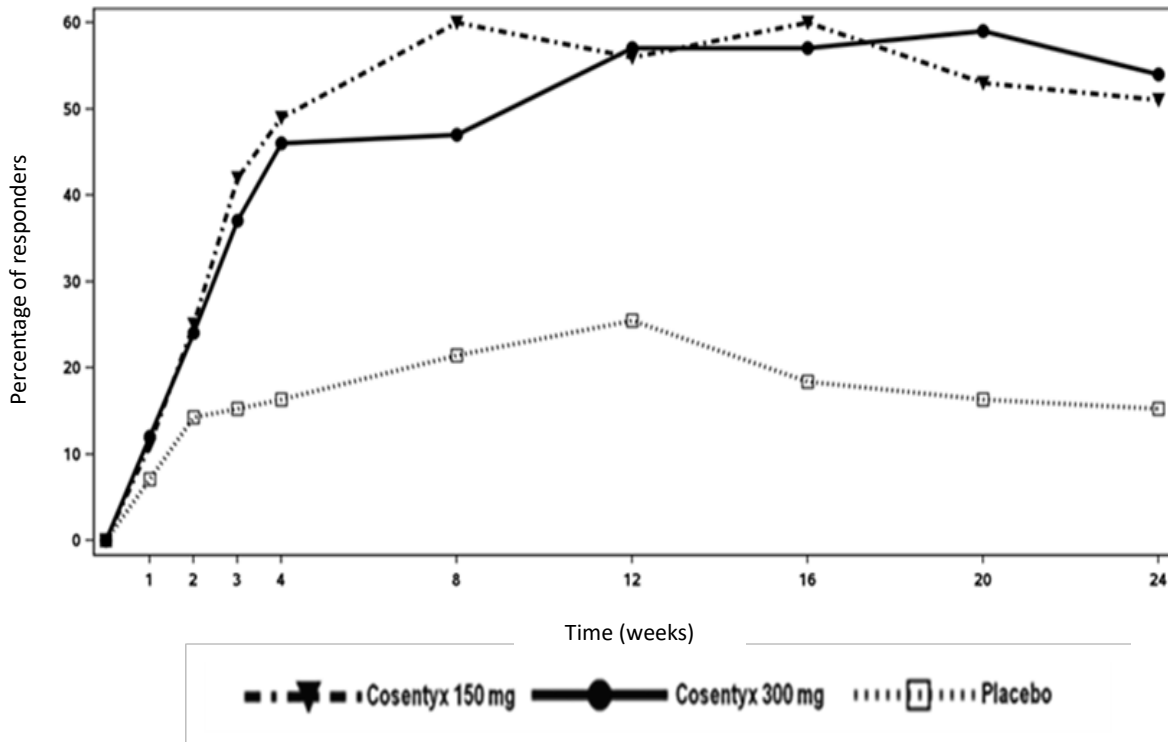
‡In patients with dactylitis at baseline (n=27, 32, 46 respectively for PsA2 and n=124, 80, 82 respectively for PsA3)

‡In patients with enthesitis at baseline (n=65, 64, 56 respectively for PsA2 and n=192, 141, 140, respectively for PsA3)

The onset of action of COSENTYX occurred as early as Week 2. Statistically significant difference in ACR 20 vs placebo was reached at Week 3. In PSA2 efficacy responses were maintained up to Week 104. At Week 16, COSENTYX-treated patients demonstrated significant improvements in signs and symptoms among which significantly higher responses in ACR 20 (60.0% and 57.0% for 150 mg and 300 mg, respectively) compared to placebo (18.4%).

The percentage of patients achieving ACR20 response by visit is shown in Figure 2.

Figure 2 ACR 20 response in PsA 2 Study over time up to Week 24



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Similar responses for primary and key secondary endpoints were seen in PsA patients regardless of whether they were on concomitant MTX treatment or not.

Both, anti-TNF-alpha-naïve and anti-TNF-alpha-IR COSENTYX-treated patients, had a significantly higher ACR 20 response compared to placebo at Week 24, with a slightly higher response in the anti-TNF-alpha-naïve group in the PsA2 study (anti-TNF-alpha-naïve: 64% and 58% for 150 mg and 300 mg, respectively, compared to placebo 15.9%; anti-TNF-alpha-IR: 30% and 46% for 150 mg and 300 mg, respectively, compared to placebo 14.3%). Anti-TNF-alpha-IR patients on 300 mg showed higher response rates on ACR20 compared to placebo patients ($p < 0.05$) and demonstrated clinical meaningful benefit over 150 mg on multiple secondary endpoints. Improvements in the PASI75 response were seen in both subgroups and the 300 mg dose showed statistically significant benefit in the anti-TNF-alpha-IR patients.

