

PsA symptoms can be unpredictable¹

START with the ALL-IN-ONE relief of COSENTYX®

Results in ALL key clinical manifestations of PsA^{2-5*}



SC or IV: 2 forms that give patients options to start and stay on COSENTYX^{6†}

Darren, an actual patient with PsA taking COSENTYX, was compensated for his time. Individual results may vary.

*All trials used SC administration.

†For adult patients with active PsA, AS, or nr-axSpA.⁶

AS, ankylosing spondylitis; IV, intravenous; nr-axSpA, non-radiographic axial spondyloarthritis; PsA, psoriatic arthritis; SC, subcutaneous.

INDICATIONS

COSENTYX® (secukinumab) is indicated for the treatment of moderate to severe plaque psoriasis (PsO) in patients 6 years and older who are candidates for systemic therapy or phototherapy.

COSENTYX is indicated for the treatment of active psoriatic arthritis (PsA) in patients 2 years of age and older.

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

COSENTYX is indicated for the treatment of adult patients with active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation.

COSENTYX is indicated for the treatment of active enthesitis-related arthritis (ERA) in patients 4 years of age and older.

COSENTYX is indicated for the treatment of adult patients with moderate to severe hidradenitis suppurativa (HS).

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

COSENTYX is contraindicated in patients with a previous serious hypersensitivity reaction to secukinumab or to any of the excipients in COSENTYX. Cases of anaphylaxis and angioedema have been reported during treatment with COSENTYX.

**Please see additional Important Safety Information throughout.
Please see full Prescribing Information, including Medication Guide.**

Choose COSENTYX® for your biologic-naïve patients

In the pivotal trial, FUTURE 2,* in patients with PsA^{6,7}

(Two-thirds biologic-naïve and one-third anti-TNF-α inadequate responders)⁷

ACR20 responses at Week 16 (NRI) were^{6,7}:

- 57% for COSENTYX 300 mg (n=100) (**P<0.0001**)
- 60% for COSENTYX 150 mg (n=100) (**P<0.0001**)
- 18% for placebo (n=98)

ACR20 responses at Week 24 (**primary end point**) (NRI) were^{6,7}:

- 54% for COSENTYX 300 mg (n=100) (**P<0.0001**)
- 51% for COSENTYX 150 mg (n=100) (**P<0.0001**)
- 15% for placebo (n=98)

- Skin lesions improved in patients with coexistent PsO who received COSENTYX (n=99) compared with placebo (n=43), as measured by the PASI^{6,7}
- Improvements in enthesitis and dactylitis scores were observed in the COSENTYX group compared with placebo at Week 24⁷

FUTURE 5* in patients with PsA at Week 16⁸

(Two-thirds biologic-naïve and one-third anti-TNF-α inadequate responders)

JOINT

FUTURE 5 primary end point

ACR20 response rates (NRI) were:

- 63% for COSENTYX 300 mg (n=222) (**P<0.0001**)
- 56% for COSENTYX 150 mg (n=220) (**P<0.0001**)
- 27% for placebo (n=332)

ENTHESITIS

Complete resolution (LEI=0) in patients with enthesitis at baseline (NRI):

- 56% for COSENTYX 300 mg (n=140)
- 55% for COSENTYX 150 mg (n=141)
- 35% for placebo (n=192)

DACTYLITIS

Complete resolution (LDI=0) in patients with dactylitis at baseline (NRI):

- 66% for COSENTYX 300 mg (n=82)
- 57% for COSENTYX 150 mg (n=80)
- 32% for placebo (n=124)

SKIN

Patients who achieved PASI 90 (NRI):

- 54% for COSENTYX 300 mg (n=110)
- 37% for COSENTYX 150 mg (n=125)
- 9% for placebo (n=162)

NAIL[†]

Reduction in nail disease (mNAPSI as observed) response rates were[‡]:

- 51% for COSENTYX 300 mg (n=125)
- 53% for COSENTYX 150 mg (n=128)
- 11% for placebo (n=203)

MAXIMISE* in biologic-naïve patients with PsA^{2,8}

ASAS20 responses at Week 12 (multiple imputation) were:

- 63% for COSENTYX 300 mg (n=164) (**primary end point**) (**P<0.0001**)
- 66% for COSENTYX 150 mg (n=157) (**key secondary end point**) (**P<0.0001**)
- 31% for placebo (n=164)

*All trials used SC administration.

[†]Nail data in PsA were consistent with those in the dedicated nail PsO study, TRANSFIGURE.* Improvement from baseline NAPSI at Week 16 (primary end point) (MMRM) was 46.1% for COSENTYX 300 mg (n=63) and 11.7% for placebo (n=56) (**P<0.0001**).⁹

[‡]At baseline, mNAPSI scores were 18.0 and 17.8 in the 300-mg and 150-mg arms, respectively. At Week 16, mNAPSI scores were 8.8 and 8.4 in the 300-mg and 150-mg arms, respectively.⁸

[§]Data from the MAXIMISE trial, whose study design, patient population, and dosing regimen are consistent with those of FUTURE 2. In FUTURE 2, 20% of patients had spondylitis with peripheral arthritis.⁶

ACR, American College of Rheumatology; ASAS, Assessment of SpondyloArthritis International Society criteria; LDI, Leeds Dactylitis Index; LEI, Leeds Enthesitis Index; MMRM, mixed-effect model repeated measure; mNAPSI, modified Nail Psoriasis Severity Index; NAPSI, Nail Psoriasis Severity Index; NRI, nonresponder imputation; PASI, Psoriasis Area and Severity Index; PsO, plaque psoriasis; TNF-α, tumor necrosis factor alpha.

