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# Transforming Psoriasis Care: Oral IL-23 Therapy and the Next Frontier in Patient-Centered Treatment

**Andrew Blauvelt, MD, MBA**

*Owner, Blauvelt Consulting, LLC*
*Annapolis, MD*

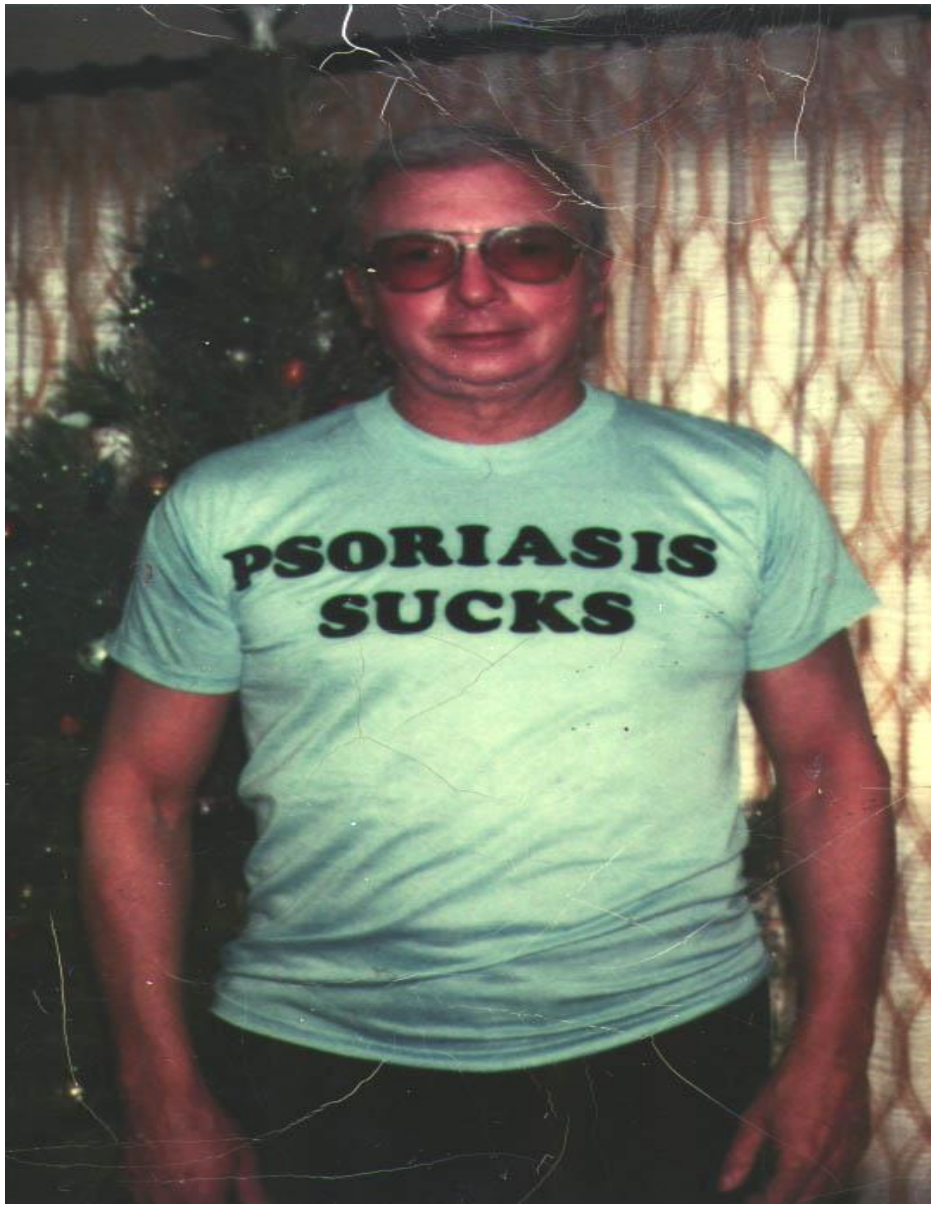
# Disclosures

- **Andrew Blauvelt, MD, MBA:** Speaker's bureau – Almirall, Eli Lilly, Leo, Sanofi, UCB; scientific advisory board – AbbVie, Almirall, Alumis, Amgen, Anaptysbio, Apogee, Arcutis, Eli Lilly, Incyte, Janssen, Leo, Novartis, Oruka, Paragon, Pfizer, Regeneron, Sanofi, Sun Pharma, Takeda, and UCB; stockholder – Lipidio, Oruka

# Learning Objectives

- Describe current challenges in PsO care, including undertreatment, treatment nonadherence, and patient dissatisfaction with available options
- Evaluate the mechanisms of action, efficacy, and safety data of oral IL-23 therapies and other targeted oral agents in PsO
- Compare oral IL-23 therapy with injectable IL-23 inhibitors and oral small molecules, including head-to-head data
- Incorporate patient-centered approaches into individualized PsO management strategies

**PSO = psoriasis; IL = interleukin.**




# My Father, Joe Blauvelt

- Hx of **severe psoriasis** for many years
- Tx with Goeckerman therapy, MTX, cyclosporine, acitretin
- **2 heart attacks and 2 strokes in his 60s**
- Passed at age 74 (1998)

**MTX = methotrexate.**

# Overview

- Psoriasis has a huge impact on overall quality of life
- Don’t undertreat psoriasis; treat to clearance or near clearance
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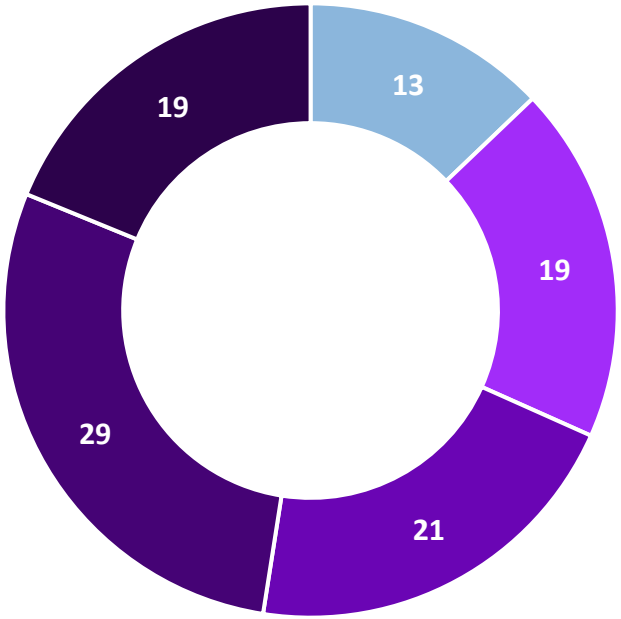
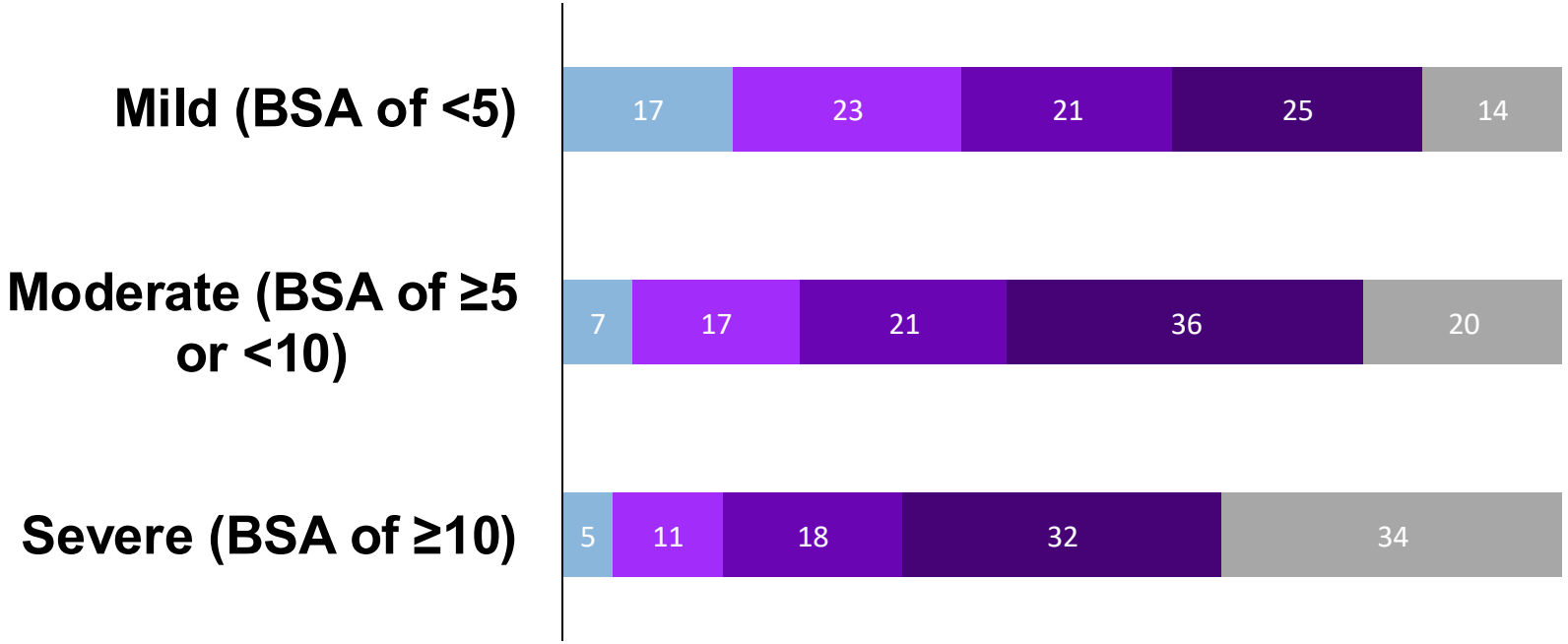
# Psoriasis Has a Significant Impact on Quality of Life

No effect on QOL (DLQI 0-1) | Small (2-5) | Moderate (6-10) | Very large (11-20) | Extremely large effect on QOL (21-30)

## Effect on Patients' QOL



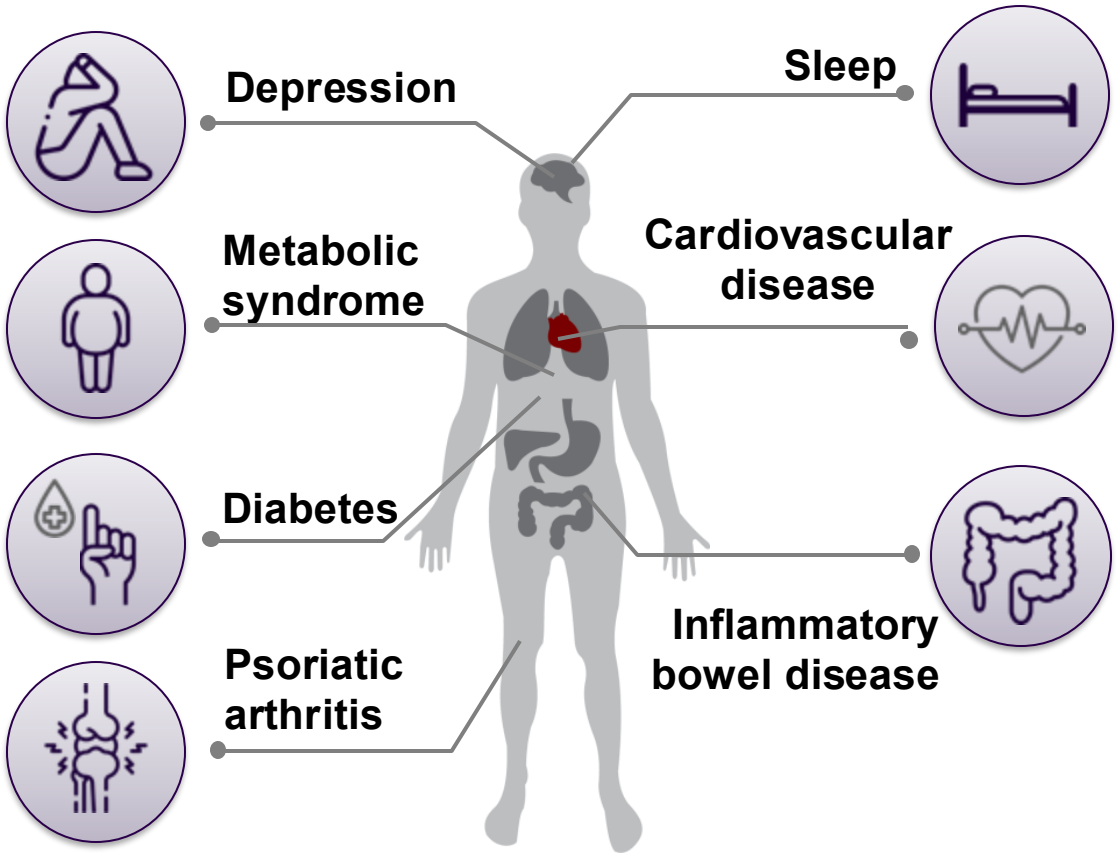

## Impact on QOL Based on Current Disease Severity




QOL = quality of life; BSA = body surface area.

Armstrong AW, et al. *Dermatology*. 2023;239(4):621-634.

# Psoriasis Affects the Whole Person




**Psoriatic arthritis affects approximately 30% of people who have psoriasis**


- Increasing evidence supports the recognition of psoriasis as a multisystem chronic inflammatory disorder with multiple associated co-morbidities
- People who treat their psoriasis effectively may also lower their risk of other comorbidities

Mease PJ, et al. *J Am Acad Dermatol*. 2013;69(5):729-735. Lecumberri A, et al. *J Invest Dermatol*. 2025;145(10):2474-2483. Armstrong AW, et al. *Nat Rev Dis Primers*. 2025;11(1):45.

# Psoriasis Involving Special Areas is Associated with Worse Quality of Life, Depression, and Limitations in the Ability to Participate in Social Roles and Activities

Andrew Blauvelt, MD, MBA[1], George C. Gondo, MA[2], Stacie Bell, PhD[2,*], Cristina Echeverría, MD[3], Marcus Schmitt-Egenolf, MD, PhD[4], Lone Skov, MD[5], Peter van de Kerkhof, MD, PhD[6], Leah McCormick Howard, JD[2], and Bruce Strober, MD, PhD[7]

Blauvelt A, et al. *J Psoriasis Psoriatic Arthritis*. 2023;8(3):100-106.

