

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER Reg No:**

Reg No: First Names: First Names:

Name: Surname: Surname:

Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Secukinumab

Initial application — plaque psoriasis

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

Patient has "whole body" plaque psoriasis with a PASI score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis
or
 Patient has plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis
or
 Patient has localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a DLQI score greater than 10

and

 Patient has received insufficient benefit (see Note) or has experienced intolerable side effects from at least 3 of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin

and

 A PASI assessment or DLQI assessment has been completed for the most recent prior treatment course, within 1 month of stopping that treatment
 Patient has had a Special Authority approval for adalimumab, etanercept, or infliximab, for plaque psoriasis
 Patient has experienced intolerable side effects
or
 Patient has received insufficient benefit to meet the renewal criteria for plaque psoriasis

Note: A treatment course is defined as a minimum of 12 weeks of treatment. "Insufficient benefit" is defined as: for whole body plaque psoriasis, a PASI score of greater than 10; for plaque psoriasis of the face, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub scores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot. As assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz

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Secukinumab - continued

Renewal — plaque psoriasis

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

Patient's PASI score has reduced by 75% or more compared to pre-secukinumab baseline

or

Patient has a DLQI improvement of 5 or more, compared to pre-secukinumab baseline

or

Patient had localised genital or flexural plaque psoriasis at the start of treatment

and

Patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, compared to the pre-secukinumab baseline

or

Patient has a DLQI improvement of 5 or more, compared to pre-secukinumab baseline

and

Maximum dose 300 mg monthly

Initial application — ankylosing spondylitis – second-line biologic

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

Patient has had a Special Authority approval for adalimumab or etanercept for ankylosing spondylitis

and

Patient has experienced intolerable side effects

or

Patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis

Renewal — ankylosing spondylitis – second-line biologic

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

BASDAI has improved from the pre-secukinumab baseline either by at least 4 points on a 10-point scale, or by at least 50%, whichever is less

and

Maximum dose 300 mg monthly

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Secukinumab - continued

Initial application — arthritis - psoriatic

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Patient has had a Special Authority approval for adalimumab, etanercept or infliximab for psoriatic arthritis and <input type="checkbox"/> Patient has experienced intolerable side effects or <input type="checkbox"/> Patient has received insufficient benefit to meet the renewal criteria for psoriatic arthritis
or
<input type="checkbox"/> Patient has received insufficient benefit from at least 3 months of methotrexate at a maximum tolerated dose unless contraindicated and <input type="checkbox"/> Patient has received insufficient benefit from at least 3 months of sulfasalazine or leflunomide at maximum tolerated doses unless contraindicated and <input type="checkbox"/> Patient has persistent symptoms of poorly controlled and active disease in at least 15 joints or <input type="checkbox"/> Patient has persistent symptoms of poorly controlled and active disease in at least 4 joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip and <input type="checkbox"/> CRP greater than 15 mg/L measured within one month before the application or <input type="checkbox"/> ESR greater than 25 mm per hour measured within one month before the application or <input type="checkbox"/> ESR and CRP not measured as patient is receiving prednisone therapy greater than 5 mg per day received for more than 3 months

Renewal — arthritis - psoriatic

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Following initial treatment, at least a 50% decrease in active joint count from baseline or <input type="checkbox"/> At least a continuing 30% improvement in active joint count from baseline
and
<input type="checkbox"/> Maximum dose 300 mg monthly

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