Improvements were shown in all components of the ACR scores, including patient assessment of pain. The proportion of patients achieving a modified PsA Response Criteria (PsARC) response was greater in the COSENTYX-treated patients (59.0% and 61.0% for 150 mg and 300 mg, respectively) compared to placebo (26.5%) at Week 24.

In PsA1 Study and PsA2 Study, efficacy was maintained up to Week 52. In PsA2 Study, among 200 patients initially randomised to COSENTYX 150 mg and 300 mg, 178 (89%) patients were still on treatment at Week 52. Of the 100 patients randomised to COSENTYX 150 mg, 64, 39 and 20 had an ACR 20/50/70 response, respectively. Of the 100 patients randomised to COSENTYX 300 mg, 64, 44 and 24 had an ACR 20/50/70 response, respectively.

Radiographic response

In PsA3 Study, inhibition of progression of structural damage was assessed radiographically and expressed by the modified Total Sharp Score (mTSS) and its components, the Erosion Score (ES) and the Joint Space Narrowing Score (JSN). Radiographs of hands, wrists, and feet were obtained at baseline Week 16 and/or Week 24 and scored independently by at least two readers who were blinded to treatment group and visit number.

COSENTYX 150 mg and 300 mg treatment significantly inhibited the rate of progression of peripheral joint damage compared with placebo treatment as measured by change from baseline in mTSS at Week 24 (Table 9).

The percentage of patients with no disease progression (defined as a change from baseline in mTSS of ≤ 0.5) from randomisation to Week 24 was 80.3%, 88.5% and 73.6% for COSENTYX 150 mg, 300 mg and placebo, respectively. An effect of inhibition of structural damage was observed irrespective of concomitant MTX use or TNF status.

Structural damage was also assessed in the PsA1 Study. Radiographs of hands, wrists, and feet were obtained at baseline and Week 24 during the double-blind period when patients were on COSENTYX or placebo and at Week 52 when all patients were on open-label COSENTYX.

By Week 24, COSENTYX 150 mg treatment significantly inhibited the rate of progression of peripheral joint damage compared with placebo treatment as measured by change from baseline in mTSS (see Table 9). Inhibition of structural damage was maintained with COSENTYX treatment up to Week 52.

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In PsA1 Study, the inhibition of progression of structural damage was assessed radiographically and expressed as the change in modified total Sharp Score (mTSS) and its components, the Erosion Score (ES) and the Joint Space Narrowing score (JSN) at Weeks 24 and 52, compared to baseline Week 24 data presented in Table 7.

Table 7 Change in modified Total Sharp Score in psoriatic arthritis

	PsA3			PsA1	
	Placebo n=296	150 mg ¹ n=213	300 mg ¹ n=217	Placebo n= 179	150 mg ² n= 185
Total Score					
Baseline	15.0	13.6	12.9	28.4	22.3
(SD)	(38.2)	(25.6)	(23.8)	(63.5)	(48.0)
Mean Change at Week 24	0.5	0.13*	0.02*	0.57	0.13*

* $p < 0.05$ based on nominal, but not adjusted, p -value

¹ Cosentyx 150 mg or 300 mg s.c. at Weeks 0, 1, 2, 3, and 4 followed by the same dose every month

² 10 mg/kg at Weeks 0, 2 and 4 followed s.c. doses of 75 mg or 150 mg

Inhibition of structural damage was maintained with COSENTYX 150 mg treatment up to Week 104 in PsA2 Study and with COSENTYX 300 mg treatment up to Week 52 in PsA3 Study.

The percentage of patients with no-disease progression (defined as a change from baseline in mTSS of ≤ 0.5) from randomisation to Week 24 was 82.3% in secukinumab 10 mg/kg i.v. load – 150 mg s.c. maintenance and 75.7% in placebo. The percentage of patients with no-disease progression, from Week 24 to Week 52, for the same above described regimen, was 85.7% and 86.8%, respectively.