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# Undertreatment of Psoriasis: Uplift Survey Summary

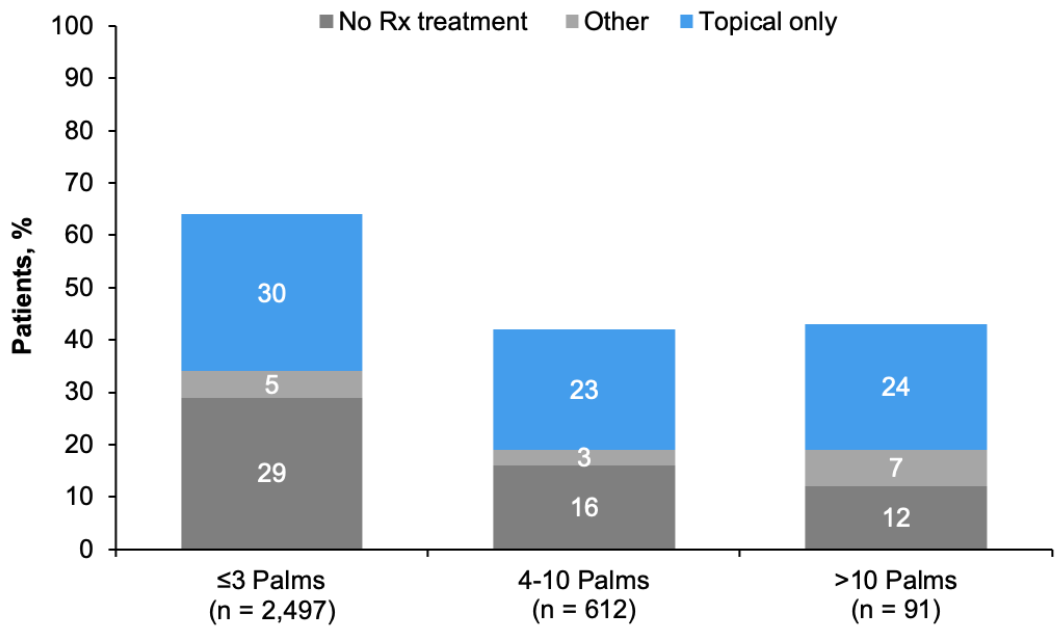
- The 2020 UPLIFT survey revealed substantial patient burden, treatment dissatisfaction, and potential undertreatment with systemic therapy in PsO, including for patients with limited skin involvement, involvement in special areas, or bothersome symptoms such as itching and pain

**Lebwohl M, et al. *Dermatol Ther (Heidelb).* 2022;12(1):61-78.**

# Moderate-to-Severe Psoriasis Remains Persistently Untreated or Undertreated

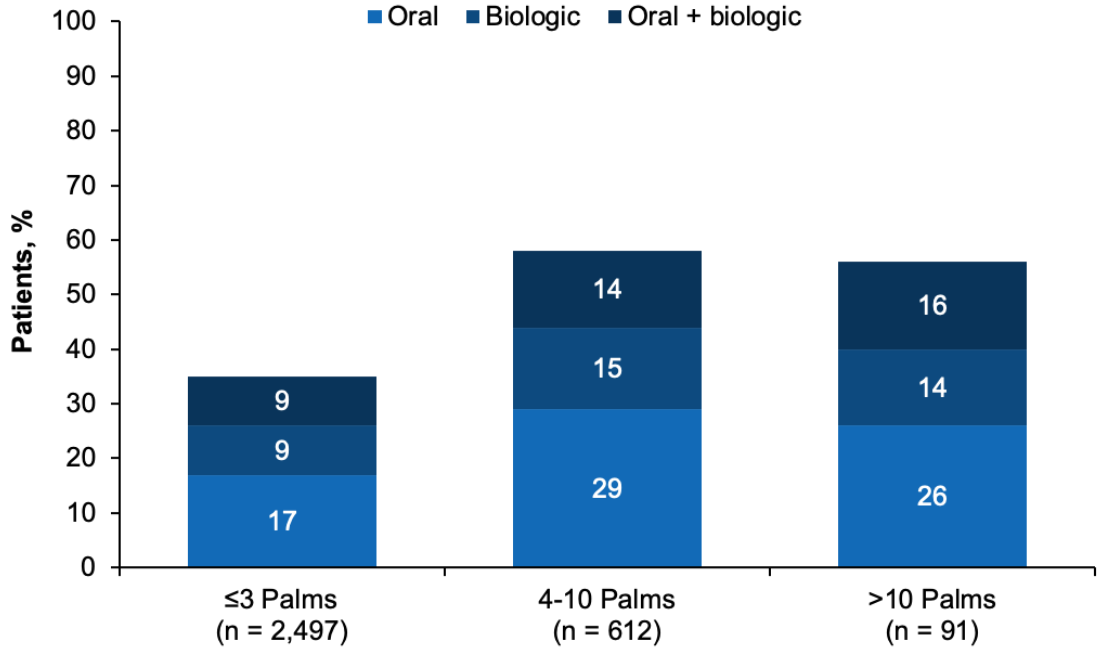
- Nearly one-quarter of people with psoriasis have cases that are considered moderate to severe

**Topical Treatment by Level of BSA Involvement**




12% (>10 palms) to 29% (≤3 palms) of patients reported they were not currently receiving **any** treatment for their PsO

**Systemic Treatment by Level of BSA Involvement**




≥50% of patients with BSA >3 palms were receiving systemic therapy (oral and/or biologic therapy) compared with 35% of those with ≤3 palms

**Armstrong AW, et al. *J Am Acad Dermatol*. 2017;76(2):290-298. Helmick CG, et al. *Am J Prev Med*. 2014;47(1):37-45. Armstrong AW, et al. *JAMA Dermatol*. 2021;157(8):940-946. Lebwohl M, et al. *Dermatol Ther (Heidelb)*. 2022;12(1):61-78.**

# Psoriasis Severity Classification

- Historically defined as as “mild,” “moderate,” and “severe”
- Historical definitions of each vary, for example
  - Trial populations: “Mild” = <10% BSA, “moderate” = 10-20% BSA, "severe" = >20% BSA
  - National Psoriasis Foundation (NPF): <3% BSA, “moderate” = 3-10% BSA, severe = >10% BSA
- Typically, **no considerations given for**
  - **Severe localized disease**
  - **Involvement of high-impact sites**
  - **Impact on quality of life**
  - **Past treatment failure(s)**

**Strober B, et al. *J Psoriasis Psoriatic Arthritis*. 2024;10(1):22-27.**

ORIGINAL ARTICLE

# Recategorization of psoriasis severity: Delphi consensus from the International Psoriasis Council

Bruce Strober, MD, PhD,[a,b] Caitriona Ryan, MD,[c] Peter van de Kerkhof, MD, PhD,[d] Joelle van der Walt, PhD,[d] Alexa B. Kimball, MD, MPH,[e] Jonathan Barker, MD, FRCP, FRCPath,[f] and Andrew Blauvelt, MD, MBA,[g] on behalf of International Psoriasis Council Board Members and Councilors

*New Haven and Cromwell, Connecticut; Dublin, Ireland; St Louis, Missouri; Boston, Massachusetts; London, United Kingdom; and Portland, Oregon*

**Strober B ... Blauvelt A, et al. *J Am Acad Dermatol*. 2020;82(1):117-122.**

# * IPC Psoriasis Severity Reclassification Statement *

- Patients with psoriasis should be classified as either ***candidates for topical therapy*** or ***candidates for systemic therapy***; the latter are patients who meet at least 1 of the following criteria
  - **BSA >10%**
  - **Disease involving special areas**
  - **Failure of topical therapy**

**IPC = International Psoriasis Council.**

**Strober B ... Blauvelt A, et al. *J Am Acad Dermatol*. 2020;82(1):117-122.**

# * NPF Psoriasis Severity Reclassification Statement *

- Psoriasis severity should be classified as either ***mild or moderate-to-severe***. ***"Mild psoriasis"*** is defined as psoriasis affecting individuals who are ***candidates for topical therapy***. ***"Moderate-to-severe psoriasis"*** is defined as psoriasis affecting individuals who are ***candidates for systemic therapy*** and who meet at least one of the following criteria
  - **BSA >10%**
  - **Disease involving high-impact sites**
  - **Failure of topical therapy**

**Blauvelt A, et al. *J Am Acad Dermatol*. 2025:S0190-9622(25)03487-5. [Epub ahead of print.]**

# Special Areas = High Impact Sites[a]

- Scalp
- Face
- Palms/soles
- Genitalia
- Nails

[a]**Jonathan Barker, former IPC President.**

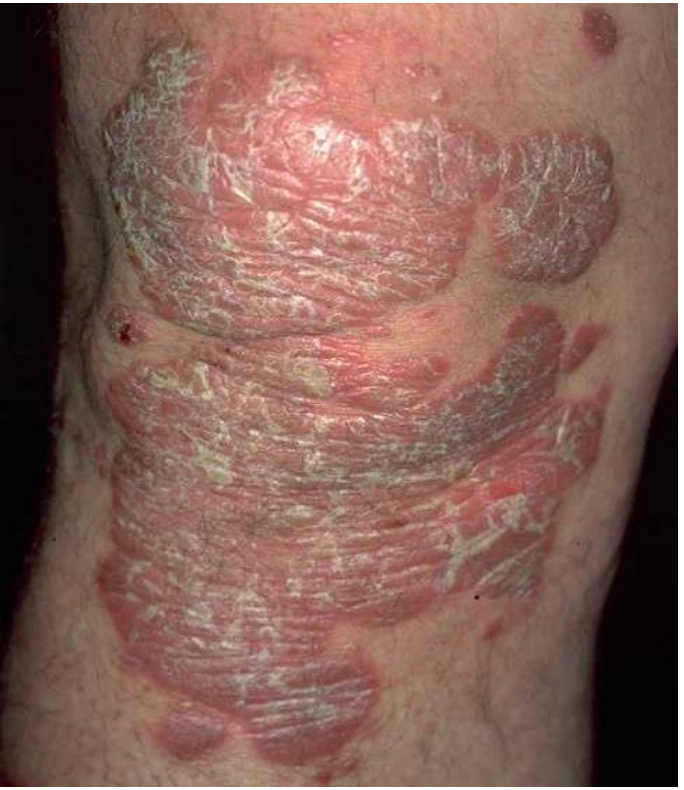
# Failure of Topical Therapy

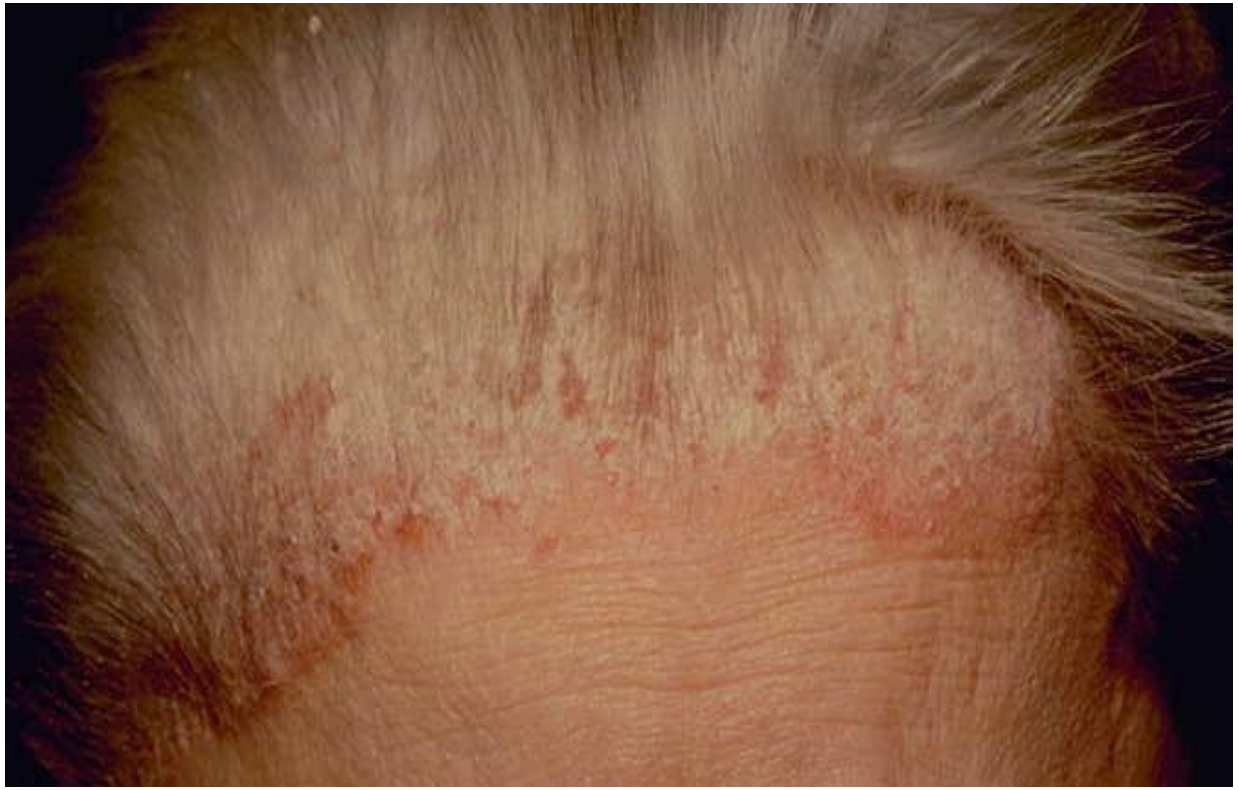
- "Inability to achieve clear/nearly clear skin (BSA 1%, Physician's Global Assessment 0/1) after two consecutive 4-week topical therapy courses, per guidelines."

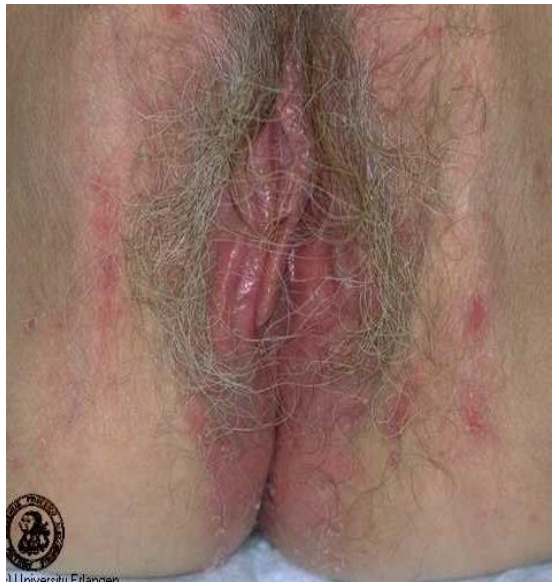
**Strober BE, Blauvelt A, et al. *J Am Acad Dermatol*. 2026;94(1):372-375.**

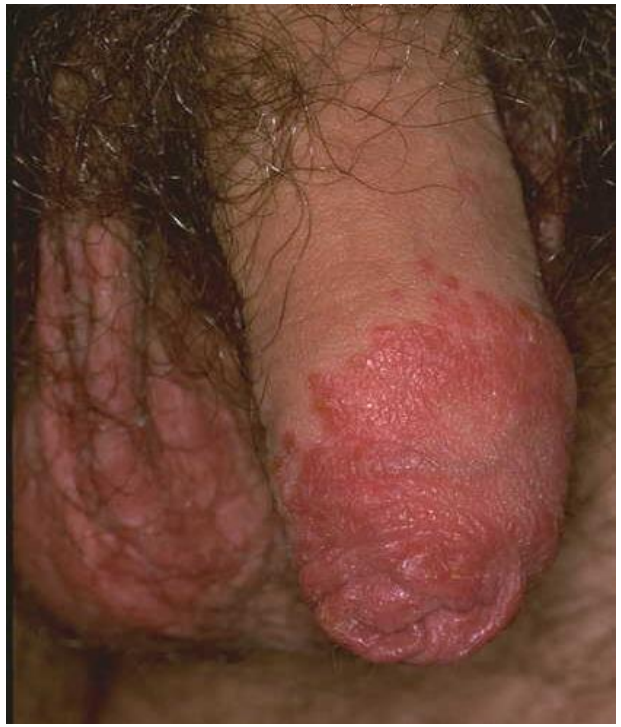
**All 4 of these patients have a total BSA of 1-4%.**

