NOVARTIS

Cosentyx Rheum - MDA in PsA- HCP

Prescribing information

Image

Image

Minimal disease activity (MDA) in psoriatic arthritis (PsA)

Cosentyx® (secukinumab) is indicated for the treatment of: moderate to severe plaque psoriasis (PsO) in adults, children and adolescents from the age of 6 years who are candidates for systemic therapy; active psoriatic arthritis (PsA) in adults (alone or in combination with methotrexate [MTX]) who have responded inadequately to disease-modifying anti-rheumatic drug therapy.[1]

Full indication for Cosentyx can be found here.

Cosentyx Summary of Product Characteristics (SmPC) can be found here.

Remission is a poorly defined and variable outcome measure in PsA[2,3]

PsA is a complex disease comprising six key manifestations: joints, axial, skin, enthesitis, dactylitis and nails.[4,5] These are known to cause fatigue, pain and impairment of daily functions, resulting in compromised quality of life.[6]
Due to its multifaceted clinical presentation, assessment of disease activity can be challenging.[5]

There is a need for a measure to accurately monitor disease activity across multiple PsA domains to assess holistic disease burden[7,8]

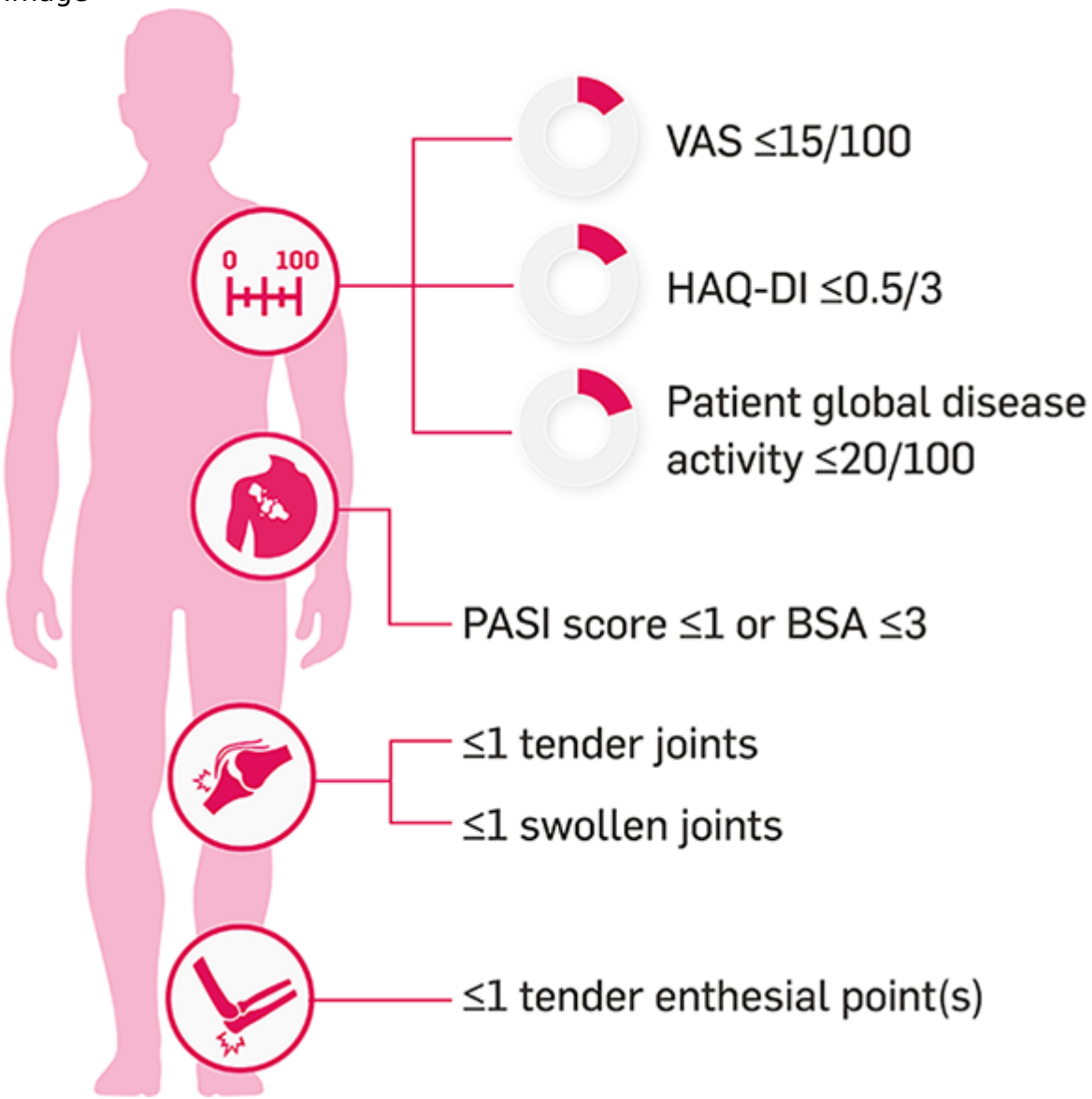
- MDA
- Achieving MDA early
- MDA with Cosentyx