Physical function and health related quality of life

In PsA2 and PsA3 studies, patients treated with COSENTYX 150 mg and 300 mg showed improvement in physical function compared to patients treated with placebo as assessed by change from baseline in Health Assessment Questionnaire-Disability Index (HAQ-DI) at Week 24 and Week 16, respectively. In PsA3 study, the change from baseline in HAQ-DI was -0.44 and -0.55 for COSENTYX 150 mg and 300 mg, respectively, versus -0.21 for placebo (< 0.0001). Improvements in HAQ-DI scores were seen regardless of previous anti-TNF-alpha exposure.

COSENTYX-treated patients reported significant improvements in health-related quality of life as measured by the Short Form (36) Health Survey Physical Component Summary (SF-36 PCS) score ($p < 0.001$) and these improvements were maintained up to Week 104 in PsA2.

Ankylosing spondylitis

The safety and efficacy of COSENTYX were assessed in 816 patients in three randomised, double-blind, placebo-controlled phase III studies in patients with active ankylosing spondylitis (AS) with a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) ≥ 4 despite non-steroidal anti-inflammatory drug (NSAID), corticosteroid or disease-modifying anti-rheumatic drug (DMARD) therapy. Patients in the AS1 Study and AS2 Study had a diagnosis of AS for a median of 2.7 to 5.8 years.

In MEASURE 1 Study (AS1 Study), MEASURE 2 Study (AS2 Study), and MEASURE 3 Study (AS3 Study), 27.0%, 38.8%, and 23.5% of patients, respectively, were previously treated with an anti-TNF-alpha agent and discontinued the anti-TNF-alpha agent for either lack of efficacy or intolerance (anti-TNF-alpha-IR patients).

Key exclusion criteria across pivotal trials were: patients with total ankylosis of the spine; use of high potency opioid analgesics; previous exposure to secukinumab or any other biologic drugs except for those targeting TNF-alpha, patients with active, ongoing inflammatory disease, other than AS; patients with active, ongoing, chronic or recurrent infectious disease; evidence of tuberculosis infection

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(enrolment was allowed for patients with latent tuberculosis if appropriate treatment was initiated and maintained according to the local treatment guideline); history of HIV, hepatitis B or hepatitis C; underlying immunocompromising conditions; presence of lymphoproliferative disease, malignancy or history of malignancy within the past 5 years; significant medical problems including uncontrolled hypertension and congestive heart failure (NYHA Class III and IV); patients with serum creatinine >132.6 micromol/L or with white blood cell count <3,000 /microL, platelets <100,000/microL, neutrophils <1,500/microL or haemoglobin <8.5 g/dL; pregnant or nursing women; and women of child-bearing potential not using effective contraception during the study.

AS1 Study evaluated 371 patients, of whom 14.8% and 33.4% used concomitant MTX or sulfasalazine, respectively. Patients randomised to COSENTYX received 10 mg/kg, i.v. at Weeks 0, 2, and 4, followed by either 75 mg or 150 mg s.c. every month starting at week 8. Patients randomised to placebo who were non-responders at Week 16 (early rescue) and all other placebo patients at Week 24 were crossed over to receive COSENTYX (either 75 mg or 150 mg s.c.), followed by the same dose every month. The primary endpoint was at least a 20% improvement in Assessment of Spondyloarthritis International Society (ASAS 20) criteria at Week 16.

AS2 Study evaluated 219 patients, of whom 11.9% and 14.2% used concomitant MTX or sulfasalazine, respectively. Patients randomised to COSENTYX received 75 mg or 150 mg s.c. at Weeks 0, 1, 2, 3, and 4 followed by the same dose every month. At Week 16, patients who were randomised to placebo at baseline were re-randomised to receive COSENTYX (either 75 mg or 150 mg) s.c. every month. The primary endpoint was ASAS20 at Week 16.

AS3 Study evaluated 226 patients, of whom 13.3% and 23.5% used concomitant MTX or sulfasalazine, respectively. Patients randomised to COSENTYX received 10 mg/kg, i.v. at Weeks 0, 2, and 4, followed by either 150 mg or 300 mg s.c. every month. At Week 16, patients who were randomised to placebo at baseline were re-randomised to receive COSENTYX (either 150 mg or 300 mg) s.c. every month. The primary end point was ASAS20 at Week 16. Patients were blinded to the treatment regimen up to Week 52, and the study continued to Week 156.

Signs and symptoms

In AS2 Study, treatment with COSENTYX 150 mg resulted in greater improvement in measures of disease activity compared with placebo at Week 16 (see Table 8).