**OLD: They all have mild psoriasis and are not candidates for systemic therapy**



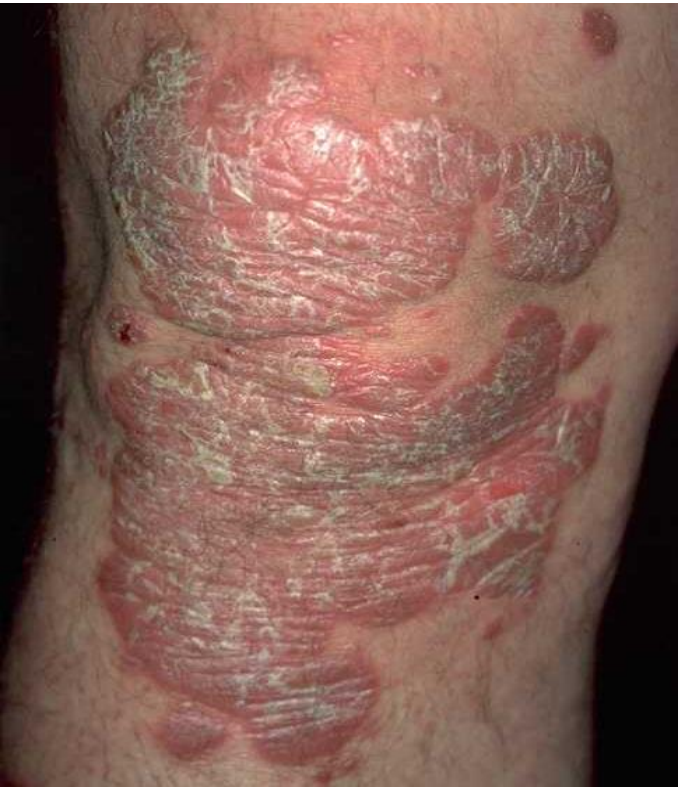


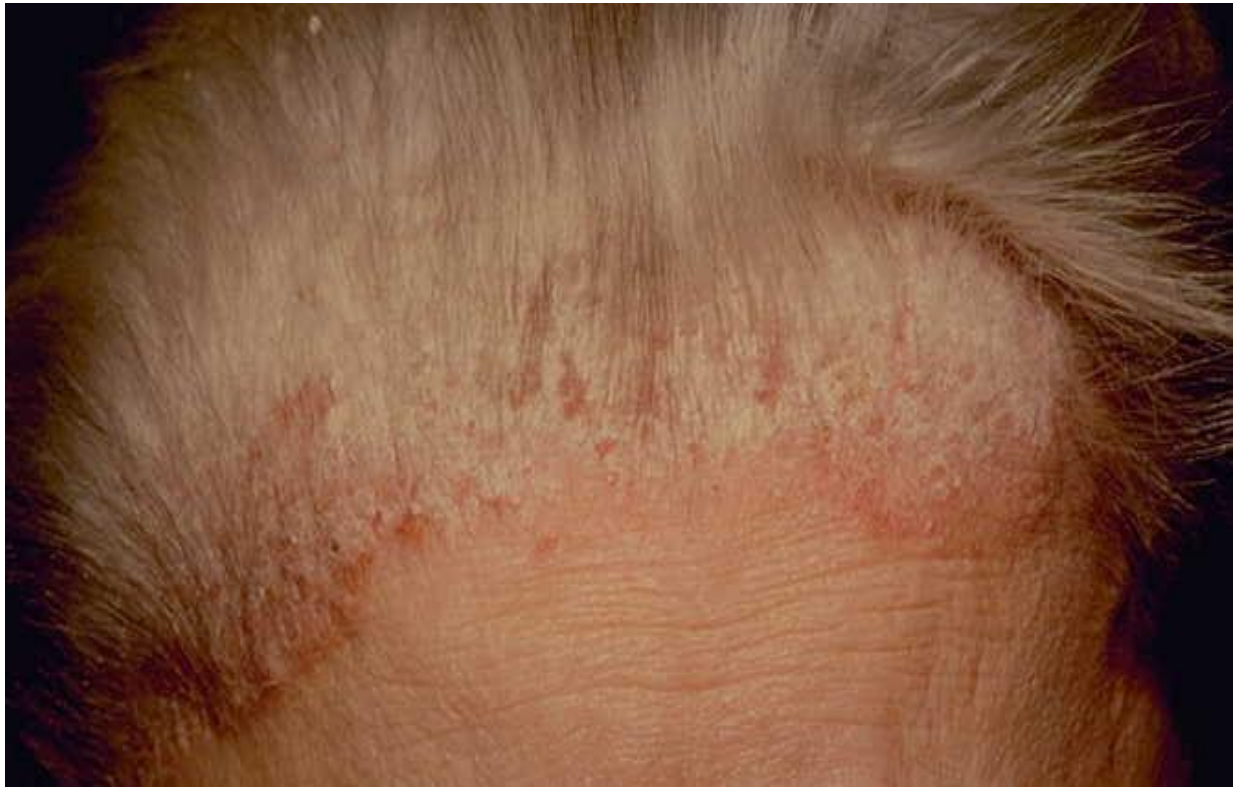


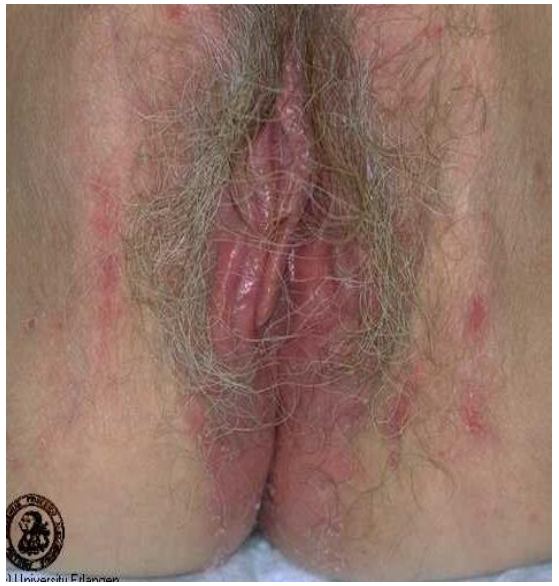


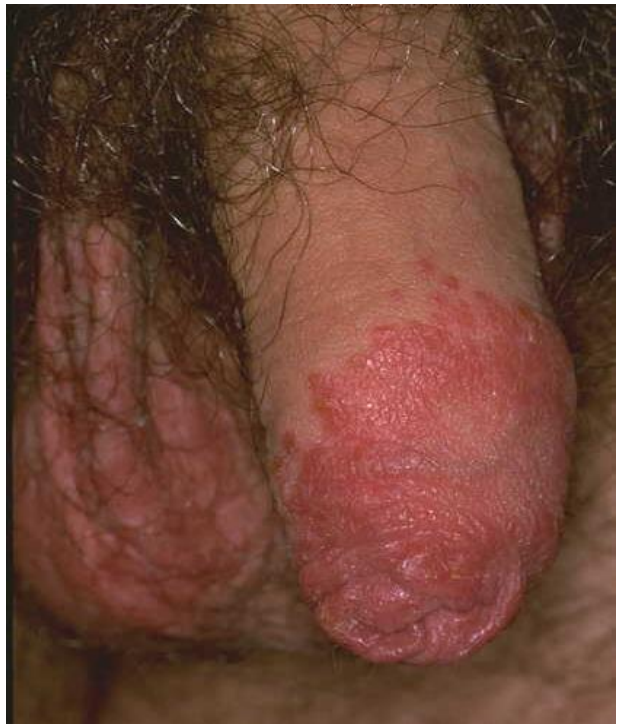
**All 4 of these patients have a total BSA of 1-4%.**

**NEW: They all have moderate-to-severe psoriasis and they are all candidates for systemic therapy**









# From the Medical Board of the National Psoriasis Foundation: Treatment targets for plaque psoriasis

April W. Armstrong, MD, MPH,[a] Michael P. Siegel, PhD,[b] Jerry Bagel, MD,[c,d] Erin E. Boh, MD, PhD,[e] Megan Buell,[b] Kevin D. Cooper, MD,[f] Kristina Callis Duffin, MD, MS,[g] Lawrence F. Eichenfield, MD,[h] Amit Garg, MD,[i] Joel M. Gelfand, MD, MSCE,[j] Alice B. Gottlieb, MD, PhD,[k] John Y. M. Koo, MD,[l] Neil J. Korman, MD, PhD,[f] Gerald G. Krueger, MD,[g] Mark G. Lebwohl, MD,[m] Craig L. Leonardi, MD,[n] Arthur M. Mandelin, MD, PhD,[o] M. Alan Menter, MD,[p] Joseph F. Merola, MD, MMSC,[q] David M. Pariser, MD,[r,s] Ronald B. Prussick, MD, FRCP,[t] Caitriona Ryan, MD,[p] Kara N. Shah, MD,[u] Jeffrey M. Weinberg, MD,[m] MaryJane O. U. Williams, MD,[a] Jashin J. Wu, MD,[v] Paul S. Yamauchi, MD, PhD,[w] and Abby S. Van Voorhees, MD[r]

**Armstrong AW, et al. *J Am Acad Dermatol*. 2017;76(2):290-298.**

# NPF Treat-to-Target

- Establishing treatment goals can help **improve treatment outcomes**
- Target response after initiating a new treatment should be a **BSA of 1% or less** (at 6 months)
- Treatment targets establish expectations and encourage providers to evaluate progress and **adjust treatments accordingly**

**Armstrong AW, et al. *J Am Acad Dermatol*. 2017;76(2):290-298.**

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- **Benefits of treating psoriasis go beyond the skin**
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# Clinical meaningfulness of complete skin clearance in psoriasis

Bruce Strober, MD, PhD,[a] Kim A. Papp, MD, PhD,[b,c] Mark Lebwohl, MD,[d] Kristian Reich, MD,[e] Carle Paul, MD, PhD,[f] Andrew Blauvelt, MD,[g] Kenneth B. Gordon, MD,[h] Cassandra E. Milmont, PhD,[i] Hema N. Viswanathan, PhD,[i] Joanne Li, PhD,[i] Lionel Pinto, PhD,[i] David J. Harrison, PhD,[i] Greg Kricorian, MD,[i] Ajay Nirula, MD, PhD,[i] and Paul Klekotka, MD, PhD[i]

# Importance of Complete Skin Clearance in Psoriasis as a Treatment Goal: Implications for Patient-Reported Outcomes

Andrew Blauvelt MD,[a] Jashin J. Wu MD,[b] April Armstrong MD,[c] Alan Menter MD,[d] Clive Liu MD,[e] Abby Jacobson MS[f]

# Complete Skin Clearance is Associated with the Greatest Benefits to Health-Related Quality of Life and Perceived Symptoms for Patients with Psoriasis

Matthias Augustin [1], Alice B Gottlieb [2], Mark Lebwohl [2], Andreas Pinter [3], Richard B Warren [4] [5], Luis Puig [6], Rhys Warham [7] [8], Jérémy Lambert [9], Susanne Wiegratz [10], Balint Szilagyi [10], Andrew Blauvelt [11]

**Strober B, et al. *J Am Acad Dermatol*. 2016;75(1):77-82.e7. Blauvelt A, et al. *J Drugs Dermatol*. 2020;19(5):487-492. Augustin M, et al. *Dermatol Ther (Heidelb).* 2024;14(10):2841-2857.**

# Improvements in Mental Health Have Been Reported Following Treatment of PsO with Systemic Therapy

- Reported for nearly every systemic therapy for psoriasis
- Improvements in quality of life
- Improvements in anxiety/depression
- Improvements in suicidal ideation and behavior

**Strober B, et al. *J Am Acad Dermatol*. 2018;78(1):70-80. Wang Y, et al. *Front Immunol*. 2025;16:1659346.**

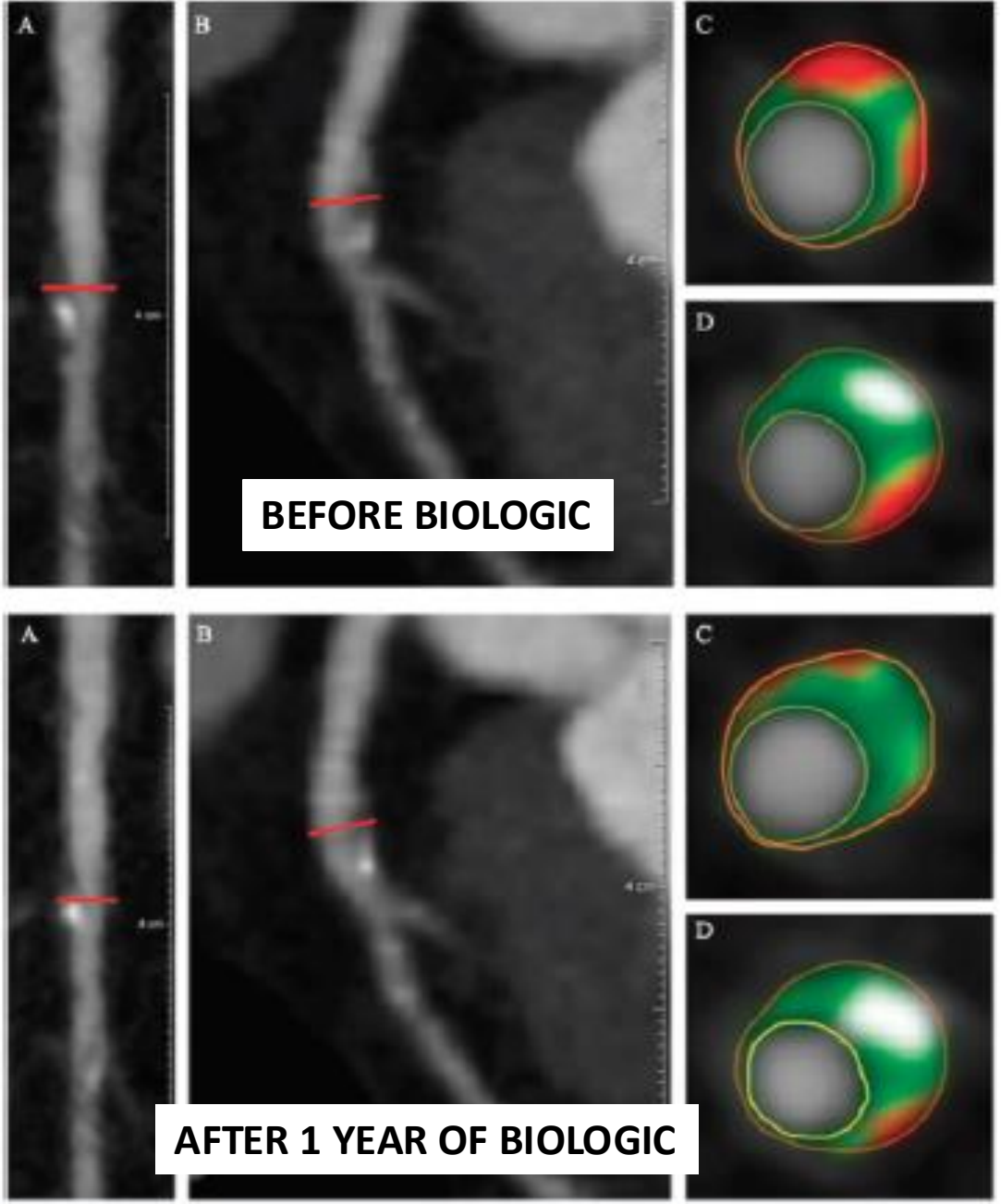
# Retrospective Studies Suggest that Biologic Treatment of PsO May Reduce Risk of PsA

- 464 patients with mod-to-sev PsO treated with biologics or phototherapy over ≥5 years
  - Biologic treatment was associated with a lower risk of incident PsA (adjusted HR 0.27, 0.11-0.66)
- 1,719 patients representing 14,721 patient years received no treatment/ topicals (n= 1387), conventional DMTs (n= 229), or biologics (n=103)
  - Risk of developing PsA in patients with PsO treated with biologics was significantly lower (IRR)=0.26; 95% CI 0.03 to 0.94; *P*=0.0111) vs topicals, but not vs conventional DMTs (IRR=0.35; 95% CI 0.035 to 1.96; *P* =0.1007)
- In 15,501 patients with psoriasis: **Treatment with IL-12/23 inhibitors or IL-23 inhibitors was associated with reduced risk of progression to inflammatory arthritis** compared with treatment with TNF inhibitors

**PsA = psoriatic arthritis; DMT = disease-modifying therapy; IRR = incidence rate ratio; TNF = tumor necrosis factor.**

**Gisondi P, et al. *Ann Rheum Dis*. 2022;81(1):68-73. Acosta Felquer ML, et al. *Ann Rheum Dis*. 2022;81(1):74-79. Singla S, et al. *Lancet Rheumatol*. 2023;5(4):e200-e207.**

# Visualization of Coronary Artery Plaques by CCTA




- Total plaque burden
- Dense-calcified plaque burden (white)
- Non-calcified plaque burden
- Plaque morphology index
  - Fibrous burden (dark green)
  - Fibro-fatty burden (light green)
  - Necrotic burden (red)

**CCTA = coronary computed tomography angiography.**

**Elnabawi YA, et al. *Cardiovasc Res*. 2019;115(4):721-728.**

# Summary of Improvements in Lipid-Rich Atherosclerosis after 1 Year of Biologics

- TNF blockers
  - **5% reduction** (48 patients)
  - **3.3% reduction** (69 patients)

- IL-12/23 blocker
  - **2% reduction** (19 patients)
  - **8.2% reduction** (26 patients)

- IL-17 blockers
  - **12% reduction** (22 patients)
  - **14.7% reduction** (29 patients)

**Elnabawi YA, et al. *Cardiovasc Res*. 2019;115(4):721-728. Choi H, et al. *Circ Cardiovasc Imaging*. 2020;13(9):e011199.**