EULAR and BSR guidelines recommend targeting remission or low disease activity in PsA[9,10]

The MDA score is a validated, composite measure that allows the assessment of low disease activity[5,9,11]

The MDA score is made up of multiple criteria that encompass important aspects of PsA, including joint and skin activity, physical function and pain.[8] Patients achieve MDA by meeting **5 of 7** of the following criteria:[2,8]

Image



What could MDA mean to your eligible patients?

Achieving MDA early is important for long-term outcomes[12]

Patients who achieved MDA in the first year after their diagnosis demonstrated improved long-term outcomes, including pain, fatigue and emotional wellbeing[12]

Potential barriers to achieving MDA in patients with PsA

Image

Skin involvement[2]

Image

High enthesitis count/dactylitis at baseline[2]

Image

Long-term disease resulting in irreversible damage[13]

Image

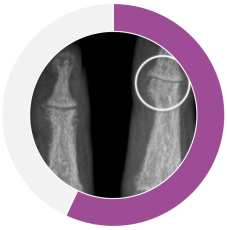
Functional impairment[2]

Image

Comorbidities such as metabolic syndrome, hepatic steatosis and fibromyalgia[2]

At 2 years, MDA is more likely to be achieved by those who do not have radiographic progression[14]

Image



57.4% of patients who were **non-progressors** were observed to achieve MDA at 2 years with Cosentyx 300 mg SC (n=169)[14]

31.6% of patients who were **progressors** were observed to achieve MDA at 2 years with Cosentyx 300 mg SC (n=19)[14]

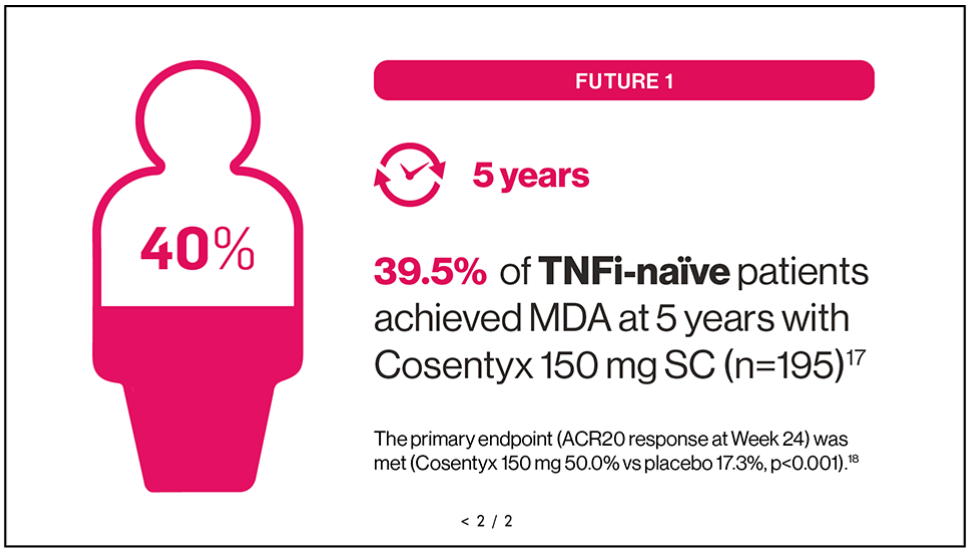
FUTURE 5 trial: The primary endpoint (ACR20 response at Week 16) was met (Cosentyx 300 mg with loading dose 62.6% vs placebo 27.4%, p<0.0001).[15]