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Table 8 Clinical response in AS2 Study at Week 16

Outcome (p-value vs placebo)	Placebo (n = 74)	75 mg (n = 73)	150 mg (n = 72)
Efficacy at Week 16			
ASAS20 response, %	28.4	41.1	61.1***
ASAS40 response, %	10.8	26.0	36.1***
hsCRP, (post-BSL/BSL ratio)	1.13	0.61	0.55***
ASAS5/6, %	8.1	34.2	43.1***
BASDAI, LS mean change from baseline score	-0.85	-1.92	-2.19***
ASAS partial remission, %	4.1	15.1	13.9
BASDAI50, %	10.8	24.7*	30.6**
ASDAS-CRP major improvement	4.1	15.1*	25.0***

*p<0.05; **p<0.01; ***p< 0.001 vs. placebo

All p-values adjusted for multiplicity of testing based on pre-defined hierarchy, except BASDAI50 and ASDAS-CRP

Non-responder imputation used for missing binary endpoint

ASAS: Assessment of SpondyloArthritis International Society Criteria; BASDAI: Bath Ankylosing Spondylitis Disease Activity Index; hsCRP: high-sensitivity C-reactive protein; ASDAS: Ankylosing Spondylitis Disease Activity Score; BSL: baseline; LS: least square

The results of the main components of the ASAS20 response criteria are shown in Table 9.

Table 9 Main components of the ASAS20 response criteria at baseline and Week 16 in AS 2 Study

	Placebo (N = 74)		75 mg (N = 73)		150 mg (N = 72)	
	Baseline	Week16	Baseline	Week16	Baseline	Week16
ASAS20 Response criteria						
-Patient global assessment (0-10)	7.0	5.5	6.5	4.5	6.7	3.8
-Total spinal pain (0-10)	6.9	5.7	6.5	4.6	6.6	3.7
-BASFI (0-10)	6.1	5.3	6.0	4.1	6.2	3.8
-Inflammation (0-10)	6.5	5.7	6.9	4.4	6.5	4.0

The onset of action of COSENTYX 150 mg occurred as early as Week 1 for ASAS20 and Week 2 for ASAS40 (superior to placebo) in AS2 Study. The percentage of patients achieving an ASAS20 response by visit is shown in Figure 3.

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Figure 3 ASAS20 responses in AS 2 Study over time up to Week 16