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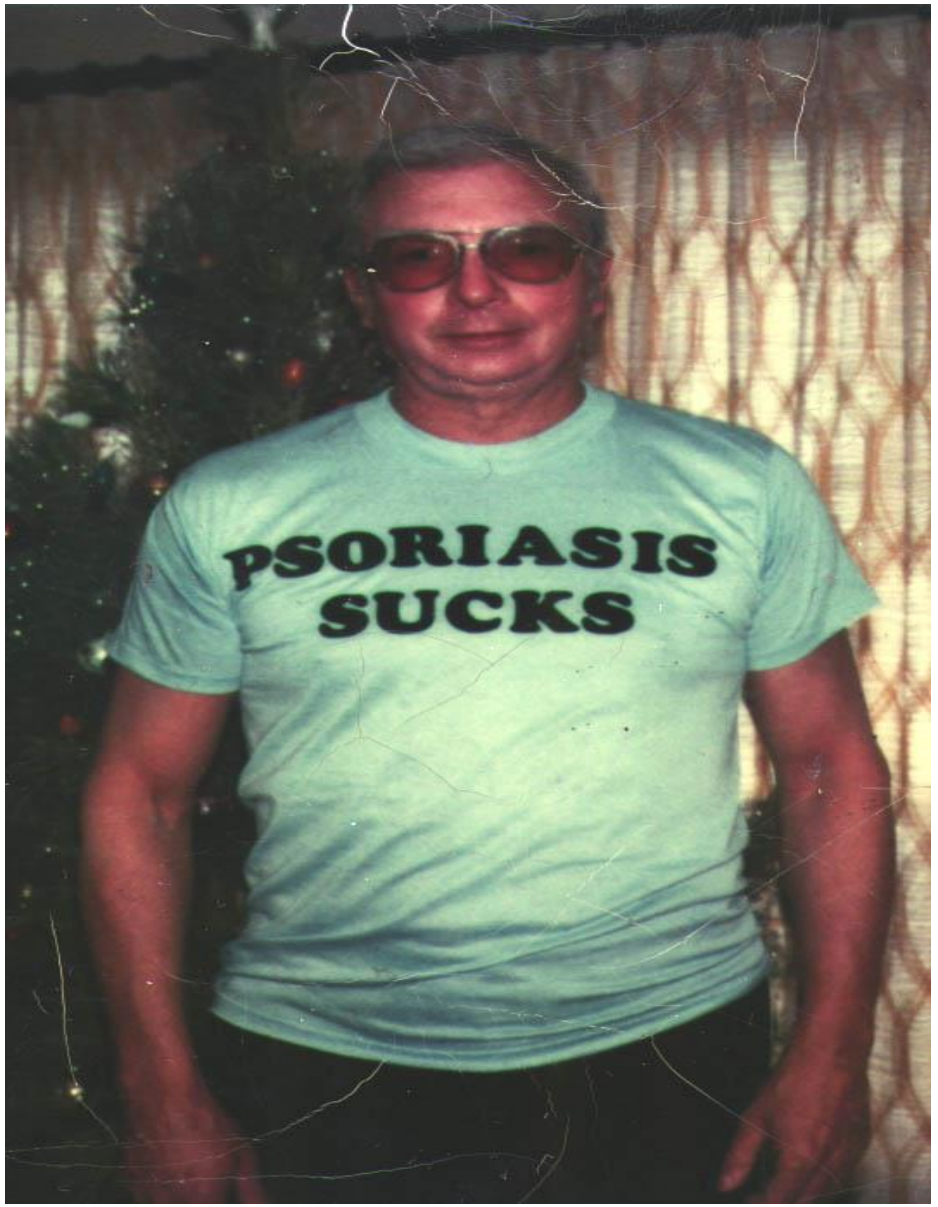
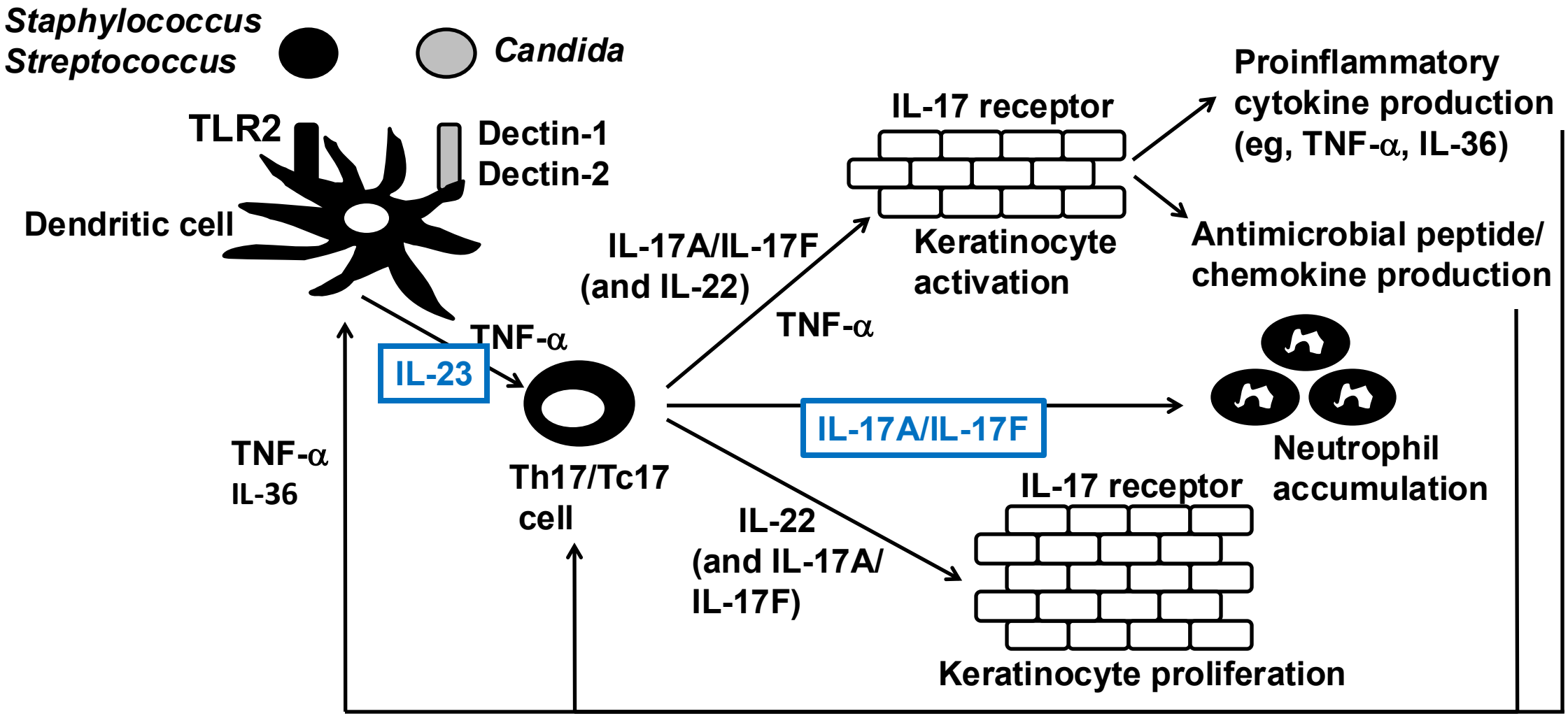



# What Do Patients Want?

- Efficacy
- Safety
- Convenience

# Understanding the Immunology of PsO Has Directly Led to the Development of Highly Safe and Effective Therapies for this Disease




Armstrong AW, et al, *Nat Rev Dis Primers*. 2025;11(1):45.

# Current and Future Biologic and Oral Drug Choices for PsO

| | |
|---|---|
| **TNFi** | **Etanercept**<br>**Infliximab**<br>**Adalimumab**<br>**Certolizumab**<br>**Biosimilars** |
| **IL-17i** | **Secukinumab**<br>**Ixekizumab**<br>**Brodalumab**<br>**Bimekizumab** |
| **IL-23i** | **Ustekinumab**<br>**+biosimilars**<br>**Guselkumab**<br>**Tildrakizumab**<br>**Risankizumab** |

- **Methotrexate**
- **Cyclosporine**
- **Acitretin**
- **Apremilast**
  - **Roflumilast**
  - **Other PDE4 B/D inhibitors**
- **Deucravacitinib**
  - **Zasocitinib**
  - **Envudeucitinib**
- **Cytokine inhibitors**
  - **Icotrokinra**
  - **Simepdekinra**

**BLUE HIGHLIGHTS = PIPELINE**

# Comparison of Biologics and Oral Treatments for Plaque PsO: A Meta-Analysis

Table. Estimated Response Rates From the NMA of Short-term PASI (Base Case)

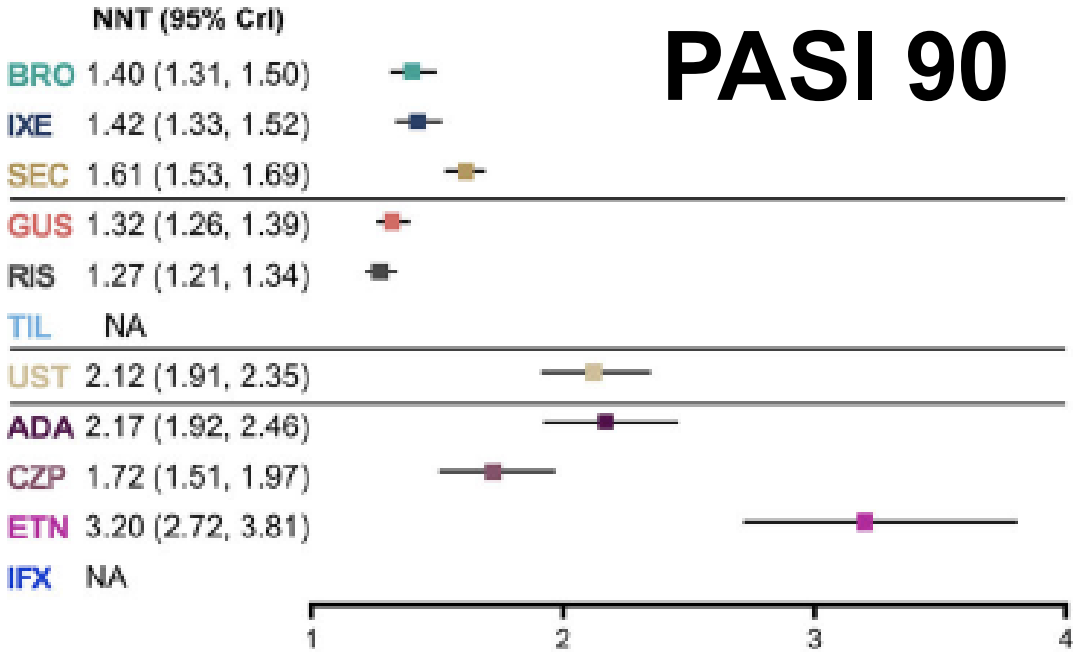
| Treatment | Posterior Median, % (95% CrI) | | |
|---|---|---|---|
| | PASI 75 | PASI 90 | PASI 100 |
| Risankizumab-rzaa, 150 mg | 89.2 (86.9-91.3) | 71.6 (67.5-75.4) | 40.4 (35.9-45.0) |
| Ixekizumab, 80 mg | 88.8 (86.5-90.9) | 70.8 (66.8-74.6) | 39.5 (35.2-44.0) |
| Brodalumab, 210 mg | 88.7 (86.5-90.8) | 70.6 (66.8-74.6) | 39.2 (35.2-43.9) |
| Guselkumab, 100 mg | 86.8 (83.8-89.4) | 67.3 (62.5-71.9) | 35.7 (30.9-40.7) |
| Secukinumab, 300 mg | 83.1 (80.2-85.7) | 61.4 (57.2-65.6) | 29.9 (26.3-33.9) |
| Infliximab, 5 mg/kg | 80.4 (76.5-84.0) | 57.4 (52.2-62.8) | 26.5 (22.3-31.4) |
| Certolizumab pegol, 400 mg | 71.1 (65.4-76.5) | 45.6 (39.3-52.2) | 17.7 (13.8-22.3) |
| Ustekinumab, 45 mg ≤100 kg, 90 mg >100 kg | 69.7 (66.3-73.1) | 43.9 (40.2-47.9) | 16.7 (14.4-19.3) |
| Adalimumab, 40 mg | 69.5 (66.0-72.6) | 43.7 (40.0-47.4) | 16.5 (14.2-19.0) |
| Certolizumab pegol, 200 mg | 66.2 (59.6-72.4) | 40.2 (33.5-47.2) | 14.4 (10.7-18.8) |
| Tildrakizumab-asmn, 200 mg | 64.9 (59.4-70.3) | 38.8 (33.3-44.7) | 13.6 (10.6-17.1) |
| Tildrakizumab-asmn, 100 mg | 62.9 (57.3-68.4) | 36.8 (31.4-42.5) | 12.5 (9.7-15.8) |
| Etanercept, 25 mg twice weekly/50 mg once weekly | 40.1 (35.4-45.1) | 17.9 (14.9-21.4) | 4.2 (3.1-5.4) |
| Apremilast, 30 mg | 30.8 (26.8-35.0) | 12.1 (9.9-14.7) | 2.4 (1.8-3.1) |
| Dimethyl fumarate | 29.6 (22.0-38.3) | 11.4 (7.5-16.7) | 2.2 (1.2-3.8) |
| Placebo | 5.3 (4.8-5.9) | 1.1 (1.0-1.3) | 0.1 (0.1-0.1) |

**PASI = Psoriasis Area and Severity Index; NMA = network meta-analysis.**

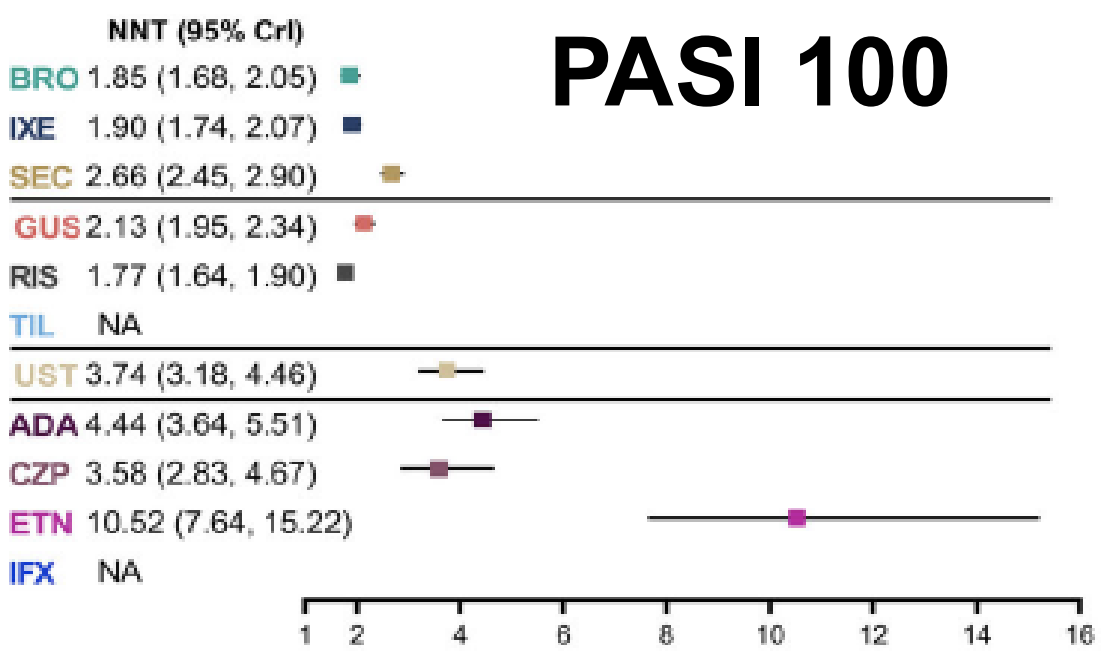
**Armstrong AW, et al. *JAMA Dermatol*. 2020;156(3):258-269.**