Please see FUTURE 2, FUTURE 5, MAXIMISE, and TRANSFIGURE study design details on [page 7](#).

IMPORTANT SAFETY INFORMATION (cont)

WARNINGS AND PRECAUTIONS

Infections

COSENTYX may increase the risk of infections. In clinical trials, a higher rate of infections was observed in COSENTYX treated subjects compared to placebo-treated subjects. In placebo-controlled clinical trials in subjects with moderate to severe PsO, higher rates of common infections, such as nasopharyngitis (11.4% versus 8.6%), upper respiratory tract infection (2.5% versus 0.7%) and mucocutaneous infections with candida (1.2% versus 0.3%) were observed in subjects treated with COSENTYX compared to placebo-treated subjects. A similar increase in risk of infection in subjects treated with COSENTYX was seen in placebo-controlled trials in subjects with PsA, AS and nr-axSpA. The incidence of some types of infections, including fungal infections, appeared to be dose-dependent in clinical trials.

In the postmarketing setting, serious bacterial, viral, and fungal opportunistic infections, and some fatal infections have been reported in patients receiving IL-17 inhibitors including COSENTYX. Cases of Hepatitis B virus reactivation have been reported.

Exercise caution when considering the use of COSENTYX in patients with a chronic infection or a history of recurrent infection. Instruct patients to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, monitor the patient closely and discontinue COSENTYX until the infection resolves.

If signs of Hepatitis B virus reactivation occur, consult a hepatitis specialist. COSENTYX is not recommended for use in patients with active viral hepatitis.

Please see additional Important Safety Information throughout.
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PsA symptoms can be unpredictable¹—consider a therapy with

ALL-IN-ONE relief

Results in ALL key clinical manifestations of PsA²⁻⁵

Help your patients achieve remission as defined by disease activity at 2 years^{3,10-12*}

- In FUTURE 5,[†] 58% and 50% of biologic-naïve patients achieved MDA at 2 years (as observed) with COSENTYX® 300 mg (n=140) and COSENTYX 150 mg (n=138), respectively³
- 40% of biologic-naïve patients in the COSENTYX 150-mg arm were up-titrated to 300 mg starting at Week 52, at the investigator's discretion³

Results up to 2 years, as observed in patients on 300 mg



JOINT
54% (ACR50)
achieved joint relief
(n=137)³

SKIN
71%
(PASI 90)
achieved clearer skin (n=68)⁴
• 50% of patients achieved completely clear skin (PASI 100)¹³



ENTHESITIS
80%
had **NO** enthesitis
(n=88)³

DACTYLITIS
~90%
had **NO** dactylitis
(n=48)³



AXIAL[‡]
81%
at **1 year** achieved axial relief
(ASAS20) (n=139)²

NAIL[§]
84%
reduction in nail disease
(mNAPSI) (n=81)⁵



- COSENTYX 150 mg across manifestations up to 2 years: ACR50: 60% (n=132); ASAS20: 80% at 1 year (n=141); enthesitis: 82% (n=85); dactylitis: 86% (n=43); PASI 90: 66% (n=84); mNAPSI: 89% (n=78)²⁻⁵

In FUTURE 5, ACR50, dactylitis, enthesitis, mNAPSI, PASI 90, and MDA were prespecified exploratory end points at 2 years in biologic-naïve patients, and PASI 100 was a post hoc analysis based on PASI 90. In MAXIMISE, ASAS20 was a prespecified exploratory end point at 1 year in biologic-naïve patients. No clinical or statistical conclusions can be drawn.^{2-5,8}

COSENTYX is effective with or without MTX⁶

*All patients who met escape criteria (<20% improvement in tender or swollen joint counts) at Week 16 were considered nonresponders at Week 20 and Week 24. Results were analyzed using nonresponder imputation. In addition to MDA, PsA disease activity may be assessed using DAS28, which is based on a count of 28 swollen and tender joints, patient global assessment of disease activity VAS, and either ESR or CRP level. A DAS28 score >5.1 implies active disease, ≤3.2 low disease activity, and <2.6 remission. EULAR response criteria are based on DAS28 status in combination with DAS28 improvements. EULAR states that until the definition of remission in PsA is agreed upon, remission of PsA is the abrogation of inflammation.^{11,12,14,15}

[†]All trials used SC administration.

[‡]Data from the MAXIMISE trial, whose study design, patient population, and dosing regimen are consistent with those of FUTURE 2. In FUTURE 2, 20% of patients had spondylitis with peripheral arthritis.⁶

[§]Nail data in PsA were consistent with those in the dedicated nail PsO study, TRANSFIGURE.¹ Improvement from baseline NAPSI at Week 16 (primary end point) (MMRM) was 46.1% for COSENTYX 300 mg (n=63) and 11.7% for placebo (n=56) (**P<0.0001**).⁹

CRP, C-reactive protein; DAS28, 28-joint Disease Activity Score; ESR, erythrocyte sedimentation rate; EULAR, European Alliance of Associations for Rheumatology; MDA, minimal disease activity; MTX, methotrexate; VAS, visual analog scale

Please see FUTURE 5 and MAXIMISE study design details on [page 7](#).