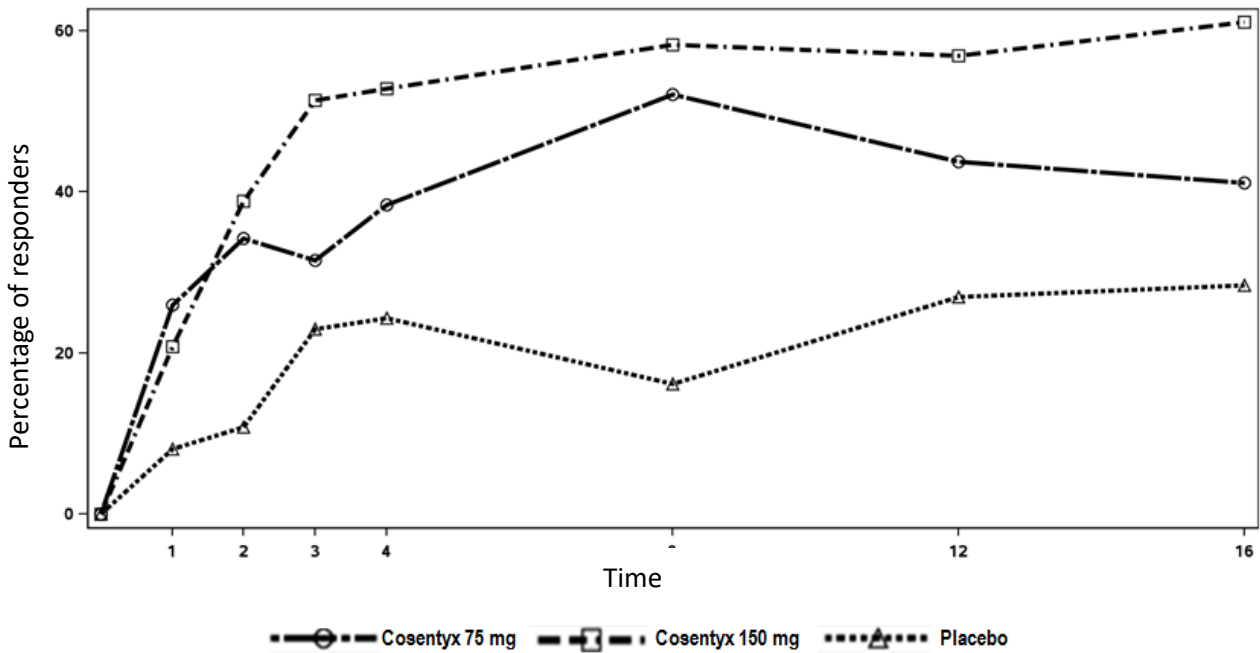
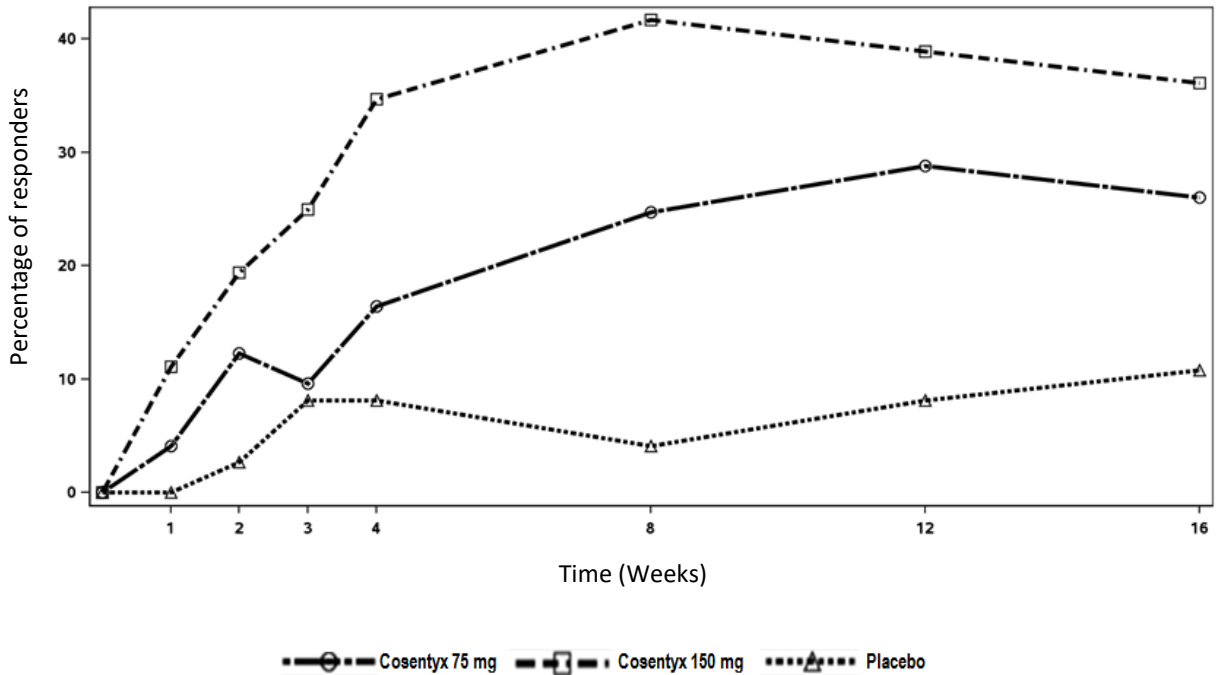


Figure 4 ASAS40 responses in AS 2 Study over time up to Week 16



ASAS20 responses were improved at Week 16 in both antiTNF α -naïve patients (68.2% vs. 31.1%; $p < 0.05$) and anti-TNF α -IR patients (50.0% vs. 24.1%; $p < 0.05$) for COSENTYX 150 mg compared with placebo, respectively.

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AS1 Study and AS2 Study, COSENTYX -treated patients (150 mg in AS2 Study and both regimens in AS1 Study) demonstrated significantly improved signs and symptoms at Week 16, with comparable magnitude of response and efficacy was maintained up to Week 52. The magnitude of response (treatment difference versus placebo) with regards to signs and symptoms at Week 16 was similar in anti-TNF-alpha-naïve and anti-TNF-alpha-IR patients in both studies, with higher absolute response rates in anti-TNF-alpha-naïve patients. Efficacy was maintained in anti-TNF-alpha-naïve and anti-TNF-alpha-IR patients up to Week 52 in both studies.

