

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

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

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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](mailto: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)

Patient has had a Special Authority approval for adalimumab, etanercept or infliximab for psoriatic arthritis

**and**

Patient has experienced intolerable side effects

**or**

Patient has received insufficient benefit to meet the renewal criteria for psoriatic arthritis

**or**

Patient has received insufficient benefit from at least 3 months of methotrexate at a maximum tolerated dose unless contraindicated

**and**

Patient has received insufficient benefit from at least 3 months of sulfasalazine or leflunomide at maximum tolerated doses unless contraindicated

**and**

Patient has persistent symptoms of poorly controlled and active disease in at least 15 joints

**or**

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**

CRP greater than 15 mg/L measured within one month before the application

**or**

ESR greater than 25 mm per hour measured within one month before the application

**or**

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)

Following initial treatment, at least a 50% decrease in active joint count from baseline

**or**

At least a continuing 30% improvement in active joint count from baseline

**and**

Maximum dose 300 mg monthly

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