Are you choosing a treatment with MDA in mind?

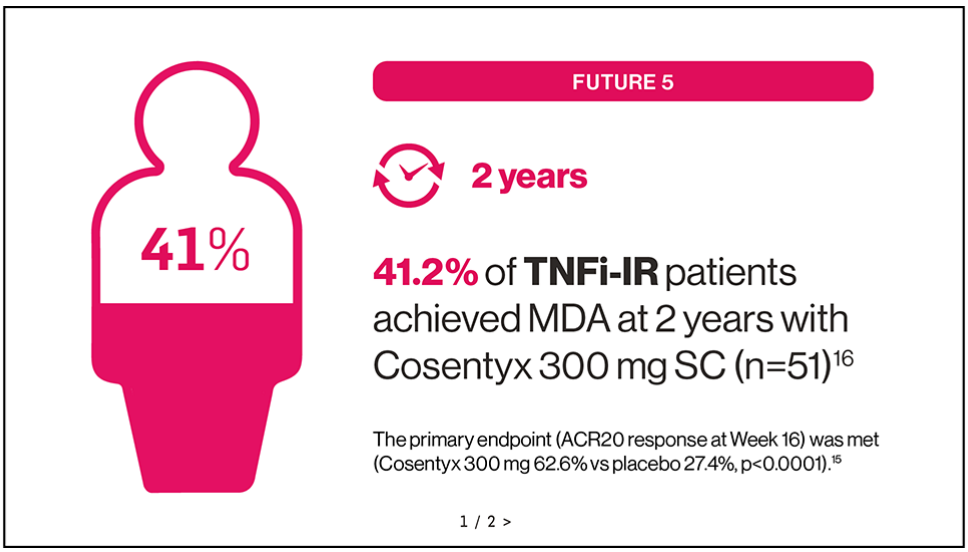
Sustained MDA could be achievable for your eligible adult patients with PsA[16,17]

SUSTAINED: results up to Year 5.[17]