In AS3 Study, COSENTYX treated patients (150 mg and 300 mg) demonstrated improved signs and symptoms, and had comparable efficacy responses regardless of dose that were superior to placebo at Week 16 for the primary endpoint (ASAS20). Greater response rates favouring 300 mg were also observed for ASAS partial remission (ASAS PR) response at week 16. During the blinded period, the ASAS20 and ASAS40 responses were 69.7% and 47.6% for 150 mg and 74.3% and 57.4% for 300 mg at Week 52, respectively. The ASAS20 and ASAS40 responses were maintained through Week 156 (69.5% and 47.6% for 150 mg vs. 74.8% and 55.6% for 300 mg). The ASAS partial remission (ASAS PR) responses were 9.5% and 21.1% for 150 mg and 300 mg respectively, compared to 1.3% for placebo at Week 16. The ASAS PR responses were 18.1% and 24.3% for 150 mg and 300 mg at Week 52, respectively. These responses were maintained through Week 156 (15.1% for 150 mg and 27.2% for 300 mg).

Spinal mobility

Spinal mobility was assessed by BASMI up to Week 52. In AS2 Study (150 mg) and in AS1 Study (75 mg and 150 mg), numerically greater improvements in each BASMI component were demonstrated in COSENTYX-treated patients compared with placebo-treated patients at Weeks 4, 8, 12, and 16 (except for lateral lumbar flexion in patients on 75 mg following the IV load at Weeks 4, 8, and 12).

Physical function and health-related quality of life

In AS Study 1 and 2, patients treated with COSENTYX 150 mg showed improvements in health-related quality of life as measured by ASQoL (LS mean change: -4.00 vs -1.37, $p = 0.001$) and SF-36 PCS (LS mean change: 6.06 vs 1.92, $p < 0.001$). COSENTYX 150 mg had numerically larger mean improvements than placebo for three of the four Work Productivity and Activity Impairment-General Health (WPAI-GH) outcomes at Week 16. These improvements were sustained up to Week 52.

Patients treated with COSENTYX 150 mg also showed improvements on exploratory endpoints in physical function as assessed by the Bath Ankylosing Spondylitis Functional Index (BASFI) compared to placebo (-2.15 versus -0.68).

Inhibition of inflammation in magnetic resonance imaging (MRI)

In an imaging sub-study including 105 anti-TNF-alpha-naïve patients in AS1 Study, signs of inflammation were assessed by MRI at baseline and Week 16 and expressed as change from baseline in Berlin SI-joint edema score for sacroiliac joints and ASspiMRI-a score and Berlin spine score for the spine. Inhibition of inflammatory signs in both sacroiliac joints and the spine was observed in secukinumab-treated patients.

Non-clinical safety data

Non-clinical data revealed no special hazard for humans based on tissue cross-reactivity testing, safety pharmacology, repeated dose and reproductive toxicity studies performed with secukinumab or a murine anti-murine IL-17A antibody.

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Since secukinumab binds to cynomolgus monkey and human IL-17A, its safety was studied in the cynomolgus monkey. No undesirable effects of secukinumab were seen following subcutaneous administration to cynomolgus monkeys for up to 13 weeks and intravenous administration up to 26 weeks (including pharmacokinetic, pharmacodynamic, immunogenicity and immunotoxicity (e.g. T cell dependent antibody response and NK cell activity) evaluations). The average serum concentrations observed in monkeys after 13 weekly subcutaneous doses of 150 mg/kg are 48-fold higher than the predicted average serum concentration expected in psoriatic patients at the highest clinical dose. The exposure multiples are even higher when the average serum concentration from the 26 weeks intravenous toxicology study in cynomolgus monkeys are taken into consideration. Antibodies to secukinumab were detected in only one out of 101 animals. No non-specific tissue cross-reactivity was demonstrated when secukinumab was applied to normal human tissues.

No undesirable effects of a murine anti-murine IL-17A antibody were seen in fertility and early embryonic development and pre-and postnatal development studies in mice. The high dose used in these studies was in excess of the maximally effective dose in terms of IL-17A suppression and activity (see Fertility, Use in Pregnancy and Use in Lactation).

5.2 Pharmacokinetic properties

The mean pharmacokinetic parameters of secukinumab following single and multiple subcutaneous administration in adult patients with psoriasis, resulting from population pharmacokinetic analysis, are shown in Table 10. C_{max} and AUC were dose-proportional at 150 mg and 300 mg subcutaneous doses.