IMPORTANT SAFETY INFORMATION (cont)

WARNINGS AND PRECAUTIONS (cont)

Pre-treatment Evaluation for Tuberculosis

Evaluate patients for tuberculosis (TB) infection prior to initiating treatment with COSENTYX. Avoid administration of COSENTYX to patients with active TB infection. Initiate treatment of latent TB prior to administering COSENTYX. Consider anti-TB therapy prior to initiation of COSENTYX in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Monitor patients closely for signs and symptoms of active TB during and after treatment.

Please see Important Safety Information throughout.

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Cosentyx[®]
(secukinumab)

A robust safety profile...

PsA safety in pivotal trials through Week 16⁶

AEs ≥2% in FUTURE 2 ^{7*}	COSENTYX® 300 mg (n=100), %	COSENTYX 150 mg (n=100), %	Placebo (n=98), %
Upper respiratory tract infection	4.0	8.0	7.1
Nasopharyngitis	6.0	4.0	8.2
Headache	7.0	4.0	4.1
Nausea	3.0	4.0	4.1
Diarrhea	2.0	2.0	3.1
Urinary tract infection	2.0	4.0	4.1
Hematuria	2.0	3.0	1.0
Vomiting	2.0	2.0	1.0

Selected AEs in the pivotal PsA program (FUTURE 1 and 2) (N=1003) ^{16†}	COSENTYX any dose [‡] (n=703), %	Placebo (n=300), %
Infections	29	26
Serious infections	1.3	0.3

There were cases of Crohn's disease and ulcerative colitis that included patients who experienced either exacerbations or the development of new disease. There were 3 cases of inflammatory bowel disease, of which 2 patients received COSENTYX and 1 received placebo.⁶

If a serious infection develops, discontinue COSENTYX until the infection resolves.⁶

If an anaphylactic reaction or other serious allergic reaction occurs, discontinue COSENTYX immediately and initiate appropriate therapy.⁶

In FUTURE 3, COSENTYX did not show any new or unexpected safety signals through Week 16.¹⁷

In MAXIMISE, COSENTYX did not show any new or unexpected safety signals through 1 year.¹⁸

1.6% ISR low rate of injection site reactions at Week 16 (n=703)^{19§}

A well-studied safety profile overall across ALL COSENTYX indications⁶

*AEs listed are those occurring in at least 2% of patients in pooled COSENTYX dose group up to Week 16.⁷

[†]Pivotal PsA program was FUTURE 1 and FUTURE 2.¹⁶

[‡]Some patients were IV loaded (10 mg/kg at Weeks 0, 2, and 4).¹⁶

[§]Rate of injection site reactions means the percentage of patients affected by 1 or more injection site reaction(s) during the first 16 weeks of the pooled FUTURE 1 and 2 trials.¹⁹

AE, adverse event; ISR, injection site reaction.

Please see FUTURE 1, FUTURE 2, FUTURE 3, and MAXIMISE study design details on [page 7](#).

Please see Important Safety Information throughout.

Please see full [Prescribing Information](#), including [Medication Guide](#).



Cosentyx[®]
(secukinumab)

...that is tried through 5 years

PsA safety profile through Year 5

• Pooled analysis of long-term safety profile demonstrated in 1380 patients across 3 phase 3 trials (FUTURE 1-3)^{20,21}

◦ Based on a total of 3800+ PY of exposure²⁰

AEs of special interest (COSENTYX® any dose, EAIR per 100 PY) ²⁰⁻²²	Year 1 N=1380	Year 2 N=1183	Year 3 N=948	Year 4 N=587	Year 5 N=290
Serious infections [*]	2.3	2.4	1.4	2.5	1.7
Malignancy	1.2	1.2	1.1	2.0	0.8
Herpes viral infections	4.0	2.6	1.0	1.5	0.0
<i>Candida</i> infections [†]	2.3	2.1	1.1	0.7	0.0
Major adverse cardiac events [‡]	0.4	0.6	0.7	0.7	0.0
Crohn's disease [§]	0.08	0.00	0.3	0.0	0.0
Ulcerative colitis [§]	0.08	0.09	0.1	0.0	0.0
IBD unclassified [§]	0.08	0.00	0.1	0.0	0.0

Background rate: According to a pooled estimate from a meta-analysis across 8 studies and ~31,000 patients with PsA, 3.3% had IBD (95% CI: 1.5%, 7.1%; I²=97%). These studies did not specifically assess COSENTYX.²³

NO Boxed WARNING ⁶	NO trend toward increased AE incidence rates of MACE, malignancy, IBD, <i>Candida</i> infection, or herpes infection through 5 years ^{20-22¶}	NO warning for suicidal ideation and behavior ⁶ COSENTYX PsA trials did not screen out patients with depression or suicidal ideation ^{7,8,24,25¶}	NO required routine lab monitoring, including liver enzymes, during treatment ⁶ Evaluate patients for TB infection prior to initiating treatment ⁶	NO required premedication with IV formulation ⁶
How do these considerations change counseling conversations with your patients?				