# Ranking Efficacy: Many Meta-Analyses Showing Similar Results

## Number Needed to Treat Network Meta-Analysis to Compare Biologic Drugs for Moderate-to-Severe Psoriasis




**PASI 90**

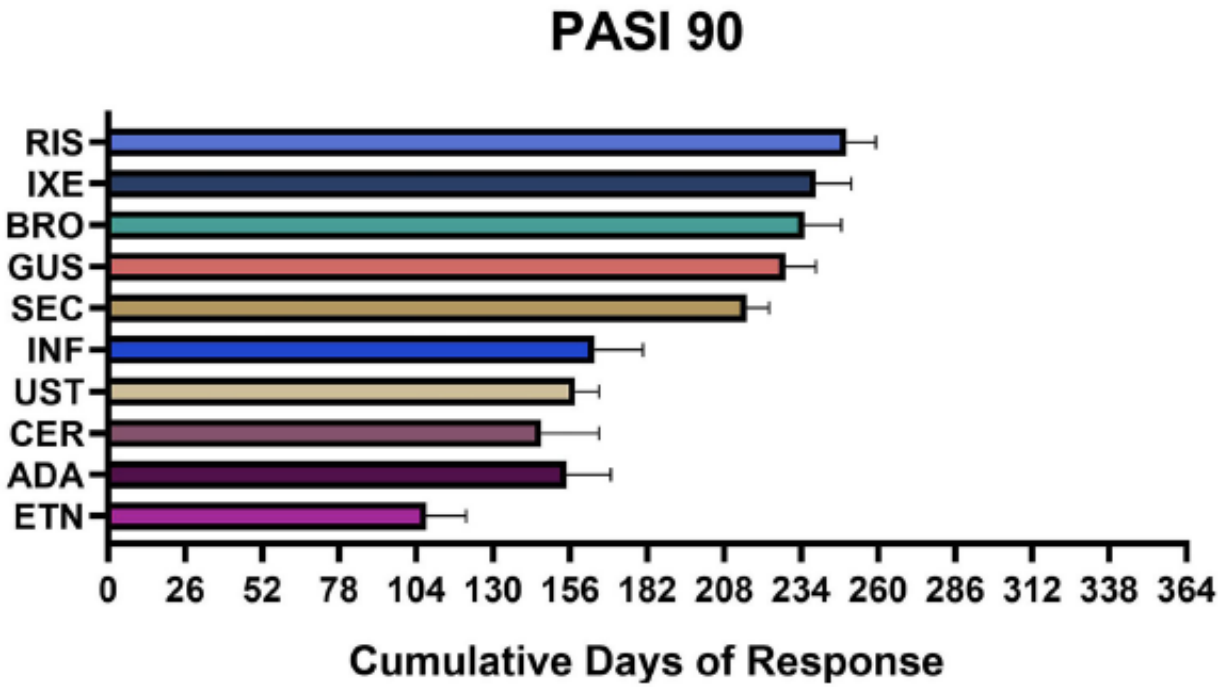


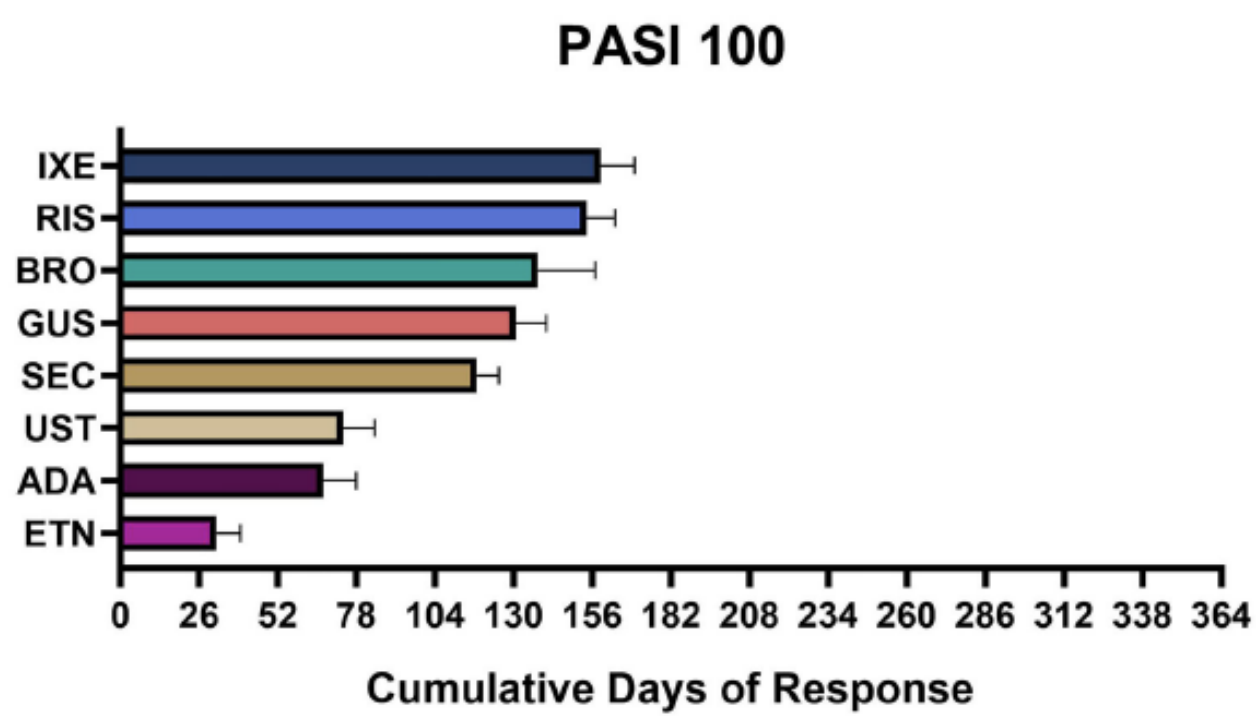

**PASI 100**

Leonardi CL, et al. *Adv Ther.* 2022;39(5):2256-2269.

# Ranking Efficacy: Many Meta-Analyses Showing Similar Results

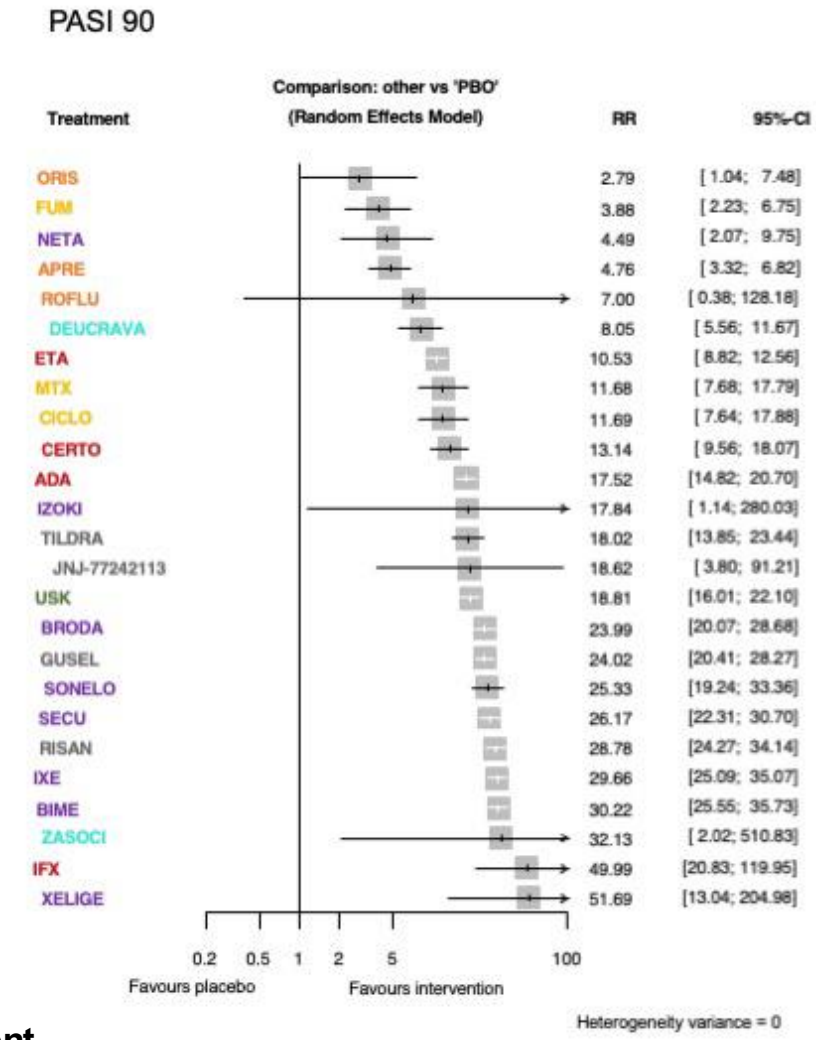
## Cumulative Clinical Benefits of Biologics in the Treatment of Patients with Moderate-to-Severe Psoriasis over 1 Year: a Network Meta-Analysis

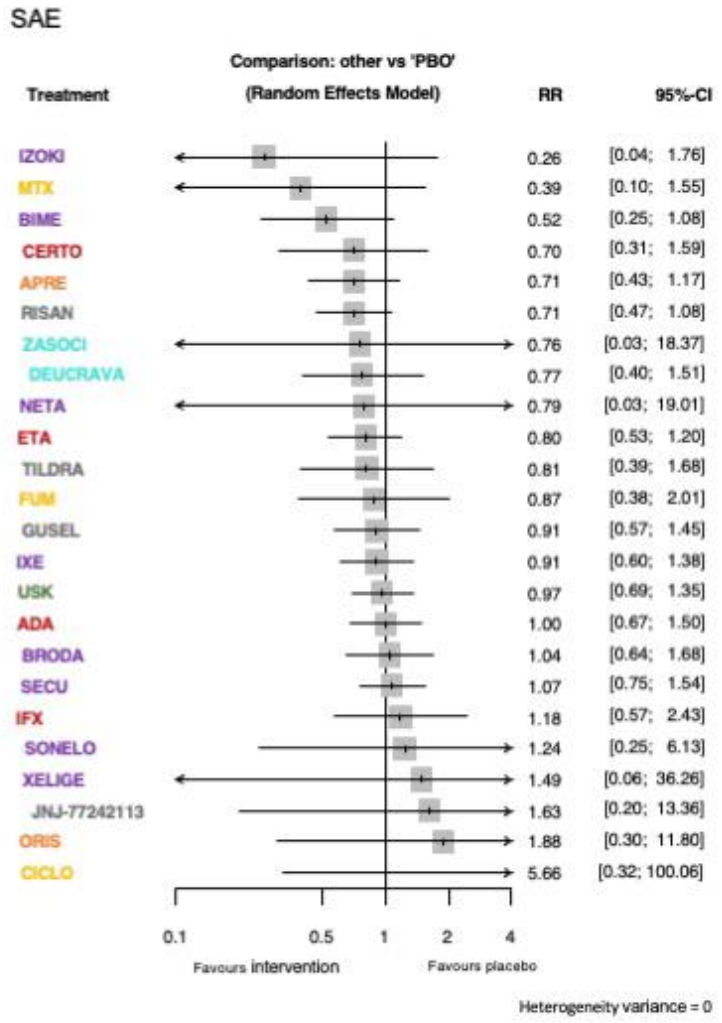



Blauvelt A, et al. *Dermatol Ther (Heidelb).* 2022;12(3):727-740.