Image

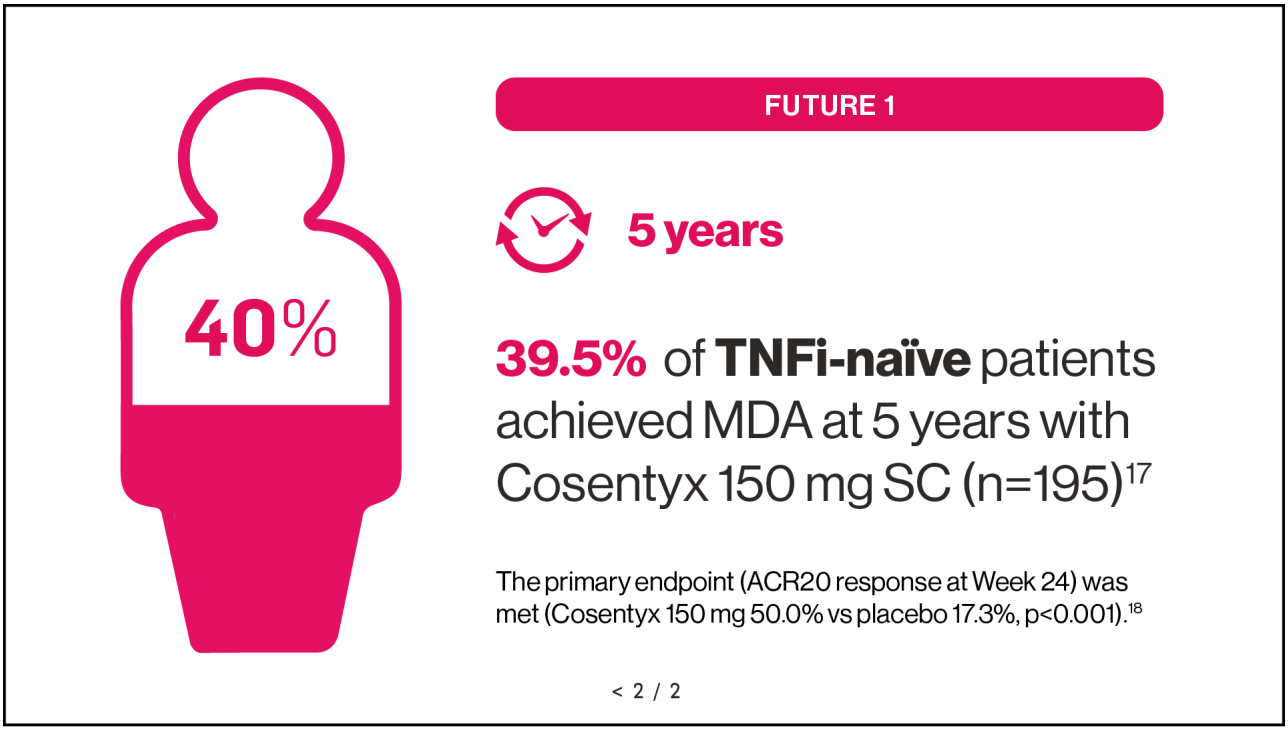


Image



Previous Next

41%
FUTURE 5
2 years
41.2% of TNFi-IR patients achieved MDA at 2 years with Cosentyx 300 mg SC (n=51)16
The primary endpoint (ACR20 response at Week 16) was met (Cosentyx 300 mg 62.6% vs placebo 27.4%, p<0.0001).15
1 / 2 >



Image

Efficacy in PsA

Image

Efficacy in axSpA

Image

Efficacy in JIA

Image

Safety profile

Image

Dosing

Image

Mechanism of action

Image

Contact us

Image

HCP resources

Therapeutic Indications[1]

Cosentyx is indicated for the treatment of moderate to severe plaque psoriasis (PsO) in adults, children and adolescents from the age of 6 years who are candidates for systemic therapy; active psoriatic arthritis (PsA) in adult patients (alone or in combination with methotrexate [MTX]) when the response to previous disease-modifying anti-rheumatic drug therapy has been inadequate; active ankylosing spondylitis (AS) in adults who have responded inadequately to conventional therapy; active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation as indicated by elevated C-reactive protein and/or magnetic resonance imaging evidence in adults who have responded inadequately to non-steroidal anti-inflammatory drugs; active moderate to severe hidradenitis suppurativa (HS; acne inversa) in adults with an inadequate response to conventional systemic HS therapy; active enthesitis-related arthritis (ERA) in patients 6 years and older (alone or in combination with MTX) whose disease has responded inadequately to, or who cannot tolerate, conventional therapy; active juvenile psoriatic

arthritis (JPsA) in patients 6 years and older (alone or in combination with MTX) whose disease has responded inadequately to, or who cannot tolerate, conventional therapy.[1]