~99.4% had NO immunogenicity over 5 years²⁶

• Neutralizing antibodies developed in approximately 0.6% of patients with PsO and were not associated with loss of efficacy^{26#}

^{*}Rates are for the system organ class "infections and infestations," which includes multiple associated PTs.²⁰

[†]Rates are for *Candida* infections high-level term, which includes multiple associated PTs.²⁰

[‡]Rates are for the Novartis MedDRA Query term, which comprises (1) any MI, any CV accident, and (2) all other CV events that are fatal, out of a listing of 2200+ terms.²⁰

[§]Data are displayed to 2 decimals where N>1000 and to 1 decimal if N<1000.

[¶]All trials used SC administration.

[#]Protocol permitted investigator discretion to exclude any individuals with any medical or psychiatric condition that, in the investigator's opinion, would preclude the patient from adhering to the protocol or completing the study.^{7,8,24,25}

[¶]The detection of antibody formation is highly dependent on the sensitivity and specificity of the assay. Additionally, the observed incidence of antibody (including neutralizing antibody) positivity in an assay may be influenced by several factors, including assay methodology, sample handling, timing of sample collection, concomitant medications, and underlying disease.

CV, cardiovascular; EAIR, exposure-adjusted incidence rate; IBD, inflammatory bowel disease; MACE, major adverse cardiovascular event; MedDRA, Medical Dictionary for Regulatory Activities; MI, myocardial infarction; PTs, preferred terms; PY, patient-years; TB, tuberculosis.

Please see FUTURE 1, FUTURE 2 and FUTURE 3 study design details on [page 7](#).

Please see Important Safety Information throughout.

Please see full [Prescribing Information](#), including [Medication Guide](#).

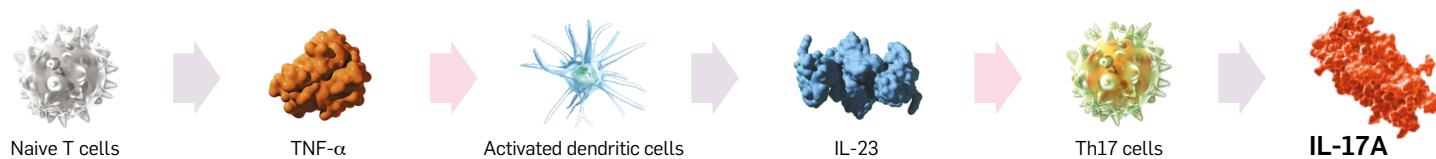


Cosentyx[®]
(secukinumab)

COSENTYX® blocks IL-17A from both adaptive and innate immune sources

Adaptive immune source^{27,28}

Although Th17 cells produce IL-17A, they are **not the only cellular source of IL-17A** in PsO, PsA, AS, and nr-axSpA.²⁹⁻³¹



These signaling molecules initiate the release of several cytokines, including IL-17A.³²

Produces = Interacts with =

Innate immune sources (including IL-23-independent sources)^{29,30,33,34}

In addition to the adaptive immune system, **innate immune cells are sources of IL-17A**, which may contribute to pathogenesis.²⁹



The immune pathophysiology of PsA, AS, nr-axSpA, and PsO involves complex molecular mechanisms not shown in the MOA graphic.

COSENTYX selectively **binds to IL-17A**, and **inhibits its interaction** with the IL-17 receptor⁶

Trust the original IL-17 inhibitor with the most in-market experience^{6*}

Clinical significance of the COSENTYX mechanism of action is unknown.

Images shown are not drawn to scale.

*First IL-17A antagonist approved by the FDA in 2015.⁶

FDA, US Food and Drug Administration; IL, interleukin; MOA, mechanism of action; Th17, T helper 17.

IMPORTANT SAFETY INFORMATION (cont)

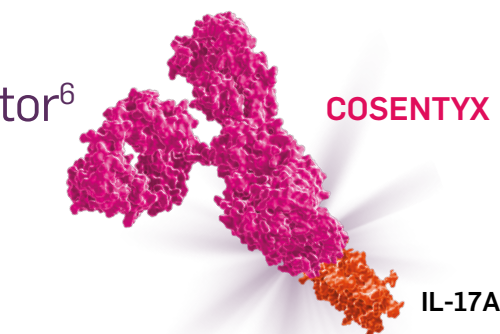
WARNINGS AND PRECAUTIONS (cont)

Inflammatory Bowel Disease

Inflammatory Bowel Disease (IBD) exacerbations, in some cases serious and/or leading to discontinuation of COSENTYX, occurred in COSENTYX treated subjects during clinical trials in PsO, PsA, AS, nr-axSpA, and HS. In adult subjects with HS, the incidence of IBD was higher in subjects who received COSENTYX 300 mg every 2 weeks (Ulcerative Colitis [UC] 1 case, EAIR 0.2/100 subject-years; Crohn's Disease [CD] 1 case, EAIR 0.2/100 subject-years) compared to subjects who received COSENTYX 300 mg every 4 weeks (IBD 1 case, EAIR 0.2/100 subject-years). In addition, new onset IBD cases occurred in subjects treated with COSENTYX in clinical trials. In an exploratory trial in 59 subjects with active Crohn's disease [COSENTYX is not approved for the treatment of Crohn's disease], there were trends toward greater disease activity and increased adverse reactions in subjects treated with COSENTYX as compared to placebo-treated subjects.