# Ranking Efficacy: Many Meta-Analyses Showing Similar Results

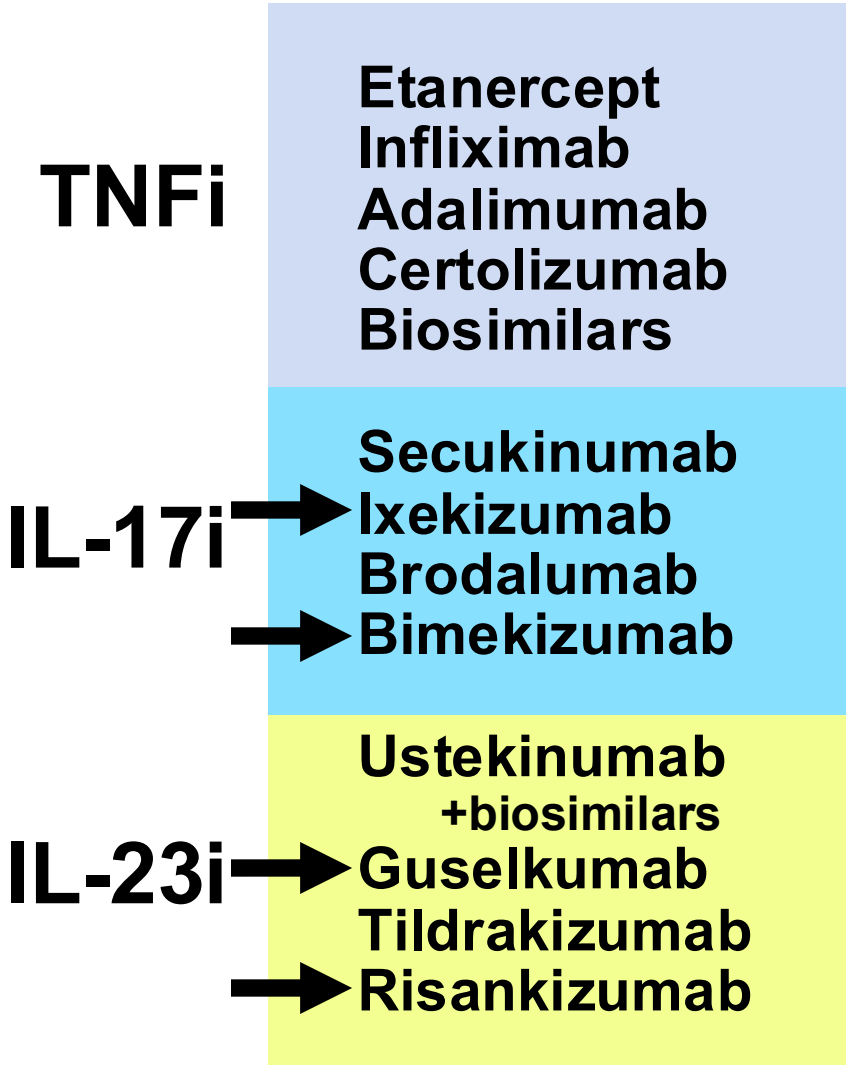



**SAE = serious adverse event.**

**Sbidian E, et al. *Cochrane Database Syst Rev*. 2025;8(8):CD011535**

# Current and Future Biologic and Oral Drug Choices for PsO

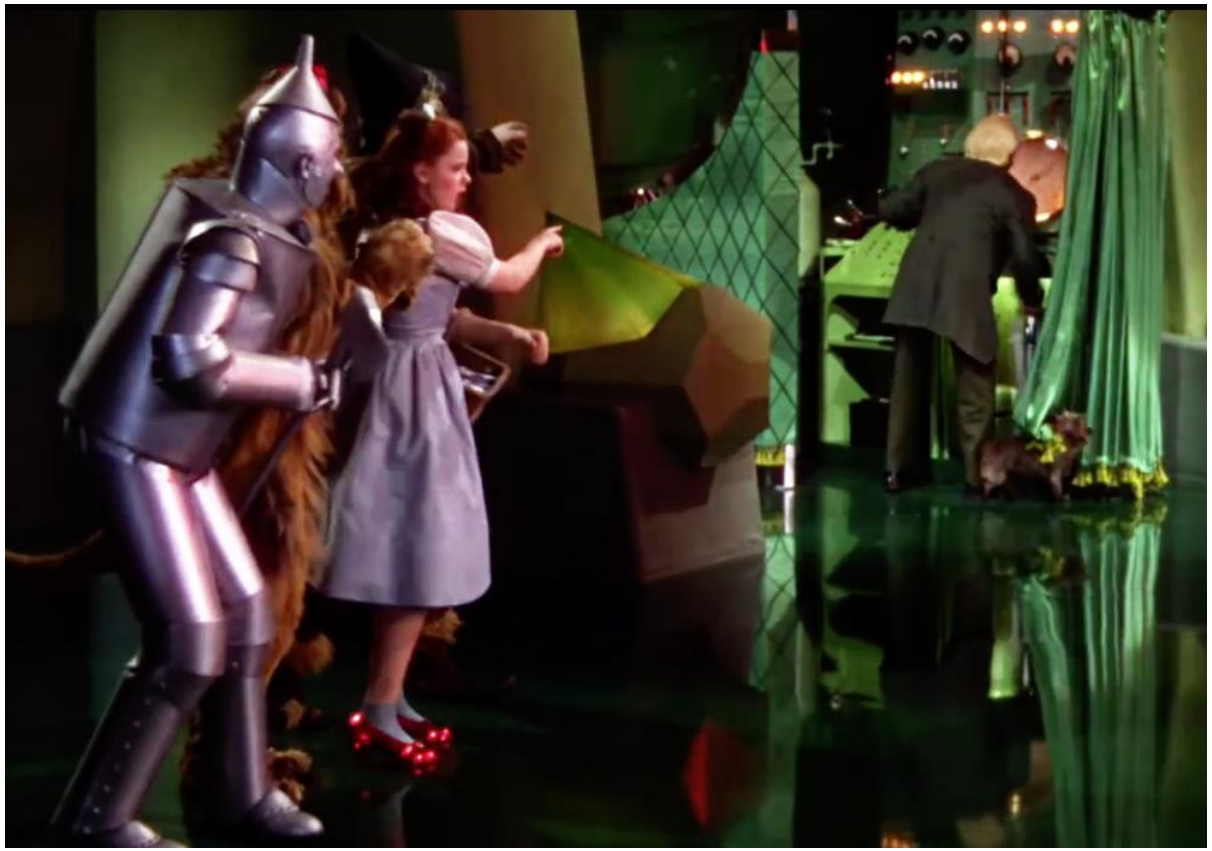


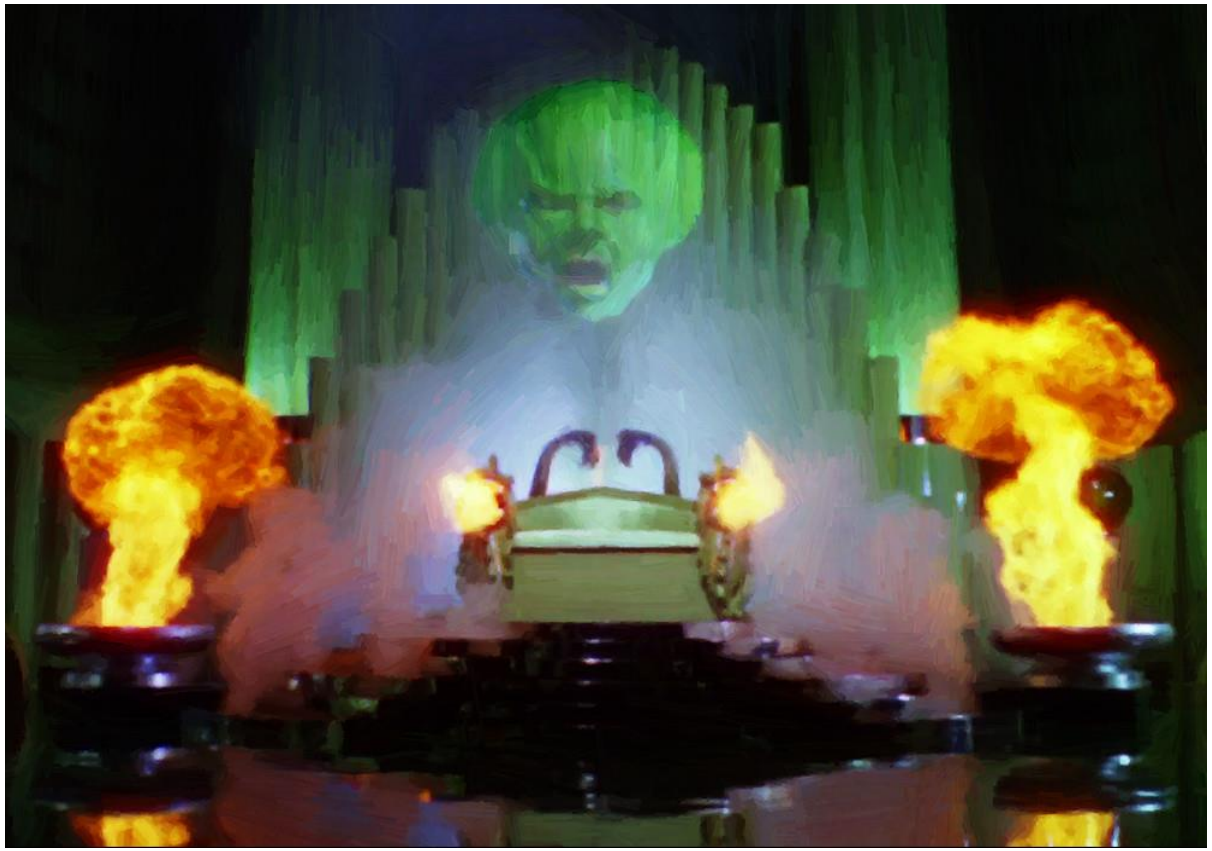

→ BEST IN CLASS

- Methotrexate
- Cyclosporine
- Acitretin
- Apremilast
  - Roflumilast
  - Other PDE4 B/D inhibitors
- → Deucravacitinib
  - Zasocitinib
  - Envudeucitinib
- Cytokine inhibitors
  - Icotrokinra
  - Simepdekinra

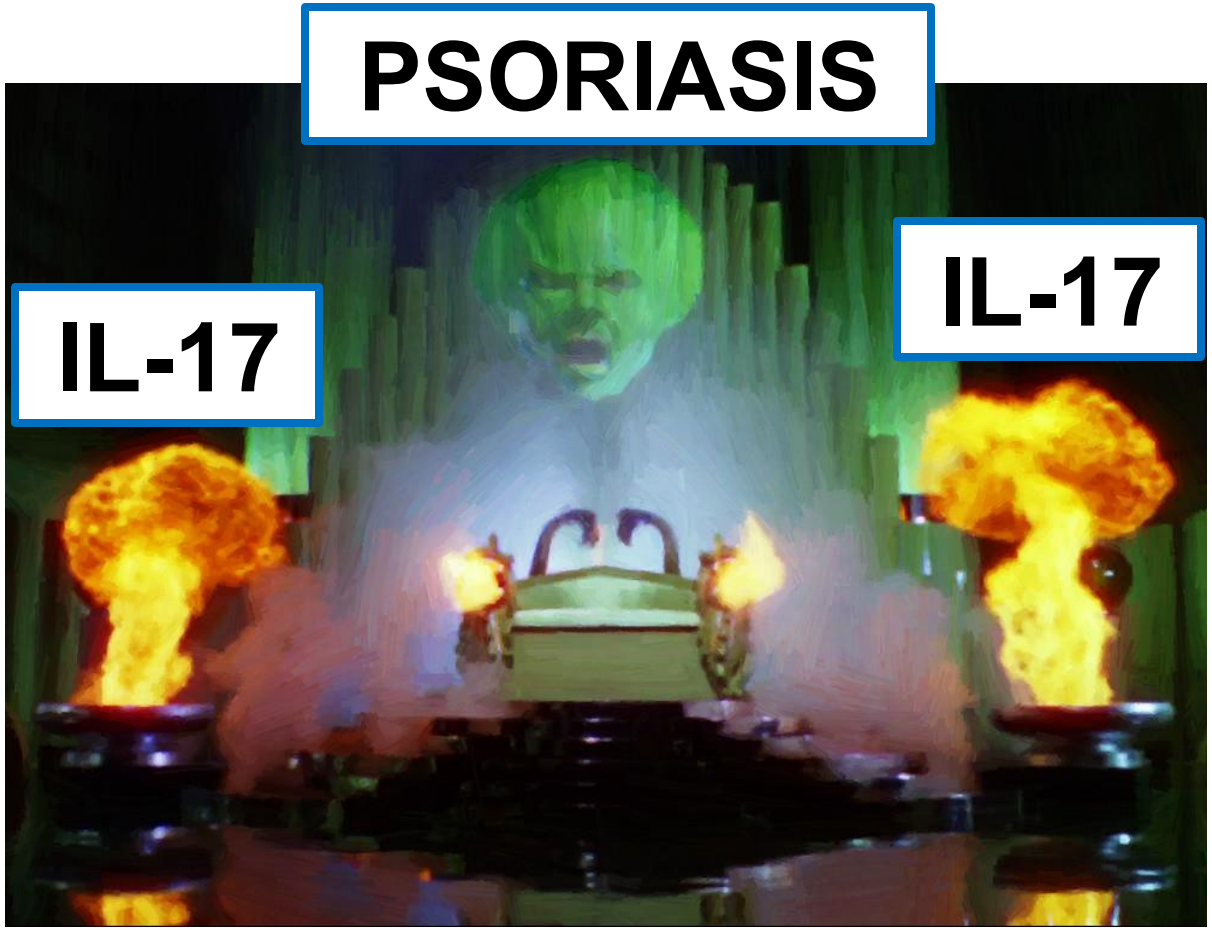
BLUE HIGHLIGHTS = PIPELINE

# Il-23 Is the Master Cytokine *Regulator* in Psoriasis

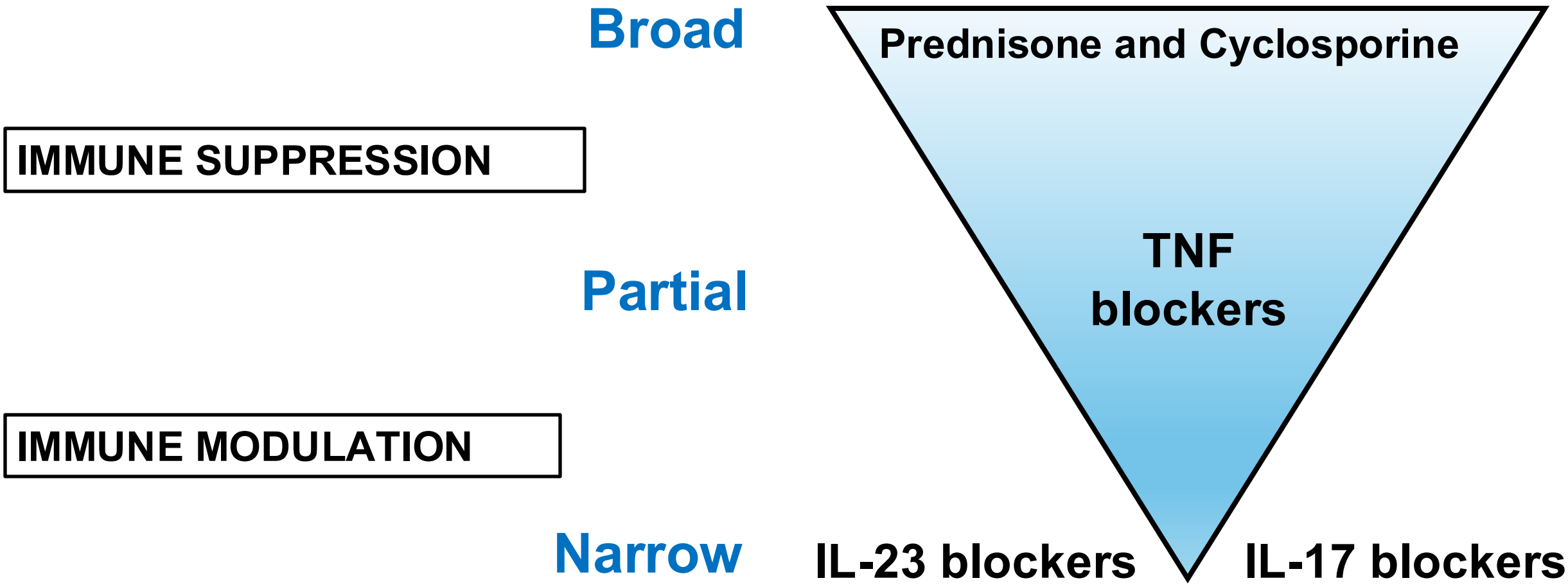




# Il-17 Is the Key *Effector* Cytokine in Psoriasis

# “Which Are the Safest Biologics for Psoriasis?”




Blauvelt A, et al. *Adv Ther*. 2023;40(8):3410-3433. Armstrong AW, et al, *Nat Rev Dis Primers*. 2025;11(1):45.

# TNFi and Other Drugs that Affect Th1 Immunity Can Impact Control of Latent Tuberculosis

- TNF is involved in granuloma formation; **TNFi** can impair granuloma formulation

- Other psoriasis drugs, like **ustekinumab** (blocks IL-12 in addition to IL-23) and **JAK inhibitors** (block a number of Th1 cytokines), can also impair granuloma formation

**JAK = Janus kinase.**

**Cavalcanti YV, et al. *Pulm Med*. 2012;2012:745483. Alsayed SSR, Gunosewoyo H. *Int J Mol Sci*. 2023;24(6):5202.**

# IL-17i and IL-23i Do Not Affect Th1 Immunity and Are Not Involved in Control of Latent Tuberculosis

- In the presence of intact Th1 immunity, IL-17 and IL-23 are not involved in granuloma formation

- **IL-17i** and **IL-23i** do not impair granuloma formulation

**Cavalcanti YV, et al. *Pulm Med*. 2012;2012:745483. Alsayed SSR, Gunosewoyo H. *Int J Mol Sci*. 2023;24(6):5202.**

# Joint position statement from the National Psoriasis Foundation Medical Board and the International Psoriasis Council on routine testing for latent tuberculosis infection prior to and during treatment of psoriasis patients with interleukin 17 or interleukin 23 inhibitors

Andrew Blauvelt [1], Bruce E Strober [2], Guy S Eakin [3], Leah McCormick Howard [3], Christy Langan [4], Peter C M van de Kerkhof [5], Lluís Puig [6], Mark G Lebwohl [7], Ricardo Romiti [8], April W Armstrong [9], Siew Eng Choon [10], Ravi Ramessur [11], Joel M Gelfand [11], Joseph F Merola [12], Kevin L Winthrop [13], Tiago Torres [14]

**Blauvelt A, et al. *J Am Acad Dermatol*. 2025:S0190-9622(25)03232-3.**

# Methods: Joint Position Statement from the NPF and the IPC

- Combined forces of two major groups, consisting of **world experts in psoriasis and infectious disease**
- Reviewed existing **basic science data, clinical trial data**, and real-world evidence on roles of IL-17i and IL-23i in latent TB infection
- Reviewed **FAERS data base** for post-marketing reports of extra-pulmonary TB
- Formulated a new **Joint Position Statement**
- Presented statement to all members (approx. 200) of the NPF medical board and councilors of the IPC for a **vote**

**FAERS = FDA Adverse Event Reporting System; FDA = Food and Drug Administration; TB = tuberculosis.**

**Blauvelt A, et al. *J Am Acad Dermatol*. 2025:S0190-9622(25)03232-3.**

# The Following Statement Was Formally Adopted by Both the NPF and the IPC

***Routine testing for latent tuberculosis infection is not required prior to or during treatment of psoriasis patients with IL-17 or IL-23 inhibitors.***

**Blauvelt A, et al. *J Am Acad Dermatol*. 2025:S0190-9622(25)03232-3.**

# Summary: Joint Position Statement

- **Exceptions** can always be made if clinicians wish to know the TB status of their patients
- Routine latent TB testing should continue for patients on **concomitant medications** that affect TB immunity, eg. corticosteroids, JAKi
- This new guideline should
  - **Decrease costs** for unnecessary medical testing
  - **Allay patient fears** over drug side effects
  - Avoid complications from **false positive tests**
  - **Simplify** and quicken initiation of therapy with IL-17i and IL-23i
  - Avoid **regulatory burden**

**Blauvelt A, et al. *J Am Acad Dermatol*. 2025:S0190-9622(25)03232-3.**

# Il-23 Blockers Are the Safest Class of Systemic Drugs for Psoriasis

- **No evidence/no signals** for
  - Serious infections
  - TB reactivation
  - Hepatitis B reactivation
  - Cancer
  - Congestive heart failure (CHF)
  - Multiple sclerosis
  - Major adverse cardiovascular events (MACE)
  - **Candidiasis (reported with all IL-17 blockers)**
  - **Inflammatory bowel disease (reported with all IL-17 blockers)**
  - **Suicide (reported with IL-17RA blockers)**
  - Laboratory or EKG abnormalities
- Long-term studies have revealed no new concerns