Study designs

FUTURE 5: A randomised, double-blind, Phase III study in patients with active moderate to severe PsA (N=996) randomised to receive Cosentyx 150 mg without loading dose (n=222), Cosentyx 150 mg with loading dose (n=220), Cosentyx 300 mg with loading dose (n=222) or placebo (n=332). The primary endpoint was the percentage of patients with ACR20 response at Week 16.[15]

FUTURE 1: A multicentre, randomised, double-blind, placebo-controlled, Phase III study in patients with active PsA (N=606) randomised to receive Cosentyx or placebo. Patients in the Cosentyx group received an IV dose of 10 mg/kg of body weight at baseline, Week 2 and Week 4, followed by SC Cosentyx 150 mg or 75 mg every 4 weeks thereafter. The primary endpoint was the percentage of patients with ACR20 response at Week 24.[18]

Cosentyx is not currently available as an IV treatment.

Please note, Cosentyx should not be used without a loading dose, and the Cosentyx 75 mg dose is not licensed for PsA. The recommended dose for TNFi-IR is 300 mg by SC injection with initial dosing at Weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. For other patients, the recommended dose is 150 mg by SC injection with initial dosing at Weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Based on clinical response, this can be increased to 300 mg.[1]

Cosentyx has not been studied in renal/hepatically impaired patient populations. No dose recommendations can be made.[1]

For patients with concomitant moderate to severe PsO, please refer to adult PsO recommendations in the Cosentyx SmPC.[1]

ACR, American College of Rheumatology; AS, ankylosing spondylitis; BSA, body surface area; BSR, British Society for Rheumatology; ERA, enthesitis-related arthritis; EULAR, European Alliance of Associations for Rheumatology; HAQ-DI, health assessment questionnaire-disability index; HS, hidradenitis suppurativa; IR, inadequate responder; IV, intravenous; JPsA, juvenile psoriatic arthritis; MDA, minimal disease activity; MTX, methotrexate; nr-axSpA, non-radiographic axial spondyloarthritis; PASI, psoriasis area and severity index; PsA, psoriatic arthritis; PsO, plaque psoriasis; SC, subcutaneous; SmPC, summary of product characteristics; TNFi, tumour necrosis factor inhibitor; VAS, visual analogue scale.

References

1. Cosentyx® (secukinumab) Summary of Product Characteristics.

2. Gossec L et al. *J Rheumatol* 2018;45(1):6–13.

3. Lubrano E, et al. *Clin Exp Rheumatol* 2018;36(5):900–910.

4. Baraliakos X, et al. *Ann Rheum Dis* 2021;80(5):582–590.

5. McGagh D & Coates LC. *Rheumatology* 2020;59(Suppl 1):i29–i36.

6. Skougaard M, et al. *Rheum Adv Pract* 2021;5(3):rkab076.

7. Hackett S & Coates LC. *Musculoskeletal Care* 2022;20(Suppl 1):S22–S31.

8. Coates LC, et al. *Ann Rheum Dis* 2010;69(1):48–53.

9. Gossec L, et al. *Ann Rheum Dis* 2020;79(6):700–712.

10. Tucker L, et al. *Rheumatology* 2022;61(9):e255–e266.

11. Scriffignano S, et al. Abstract AB1135. Ann Rheum Dis 2023;82(Suppl 1):1798.

12. Henkemans SVJS, et al. *RMD Open* 2022;8(2):e002706.

13. Mease PJ, et al. *RMD Open* 2017;3(1):e000415.

14. Mease PJ, et al. Abstract POS0972. Ann Rheum Dis 2024;83(Suppl1):682–683.

15. Mease PJ, et al. *Ann Rheum Dis* 2018;77(6):890–897.

16. Novartis Data on File. CAIN457F2342 (FUTURE 5): Week 104 Interim Report. May 2019.

17. Mease PJ, et al. *ACR Open Rheumatol* 2020;2(1):18–25.

18. Mease PJ, et al. *N Engl J Med* 2015;373(14):1329–1339.

UK | July 2025 | FA-11426990