Exercise caution when prescribing COSENTYX to patients with IBD. Patients treated with COSENTYX should be monitored for signs and symptoms of IBD.

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 **Cosentyx**®
(secukinumab)

Study designs

FUTURE 1

FUTURE 1 was a multicenter, randomized, double-blind, placebo-controlled study that evaluated 606 patients with active PsA. Patients were treated with secukinumab 10 mg/kg IV treatment (or placebo) at Weeks 0, 2, and 4, followed by 75 mg or 150 mg subcutaneous COSENTYX® treatment (or placebo) every 4 weeks. Patients receiving placebo were rerandomized to receive COSENTYX 75 mg or 150 mg every 4 weeks based on responder status at Week 16 or Week 24. Primary end point was the percentage of patients with ACR20 response at Week 24.^{6,35}

FUTURE 2

FUTURE 2 was a multicenter, randomized, double-blind, placebo-controlled trial that evaluated 397 adult patients with active PsA (≥ 3 swollen and ≥ 3 tender joints) despite use of NSAIDs, corticosteroids, or DMARDs. Patients had a diagnosis for ≥ 5 years and received subcutaneous COSENTYX 75 mg (n=99), 150 mg (n=100), 300 mg (n=100), or placebo (n=98) at Weeks 0, 1, 2, 3, and 4, followed by the same dose every 4 weeks thereafter. Patients who received placebo were rerandomized to COSENTYX 150 mg or 300 mg every 4 weeks at Week 16 or Week 24 based on responder status. Primary end point was the percentage of patients with ACR20 response at Week 24. Study population was mixed: two-thirds of patients were biologic-naïve and one-third were anti-TNF- α inadequate responders.^{6,7,36}

FUTURE 3

FUTURE 3 was a multicenter, randomized, double-blind, double-dummy, placebo-controlled, parallel-group, 3-year study that evaluated 414 adult patients with active PsA. Patients received subcutaneous COSENTYX 150 mg (n=138), 300 mg (n=139), or placebo (n=137) at Weeks 0, 1, 2, 3, and 4, followed by the same dose every 4 weeks thereafter. At Week 16, patients who received placebo were rerandomized to COSENTYX 150 mg or 300 mg every 4 weeks based on responder status at Week 16 (nonresponders) or Week 24 (responders). Primary end point was the percentage of patients with ACR20 response at Week 24. Autoinjector usability was also examined. Safety assessments included evaluation of AEs, SAEs, and immunogenicity.¹⁷

FUTURE 5

FUTURE 5 was a phase 3, multicenter, randomized, double-blind, placebo-controlled trial that evaluated 996 adult patients with active PsA. Patients were randomized to receive subcutaneous COSENTYX 150 mg without load (n=222), 150 mg with load (n=220), 300 mg with load (n=222), or placebo (n=332). Patients who received placebo were rerandomized to receive COSENTYX 150 mg or 300 mg every 4 weeks, based on responder status at Week 16 (nonresponders) or Week 24 (responders). Primary end point was the percentage of patients with ACR20 response at Week 16. Secondary end points included change in mTSS at Week 24 from baseline. Study population was mixed: more than two-thirds of patients were biologic-naïve and less than one-third were anti-TNF- α inadequate responders (individual patients could have been exposed to up to 3 TNF- α inhibitors).^{8,14}

MAXIMISE

MAXIMISE was a randomized, double-blind, placebo-controlled, multicenter, 52-week study that evaluated 498 patients with active PsA and axial skeleton involvement (defined by BASDAI score ≥ 4 , spinal pain VAS ≥ 40 [0 to 100-mm scale]) who had inadequate response to at least 2 NSAIDs for at least 4 weeks. Patients were randomized to receive subcutaneous COSENTYX 150 mg (n=165), COSENTYX 300 mg (n=167), or placebo (n=166) at Weeks 0, 1, 2, 3, 4, and 8. Primary end point was the proportion of patients with ASAS20 response at Week 12. After Week 12, patients who were placed in the placebo group at baseline were rerandomized to active treatment with COSENTYX 150 mg or 300 mg, administered every 4 weeks from Week 12 to Week 52 (last dose on Week 48) but remained blinded to dose.³⁷

TRANSFIGURE

TRANSFIGURE was a double-blind, randomized, placebo-controlled study examining the safety and efficacy of COSENTYX in patients with moderate to severe nail PsO. Patients were randomized to COSENTYX 300 mg (n=66), COSENTYX 150 mg (n=67), or placebo (n=65). All patients were adults with moderate to severe PsO (PASI score ≥ 12 and BSA $\geq 10\%$) and significant nail involvement (fingernail NAPS1 score of ≥ 16 and ≥ 4 fingernails involved) who were candidates for systemic therapy. Primary end point: NAPS1 assessment at Week 16. Secondary end points included NAPS1 response over time up to Week 132.³⁸

BASDAI, Bath Ankylosing Spondylitis Disease Activity Index; BSA, body surface area; DMARDs, disease-modifying antirheumatic drugs; mTSS, modified Total Sharp Score; NSAIDs, nonsteroidal anti-inflammatory drugs; SAE, serious adverse event.