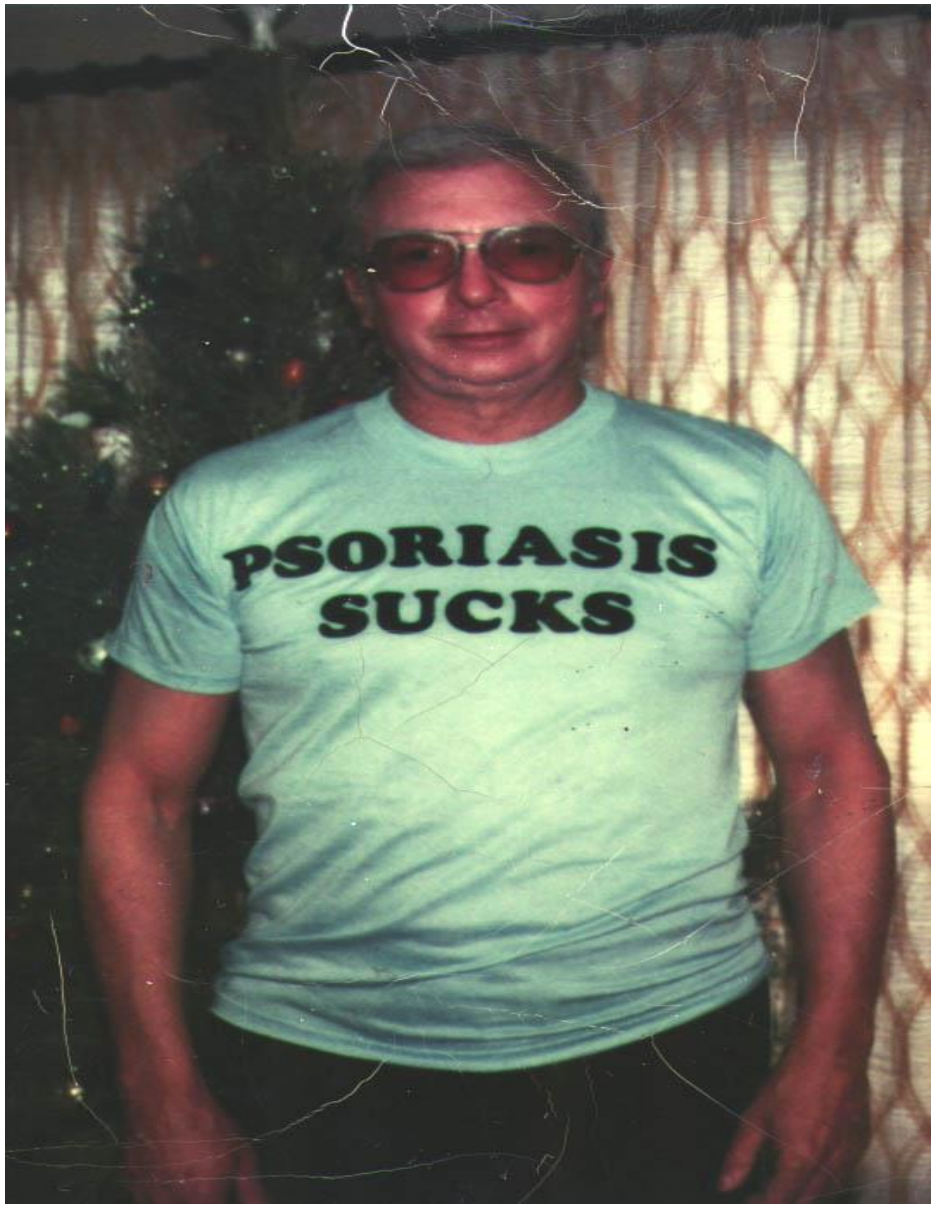
**Best biologic class to use in patients with potential safety issues, eg. patients with cancer or who are HIV+**

**Blauvelt A, et al. *Adv Ther*. 2023;40(8):3410-3433.**

# Convenience: Maintenance Dosing for Biologics

| BIOLOGIC | MOA | MAINTENANCE DOSING |
|---|---|---|
| etanercept | TNFi | every week |
| infliximab | TNFi | every 8 weeks |
| adalimumab | TNFi | every 2 weeks |
| certolizumab | TNFi | every 2 weeks |
| secukinumab | IL-17Ai | every 4 weeks |
| ixekizumab | IL-17i | every 4 weeks |
| brodalumab | IL-17RAi | every 2 weeks |
| bimekizumab | IL-17A/Fi | every 8 weeks |
| ustekinumab | IL-12/23i | every 12 weeks |
| guselkumab | iL-23i | every 8 weeks |
| tildrakizumab | IL-23i | every 12 weeks |
| risankizumab | iL-23i | every 12 weeks |

Adapted from Drugs@FDA: FDA-Approved Drugs. https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm.

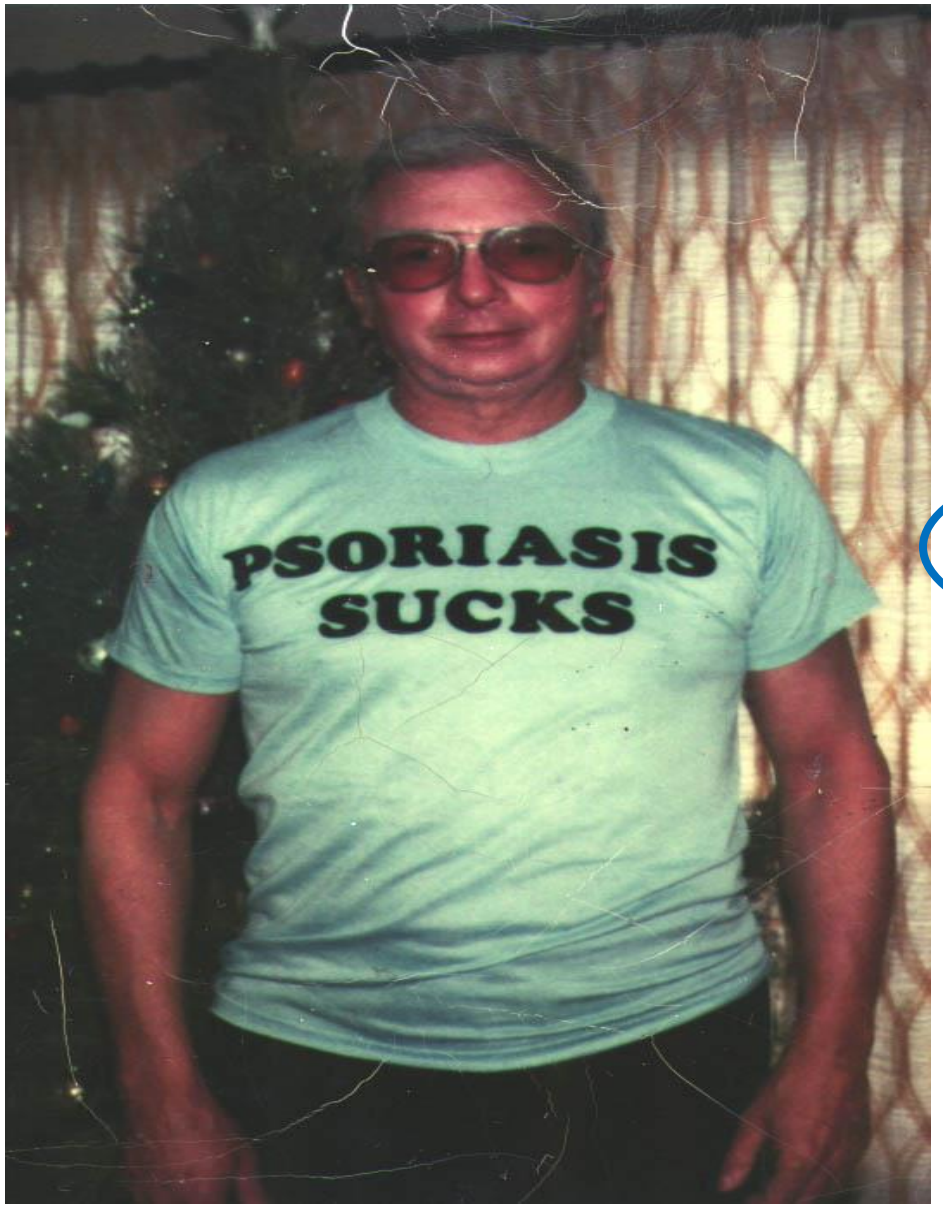



# IL-23i Deliver in All 3 Areas

- Efficacy ✓
- Safety ✓
- Convenience ✓

# Overview

- Psoriasis has a huge impact on overall quality of life
- Don’t undertreat psoriasis; treat to clearance or near clearance
- Benefits of treating psoriasis go beyond the skin
- Current biologic choices are excellent, especially IL-23 inhibitors
- **Emerging oral IL-23 inhibitors provide excellent efficacy, safety, and convenience for patients**




# IL-23i Deliver in All 3 Areas

- Efficacy ✓
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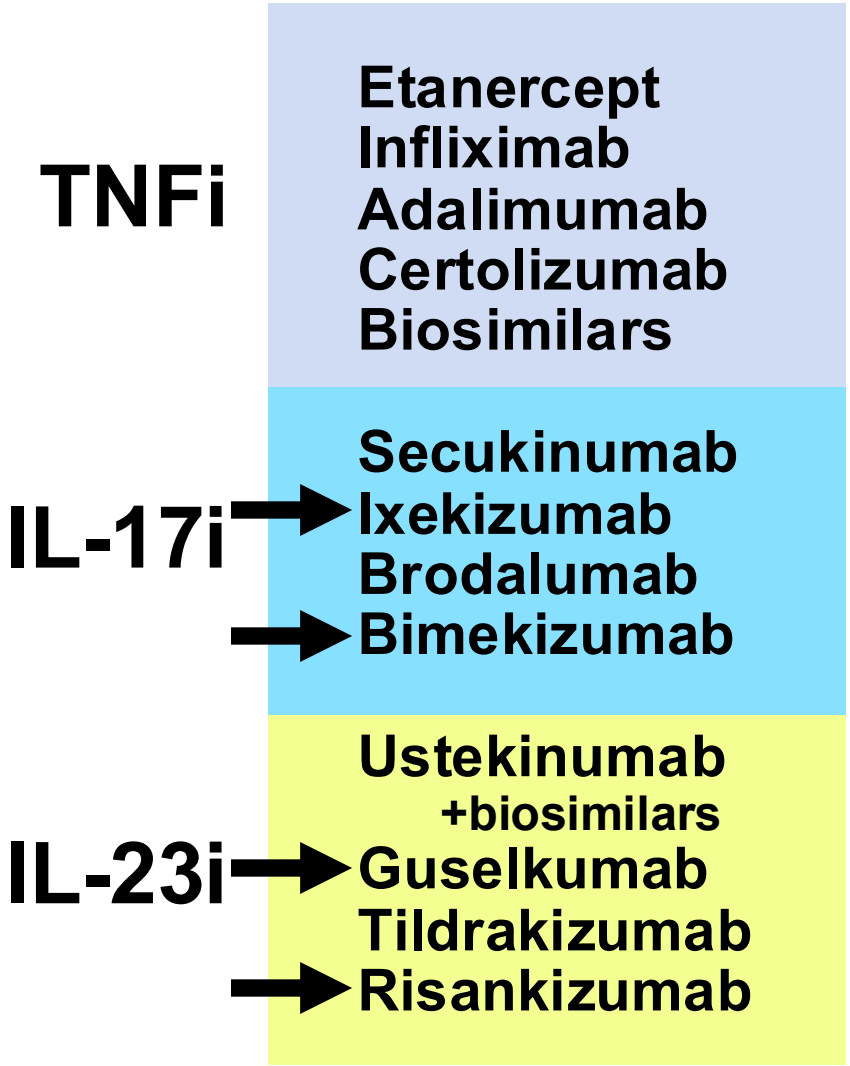
- Convenience ✓

# Current and Future Biologic and Oral Drug Choices for PsO




→ BEST IN CLASS

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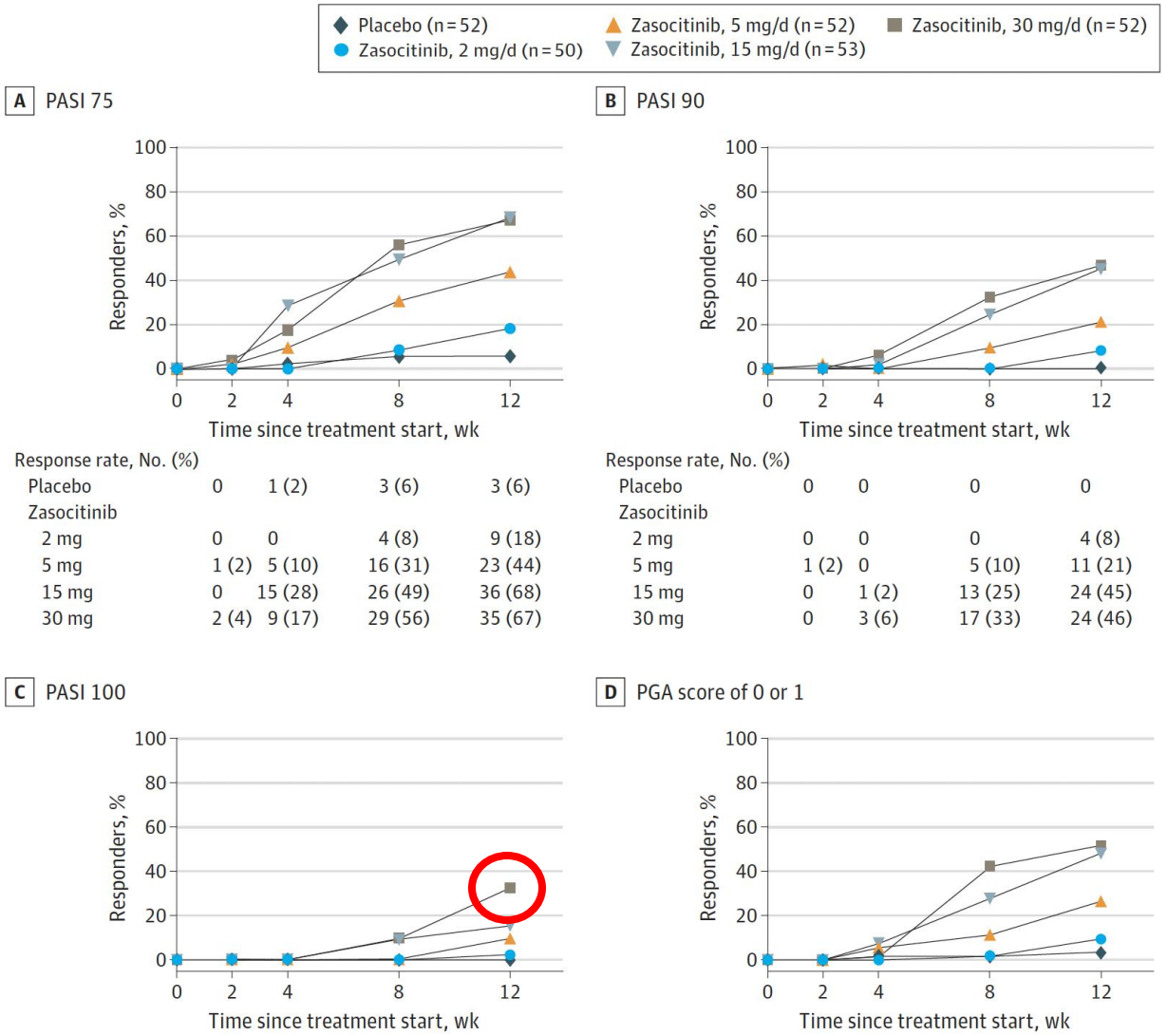
  - Zasocitinib
  - Envudeucitinib
- Cytokine inhibitors
  - Icotrokinra
  - Simepdekinra

BLUE HIGHLIGHTS = PIPELINE

# Zasocitinib: Phase 2, Short-Term Efficacy




Response rate, No. (%)