Table 10 Summary of pharmacokinetic parameters of COSENTYX at steady – state following 150 or 300 mg s.c. administration in adult patients with psoriasis

Parameter	COSENTYX 4-weekly dose			
	150 mg		300 mg	
	Mean (SD)	Range	Mean (SD)	Range
$C_{max,ss}$ (µg/mL)	27.6 (10.7)	(13.7, 47.4)	55.2 (21.5)	(27.5, 94.8)
$C_{av,ss}$ (µg/mL)	22.2 (9.2)	(10.5, 39.0)	44.5 (18.4)	(21.1, 77.9)
$T_{max,ss}$ (day)	6.0	(4.0, 8.0)	6.0	(4.0, 8.0)
AUC _{ss} (day.µg/mL)	622 (257)	(295, 1090)	1245 (515)	(590, 2180)

Absorption

Following a single subcutaneous dose of either 150 mg or 300 mg in plaque psoriasis patients, secukinumab reached peak serum concentrations of 13.7 ± 4.8 µg/mL or 27.3 ± 9.5 µg/mL, respectively, between 5 to 6 days post dose.

After the initial weekly dosing during the first month, the time to reach the maximum concentration was between 31 and 34 days.

Peak concentrations at steady-state ($C_{max,ss}$) following subcutaneous administration of 150 mg or 300 mg were 27.6 µg/mL and 55.2 µg/mL, respectively. Steady-state is reached after 20 weeks with monthly dosing regimens.

Compared with exposure after a single dose, patients exhibited a 2-fold increase in peak serum concentrations and AUC following repeated monthly dosing during maintenance.

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Secukinumab is absorbed with an average absolute bioavailability of 73%.

Distribution

The mean volume of distribution during the terminal phase (V_z) following a single intravenous administration ranged from 7.10 to 8.60 L in plaque psoriasis patients suggesting that secukinumab undergoes limited distribution to peripheral compartments.

Secukinumab concentrations in interstitial fluid in the skin of plaque psoriasis patients ranged from 28 % to 39 % of those in serum at 1 and 2 weeks after a single subcutaneous dose of 300 mg secukinumab.

Metabolism

The metabolic pathway of secukinumab has not been characterized. As a human IgG1k monoclonal antibody secukinumab is expected to be degraded into small peptides and amino acids via catabolic pathways in the same manner as endogenous IgG.

Elimination

Mean systemic clearance (CL) was 0.19 L/d in plaque psoriasis patients. Clearance was dose- and time-independent, as expected for a therapeutic IgG1 monoclonal antibody interacting with a soluble cytokine target, such as IL-17A.

The mean elimination half-life was estimated to be 27 days in plaque psoriasis patients. Estimated half-lives in individual plaque psoriasis patients range from 17 to 41 days.

Dose linearity

The single and multiple dose pharmacokinetics of secukinumab in plaque psoriasis patients were determined in several studies with intravenous doses ranging from 1 x 0.3 mg/kg to 3 x 10 mg/kg and with subcutaneous doses ranging from 1 x 25 mg to multiple doses of 300 mg. Exposure was dose proportional across all dosing regimens.

The pharmacokinetics properties of secukinumab observed in psoriatic arthritis and ankylosing spondylitis patients were similar to those displayed in plaque psoriasis patients. The bioavailability of secukinumab in PsA patients was 85% on the basis of the population pharmacokinetic model.

Pharmacokinetics in special patient groups

Paediatrics (< 18 years of age)

Specific studies of COSENTYX in paediatric patients have not been conducted.

Elderly patients

Of the 3,430 plaque psoriasis patients exposed to COSENTYX in clinical studies, a total of 230 were 65 years of age or older and 32 patients were 75 years of age or older.

Of the 2,536 psoriatic arthritis patients exposed to COSENTYX in clinical studies, a total of 236 patients were 65 years of age or older and 25 patients were 75 years of age or older.

Of the 794 ankylosing spondylitis patients exposed to COSENTYX in clinical studies, a total of 29 patients were 65 years of age or older and 3 patients were 75 years of age or older.

Based on population PK analysis, clearance in elderly patients and patients less than 65 years of age was similar.

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Patients with renal and hepatic impairment

No pharmacokinetic data are available in patients with hepatic or renal impairment.

Effect of weight on pharmacokinetics

Secukinumab clearance and volume of distribution increase as body weight increases.

5.3 Preclinical safety data

Non-clinical data revealed no special risks for humans based on tissue cross-reactivity testing, safety pharmacology, repeated dose and reproductive toxicity studies performed with secukinumab or a murine anti-murine IL-17A antibody.