IMPORTANT SAFETY INFORMATION (cont)

WARNINGS AND PRECAUTIONS (cont)

Eczematous Eruptions

In postmarketing reports, cases of severe eczematous eruptions, including atopic dermatitis-like eruptions, dyshidrotic eczema, and erythroderma, were reported in patients receiving COSENTYX; some cases resulted in hospitalization. The onset of eczematous eruptions was variable, ranging from days to months after the first dose of COSENTYX.

Treatment may need to be discontinued to resolve the eczematous eruption. Some patients were successfully treated for eczematous eruptions while continuing COSENTYX.

Hypersensitivity Reactions

Serious hypersensitivity reactions including anaphylaxis, angioedema, and urticaria have been reported in COSENTYX treated subjects in clinical trials and in the post-marketing setting. If an anaphylactic or other serious allergic reaction occurs, immediately discontinue administration of COSENTYX and initiate appropriate therapy.

The removable caps of the COSENTYX Sensoready® pen and the COSENTYX 1 mL and 0.5 mL prefilled syringes contain natural rubber latex, which may cause an allergic reaction in latex-sensitive individuals. The safe use of the COSENTYX Sensoready pen or prefilled syringe in latex-sensitive individuals has not been studied.



Please see additional Important Safety Information throughout.
Please see full [Prescribing Information](#), including [Medication Guide](#).

Write **COSENTYX®** Get **COSENTYX***

- ☒ Covered **first line for ~2 of 3** patients with commercial insurance or Medicare^{39†}
- ☒ No biosimilar substitutes⁴⁰



Explore the latest coverage updates for COSENTYX

*For SC privately insured patients and IV Medicare Part B FFS patients.

†COSENTYX for SC use is present on formularies as either a first-, second-, third-, fourth-, or fifth-line biologic. Novartis does not guarantee payment or coverage for any product or service. Actual coverage and reimbursement decisions are made by individual payers following the receipt of claims. Coverage information is subject to change by the relevant payer.

FFS, fee-for-service.

IMPORTANT SAFETY INFORMATION (cont)

WARNINGS AND PRECAUTIONS (cont)

Immunizations

Prior to initiating therapy with COSENTYX, consider completion of all age-appropriate immunizations according to current immunization guidelines. COSENTYX may alter a patient's immune response to live vaccines. Avoid use of live vaccines in patients treated with COSENTYX.

MOST COMMON ADVERSE REACTIONS

Most common adverse reactions (>1%) are nasopharyngitis, diarrhea, and upper respiratory tract infection.

INDICATIONS

COSENTYX® (secukinumab) is indicated for the treatment of moderate to severe plaque psoriasis (PsO) in patients 6 years and older who are candidates for systemic therapy or phototherapy.

COSENTYX is indicated for the treatment of active psoriatic arthritis (PsA) in patients 2 years of age and older.

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

COSENTYX is indicated for the treatment of adult patients with active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation.

COSENTYX is indicated for the treatment of active enthesitis-related arthritis (ERA) in patients 4 years of age and older.

COSENTYX is indicated for the treatment of adult patients with moderate to severe hidradenitis suppurativa (HS).

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

COSENTYX is contraindicated in patients with a previous serious hypersensitivity reaction to secukinumab or to any of the excipients in COSENTYX. Cases of anaphylaxis and angioedema have been reported during treatment with COSENTYX.

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Cosentyx®
(secukinumab)



Darren, an actual patient with PsA taking COSENTYX®, was compensated for his time. Individual results may vary. Child is not a patient and is not Darren's actual child.