Since secukinumab binds to cynomolgus monkey and human IL-17A, its safety was studied in the cynomolgus monkey. No undesirable effects of secukinumab were seen following subcutaneous administration to cynomolgus monkeys for up to 13 weeks and intravenous administration up to 26 weeks (including pharmacokinetic, pharmacodynamic, immunogenicity and immunotoxicity (e.g. T-cell dependent antibody response and NK cell activity) evaluations). The average serum concentrations observed in monkeys after 13 weekly subcutaneous doses of 150 mg/kg were considerably higher than the predicted average serum concentration expected in psoriatic patients at the highest clinical dose. Antibodies to secukinumab were detected in only one of the exposed animals. No non-specific tissue cross-reactivity was observed when secukinumab was applied to normal human tissue.

Animal studies have not been conducted to evaluate the carcinogenic potential of secukinumab.

In an embryofoetal development study in cynomolgus monkeys, secukinumab showed no maternal toxicity, embryotoxicity or teratogenicity when administered throughout organogenesis and late gestation.

No undesirable effects of a murine anti-murine IL-17A antibody were seen in fertility and early embryonic development and pre- and postnatal development studies in mice. The high dose used in these studies was in excess of the maximum effective dose in terms of IL-17A suppression and activity (see section 4.6).

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Powder for injection: water for injections, sucrose, histidine, histidine hydrochloride monohydrate, polysorbate 80.

Solution for injection (prefilled syringe and prefilled pen): trehalose dihydrate, histidine, histidine hydrochloride monohydrate, polysorbate 80, methionine, water for injections.

6.2 Incompatibilities

In the absence of compatibility studies, this medicinal product must not be mixed with other medicinal products.

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6.3 Shelf life

24 months.

6.4 Special precautions for storage

Powder for Solution: Store at 2-8°C. Store in the original package.

Prefilled syringe and prefilled pen: Store at 2-8°C. Do not freeze. Protect from light. Store in the original package. May be stored unrefrigerated (out of fridge) at room temperature for a single period up to a maximum of 4 days at a temperature not above 30°C.

6.5 Nature and contents of container

Powder for Solution: Colourless glass vial with a grey coated rubber stopper and aluminium cap with a white flip-off component.
COSENTYX is available in unit packs containing 1* or 2* single-use vials.

Prefilled syringe: Single use pre-filled 1 ml glass syringe with a FluroTec-coated plunger stopper, staked 27G x ½" needle and rigid needle shield of styrene butadiene rubber assembled in a passive safety device of polycarbonate.
COSENTYX is available in unit packs containing 1* or 2* pre-filled syringes.

Prefilled pen: Single-use pre-filled syringe assembled into a triangular-shaped pen with transparent window and label (SensoReady pen). The pre-filled syringe inside the pen is a 1 ml glass syringe with a FluroTec-coated plunger stopper, staked 27G x ½" needle and rigid needle shield of styrene butadiene rubber.
COSENTYX is available in unit packs containing 1* or 2* pre-filled pens.

**Not all pack sizes or presentations may be marketed.*

6.6 Special precautions for disposal and handling

COSENTYX 150 mg powder for solution is supplied in a single-use vial containing 150 mg secukinumab for reconstitution with sterile water for injections. The resulting solution should be clear and colourless to slightly yellow. Do not use if the lyophilised powder has not fully dissolved or if the liquid contains easily visible particles, is cloudy or is distinctly brown.

COSENTYX 150 mg/mL solution for injection is supplied in a single-use pre-filled syringe or prefilled pen for individual use. Do not shake or freeze the syringe. The syringe should be taken out of the refrigerator 20 minutes before injecting to allow it to reach room temperature. Prior to use, a visual inspection of the pre-filled syringe is recommended. The liquid should be clear. Its colour may vary from colourless to slightly yellow. You may see a small air bubble, which is normal. Do not use if the liquid contains easily visible particles, is cloudy or is distinctly brown.

Detailed instructions for use are provided in the package leaflet.

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

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7 MEDICINE SCHEDULE

Prescription medicine

8 SPONSOR

Novartis New Zealand Limited

PO Box 99102 Newmarket

Auckland 1149

New Zealand

Telephone: 0800 354 335

® = Registered Trademark

9 DATE OF FIRST APPROVAL

14 January 2016

10 DATE OF REVISION OF THE TEXT

1 July 2020

SUMMARY TABLE OF CHANGES

The overview of the last changes made to the data sheet are as follows:

Section changed	Summary of new information
8 Sponsor	Update to Sponsor address

Internal document code: cos080720iNZ based on CDS dated 21 March 2019