References: 1. National Institute of Arthritis and Musculoskeletal and Skin Diseases. Psoriatic arthritis. Accessed September 22, 2025. <https://www.niams.nih.gov/health-topics/psoriatic-arthritis> 2. Baraliakos X, Gosssec L, Pournara E, et al. Secukinumab in patients with psoriatic arthritis and axial manifestations: results from the double-blind, randomised, phase 3 MAXIMISE trial. *Ann Rheum Dis*. 2021;80(5):582-590. 3. Data on file. CAIN457F2342 (FUTURE 5): 2-Year Interim Report. Novartis Pharmaceuticals Corp; May 2019. 4. Data on file. CAIN457F2342 (FUTURE 5): 2-Year Interim Report. PASI 90 and ACR Components data. Novartis Pharmaceuticals Corp; January 2020. 5. Data on file. CAIN457F2342 (FUTURE 5): 2-Year Interim Report. mNAPSI and PASI 100 data. Novartis Pharmaceuticals Corp; October 2019. 6. Cosentyx. Prescribing information. Novartis Pharmaceuticals Corp. 7. Data on file. CAIN457F2312 (FUTURE 2): Clinical Study Report. Novartis Pharmaceuticals Corp; October 2014. 8. Data on file. CAIN457F2342 (FUTURE 5): Clinical Study Report. Interim Analysis-Week 24. Novartis Pharmaceuticals Corp; November 2017. 9. Data on file. CAIN457A2313 (TRANSFIGURE): Clinical Study Report. Novartis Pharmaceuticals Corp; November 2015. 10. Coates LC, Soriano ER, Corp N, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA): updated treatment recommendations for psoriatic arthritis 2021. *Nat Rev Rheumatol*. 2022;18(8):465-479. 11. Gosssec L, Kerschbaumer A, Ferreira RJO, et al. EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2023 update. *Ann Rheum Dis*. 2024;83(6):706-719. 12. Lubrano E, Perrotta FM. Defining low disease activity states in psoriatic arthritis using novel composite disease instruments. *J Rheumatol*. 2016;43(9):1765-1766. 13. Data on file. CAIN457F2342 (FUTURE 5): 2-Year Interim Report. PASI 100 Tender/Swollen Joints Pain Biologic-Naive. Novartis Pharmaceuticals Corp; April 2020. 14. Mease P, van der Heijde D, Landewé R, et al. Secukinumab improves active psoriatic arthritis symptoms and inhibits radiographic progression: primary results from the randomised, double-blind, phase III FUTURE 5 study. *Ann Rheum Dis*. 2018;77(6):890-897. 15. Wells G, Becker J-C, Teng J, et al. Validation of the 28-joint Disease Activity Score (DAS28) and European League Against Rheumatism response criteria based on C-reactive protein against disease progression in patients with rheumatoid arthritis, and comparison with the DAS28 based on erythrocyte sedimentation rate. *Ann Rheum Dis*. 2009;68(6):954-960. 16. Data on file. AIN457F Summary of Clinical Efficacy in Psoriatic Arthritis. Novartis Pharmaceuticals Corp; February 2015. 17. Nash P, Mease PJ, McInnes IB, et al; on behalf of the FUTURE 3 study group. Efficacy and safety of secukinumab administration by autoinjector in patients with psoriatic arthritis: results from a randomized, placebo-controlled trial (FUTURE 3). *Arthritis Res Ther*. 2018;20(1):47. 18. Data on file. CAIN457F3302 (MAXIMISE): 1-Year Clinical Study Report. Novartis Pharmaceuticals Corp; August 2020. 19. Data on file. AIN457F Summary of Clinical Safety Appendix 1. Novartis Pharmaceuticals Corp; February 2015. 20. Deodhar A, Mease PJ, McInnes IB, et al. Long-term safety of secukinumab in patients with moderate-to-severe plaque psoriasis, psoriatic arthritis, and ankylosing spondylitis: integrated pooled clinical trial and post-marketing surveillance data. *Arthritis Res Ther*. 2019;21(1):111. 21. Schreiber S, Colombel J-F, Feagan BJ, et al. Incidence rates of inflammatory bowel disease in patients with psoriasis, psoriatic arthritis and ankylosing spondylitis treated with secukinumab: a retrospective analysis of pooled data from 21 clinical trials. *Ann Rheum Dis*. 2019;78(4):473-479. 22. Data on file. AIN457 Pooled Long-term Safety. Novartis Pharmaceuticals Corp; May 2018. 23. Pittam B, Gupta S, Harrison NL, Robertson S, Hughes DM, Zhao SS. Prevalence of extra-articular manifestations in psoriatic arthritis: a systematic review and meta-analysis. *Rheumatology (Oxford)*. 2020;59(9):2199-2206. 24. Data on file. CAIN457F2306 (FUTURE 1): Clinical Trial Protocol. Novartis Pharmaceuticals Corp; December 2013. 25. Data on file. CAIN457F2318 (FUTURE 3): Clinical Trial Protocol. Novartis Pharmaceuticals Corp; December 2014. 26. Reich K, Blauvelt A, Armstrong A, et al. Secukinumab, a fully human anti-interleukin-17A monoclonal antibody, exhibits low immunogenicity in psoriasis patients treated up to 5 years. *J Eur Acad Dermatol Venerol*. 2019;33(9):1733-1741. 27. Smith JA, Colbert RA. Review: the interleukin-23/interleukin-17 axis in spondyloarthritis pathogenesis: Th17 and beyond. *Arthritis Rheumatol*. 2014;66(2):231-241. 28. Lynde CW, Poulin Y, Vender R, Bourcier M, Khalil S. Interleukin 17A: toward a new understanding of psoriasis pathogenesis. *J Am Acad Dermatol*. 2014;71(1):141-150. 29. Ruiz de Morales JMG, Puig L, Daudén E, et al. Critical role of interleukin (IL)-17 in inflammatory and immune disorders: an updated review of the evidence focusing in controversies. *Autoimmun Rev*. 2020;19(1):102429. doi:10.1016/j.autrev.2019.102429 30. Kehl AS, Corr M, Weisman MH. Enthesitis: new insights into pathogenesis, diagnostic modalities, and treatment. *Arthritis Rheumatol*. 2016;68(2):312-322. 31. Rosine N, Miceli-Richard C. Innate cells: the alternative source of IL-17 in axial and peripheral spondyloarthritis? *Front Immunol*. 2021;11:553742. doi:10.3389/fimmu.2020.553742 32. Miossec P, Korn T, Kuchroo VK. Interleukin-17 and type 17 helper T cells. *N Engl J Med*. 2009;361(9):888-898. 33. Girolomoni G, Mrowietz U, Paul C. Psoriasis: rationale for targeting interleukin-17. *Br J Dermatol*. 2012;167(4):717-724. 34. Cua DJ, Tato CM. Innate IL-17-producing cells: the sentinels of the immune system. *Nat Rev Immunol*. 2010;10(7):479-489. 35. Mease PJ, McInnes IB, Kirkham B, et al. Secukinumab inhibition of interleukin-17A in patients with psoriatic arthritis. *N Engl J Med*. 2015;373(14):1329-1339. 36. Data on file. CAIN457F2312 (FUTURE 2): Interim Study Report. Novartis Pharmaceuticals Corp; November 2015. 37. Data on file. CAIN457F3302 (MAXIMISE): Data Analysis Report. Novartis Pharmaceuticals Corp; June 2016. 38. Data on file. CAIN457A2313 (TRANSFIGURE): Clinical Study Report. Novartis Pharmaceuticals Corp; October 2017. 39. Data on file. IL-17 PsA Pharmacy Payer Coverage Data. Novartis Pharmaceuticals Corp; March 2025. 40. US Food and Drug Administration. Biosimilar product information. FDA-approved biosimilar products. Accessed August 6, 2025. <https://www.fda.gov/drugs/biosimilars/biosimilar-product-information>

IMPORTANT SAFETY INFORMATION (cont)

WARNINGS AND PRECAUTIONS

Infections

COSENTYX may increase the risk of infections. In clinical trials, a higher rate of infections was observed in COSENTYX treated subjects compared to placebo-treated subjects. In placebo-controlled clinical trials in subjects with moderate to severe PsO, higher rates of common infections, such as nasopharyngitis (11.4% versus 8.6%), upper respiratory tract infection (2.5% versus 0.7%) and mucocutaneous infections with candida (1.2% versus 0.3%) were observed in subjects treated with COSENTYX compared to placebo-treated subjects. A similar increase in risk of infection in subjects treated with COSENTYX was seen in placebo-controlled trials in subjects with PsA, AS and nr-axSpA. The incidence of some types of infections, including fungal infections, appeared to be dose-dependent in clinical trials.

In the postmarketing setting, serious bacterial, viral, and fungal opportunistic infections, and some fatal infections have been reported in patients receiving IL-17 inhibitors including COSENTYX. Cases of Hepatitis B virus reactivation have been reported.

Please see additional Important Safety Information throughout.
Please see full [Prescribing Information](#), including [Medication Guide](#).



Cosentyx[®]
(secukinumab)

START with COSENTYX®



Cosentyx®
(secukinumab)



Achieve BOTH skin clearance and joint relief^{f3,4*†}

- 71% of patients achieved PASI 90 (n=68) and 54% of patients achieved ACR50 (n=137) at 2 years with 300 mg^{3,4*†}
- Effective with or without MTX⁶



GRAPPA recommends IL-17i as a first-line PsA biologic, and EULAR recommends IL-17Ai over TNFi for skin and axial involvement^{10,11§||}



NO Boxed WARNING or trend toward increased rates of MACE or malignancy through 5 years^{6,20,22*¶||#}

SC or IV: 2 forms that give patients options to start and stay on COSENTYX^{6**}

[†]Please see pages 2 and 3 for FUTURE 2 and FUTURE 5 primary and key end point results.

[¶]Please see pages 4 and 5 for PsA safety profile and Important Safety Information throughout.

*All trials used SC administration.

[‡]In FUTURE 5, PASI 90 and ACR50 were exploratory end points at 2 years in biologic-naïve patients. No clinical or statistical conclusions can be drawn.^{3,4,8}

[§]The updated GRAPPA 2021 Guidelines expand on the overarching principles put forth in its 2015 recommendations and are based on systematic literature reviews of data published from 2013 to 2020 taken from Medline, Embase, and the Cochrane Library, including conference presentations from 2017 to 2020. The recommendations used a GRADE-informed methodology (Grading of Recommendations Assessment, Development and Evaluation) to analyze data, and resulted in strong or conditional recommendations, or a decision that no recommendation could be made. Novartis is one of the many corporate supporters of the GRAPPA network.¹⁰

^{||}The updated 2023 EULAR Guidelines expand on the previous 2019 recommendations for the pharmacological management of PsA. Updated recommendations were developed by a steering committee and task force of members from 19 different countries and are based on a systematic literature review from the end of 2018 through April 2023; experience- and consensus-based considerations were also examined. The levels of evidence and grades of recommendation were determined based on the levels of evidence established by the Oxford Centre for Evidence-Based Medicine. Novartis is one of the many corporate supporters of the EULAR network.¹¹

[#]Based on an analysis of long-term safety in 1380 patients across 3 phase 3 trials through 5 years.^{20,22}

^{¶¶}For adult patients with active PsA, AS, or nr-axSpA.⁶

GRAPPA, Group for Research and Assessment of Psoriasis and Psoriatic Arthritis; IL-17Ai, interleukin-17A inhibitor; TNFi, tumor necrosis factor inhibitor.

IMPORTANT SAFETY INFORMATION (cont)

WARNINGS AND PRECAUTIONS (cont)

Infections (cont)

Exercise caution when considering the use of COSENTYX in patients with a chronic infection or a history of recurrent infection. Instruct patients to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, monitor the patient closely and discontinue COSENTYX until the infection resolves.

If signs of Hepatitis B virus reactivation occur, consult a hepatitis specialist. COSENTYX is not recommended for use in patients with active viral hepatitis.

Please see additional Important Safety Information throughout.

Please see full Prescribing Information, including Medication Guide.