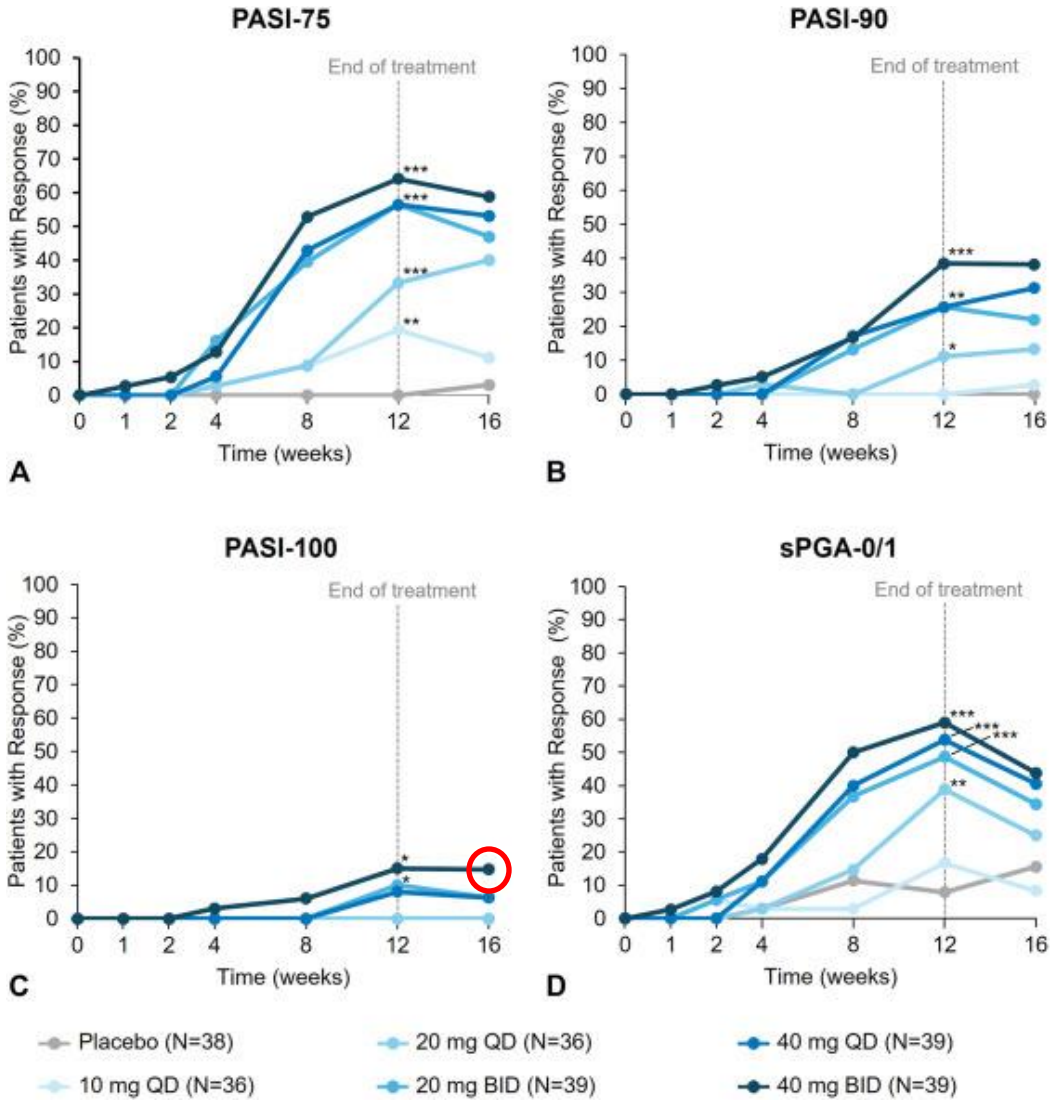
| | | | | |
|---|---|---|---|---|
| Placebo | 0 | 1 (2) | 3 (6) | 3 (6) |
| Zasocitinib | | | | |
| 2 mg | 0 | 0 | 4 (8) | 9 (18) |
| 5 mg | 1 (2) | 5 (10) | 16 (31) | 23 (44) |
| 15 mg | 0 | 15 (28) | 26 (49) | 36 (68) |
| 30 mg | 2 (4) | 9 (17) | 29 (56) | 35 (67) |

Response rate, No. (%)

| | | | | |
|---|---|---|---|---|
| Placebo | 0 | 0 | 0 | 0 |
| Zasocitinib | | | | |
| 2 mg | 0 | 0 | 0 | 4 (8) |
| 5 mg | 1 (2) | 0 | 5 (10) | 11 (21) |
| 15 mg | 0 | 1 (2) | 13 (25) | 24 (45) |
| 30 mg | 0 | 3 (6) | 17 (33) | 24 (46) |

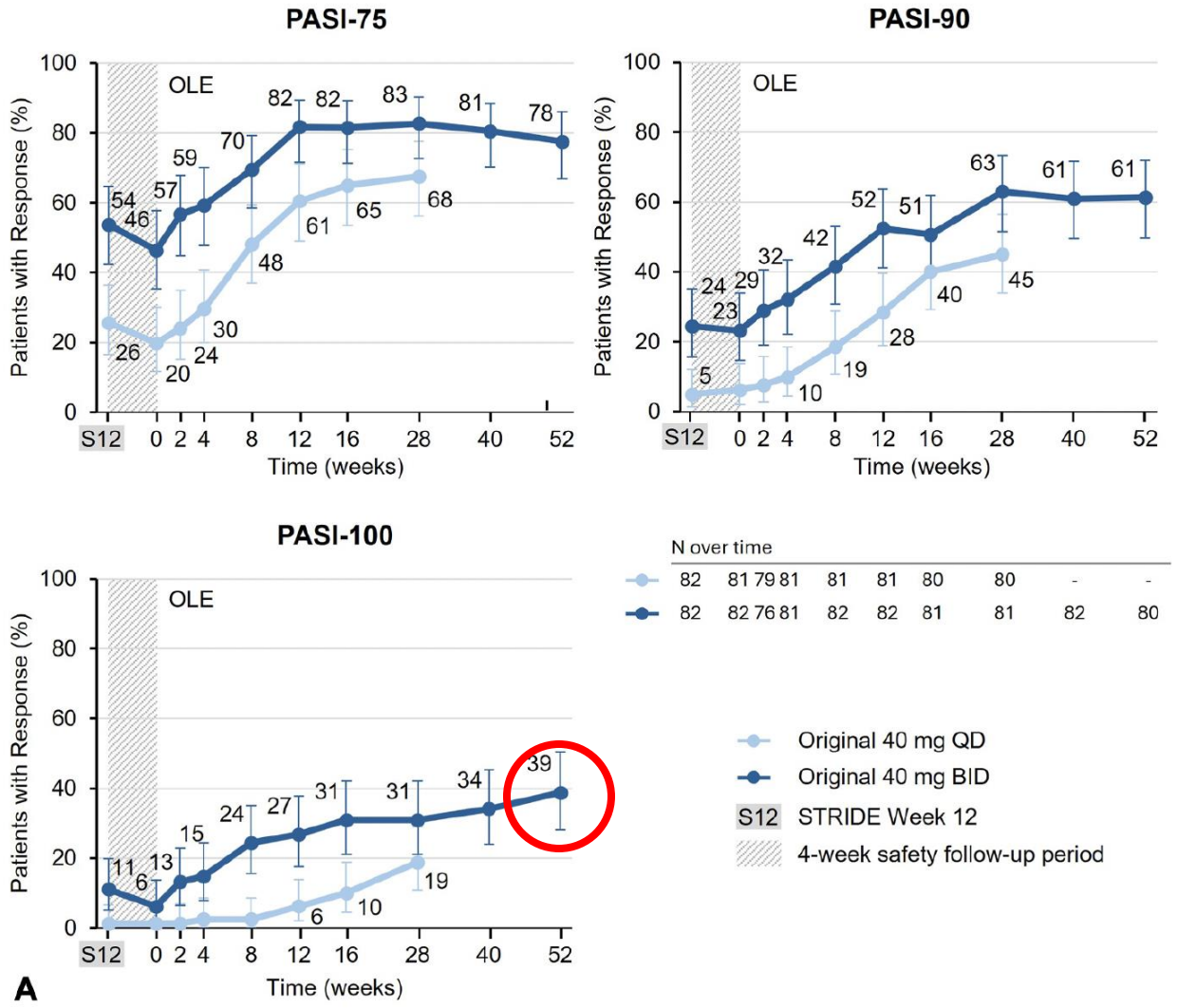
**Armstrong AW, et al. *JAMA Dermatol*. 2024;160(10):1066-1074.**

# Envudeucitinib: Phase 2, Short-Term Efficacy




Blauvelt A, et al. *J Am Acad Dermatol*. 2026;94(1):57-65.

# Envudeucitinib: Phase 2, Long-Term Efficacy

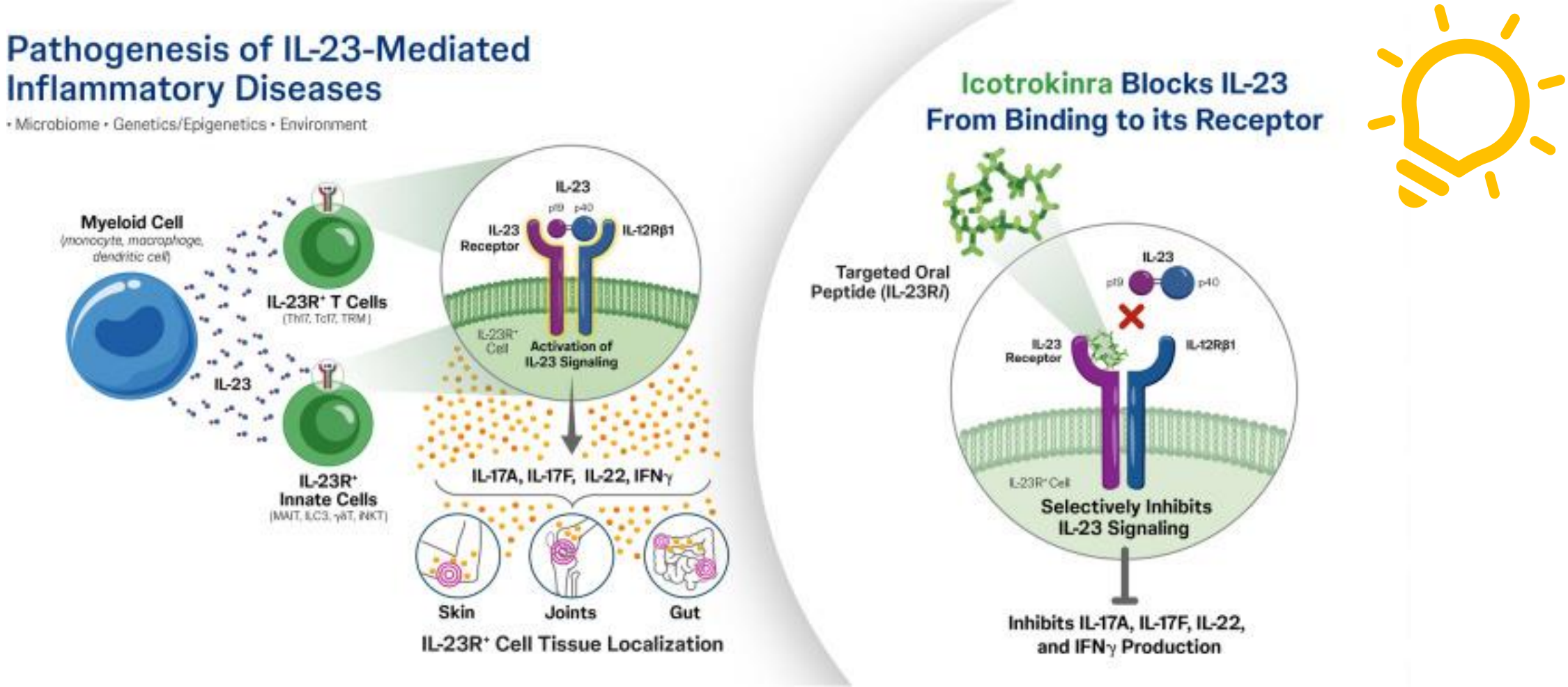



**Papp KA, et al. *J Am Acad Dermatol*. 2026;94(1):187-195.**

# Zasocitinib and Envudeucitinib Highlights

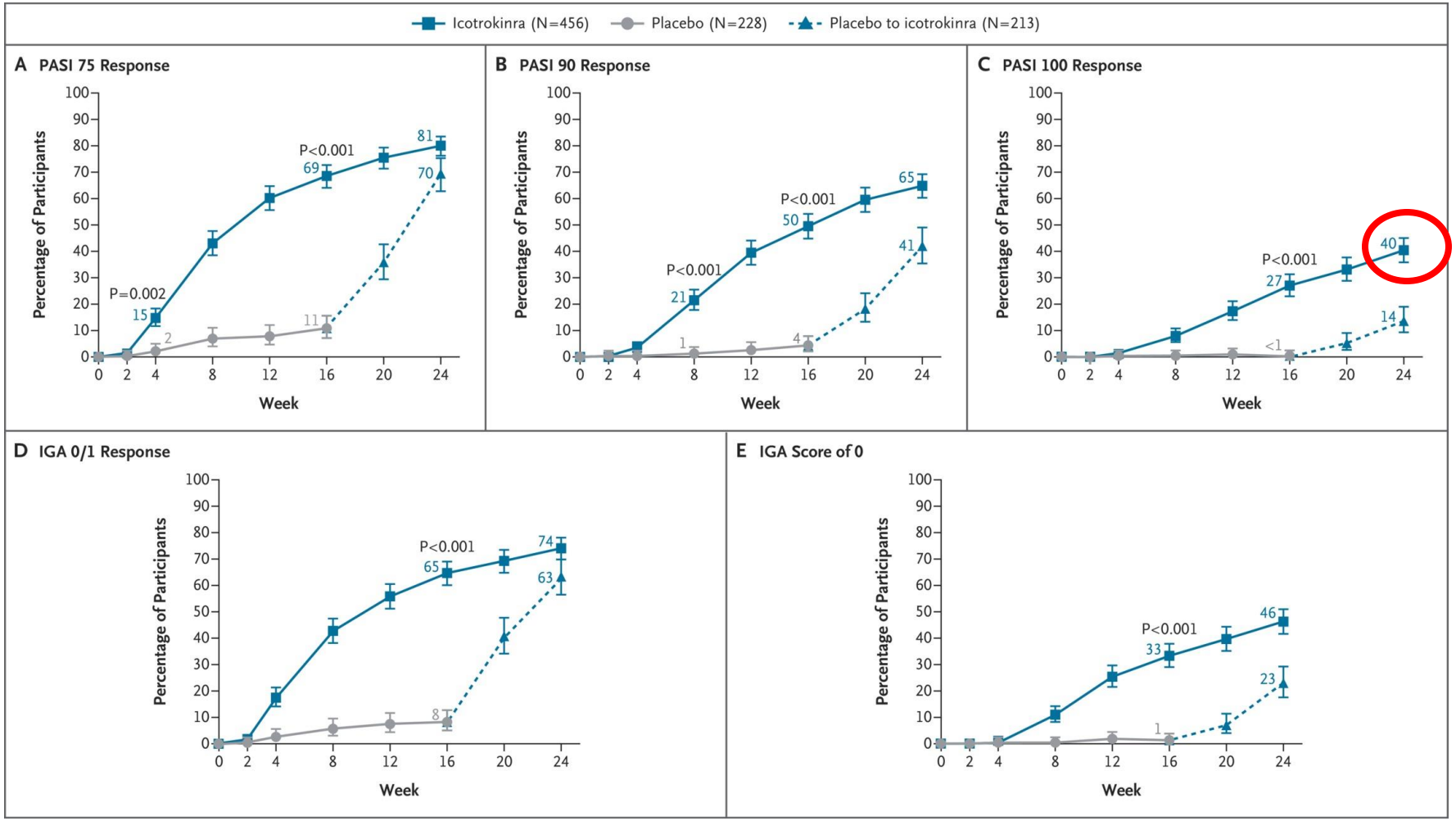
- Novel oral TYK2 inhibitors
- **Phase 2 efficacy better than deucravacitinib**
- Also being studied in **PsA** and **lupus**
- **Approvals in 2027?**

# Icotrokinra Blocks IL-23 from Binding to Its Receptor



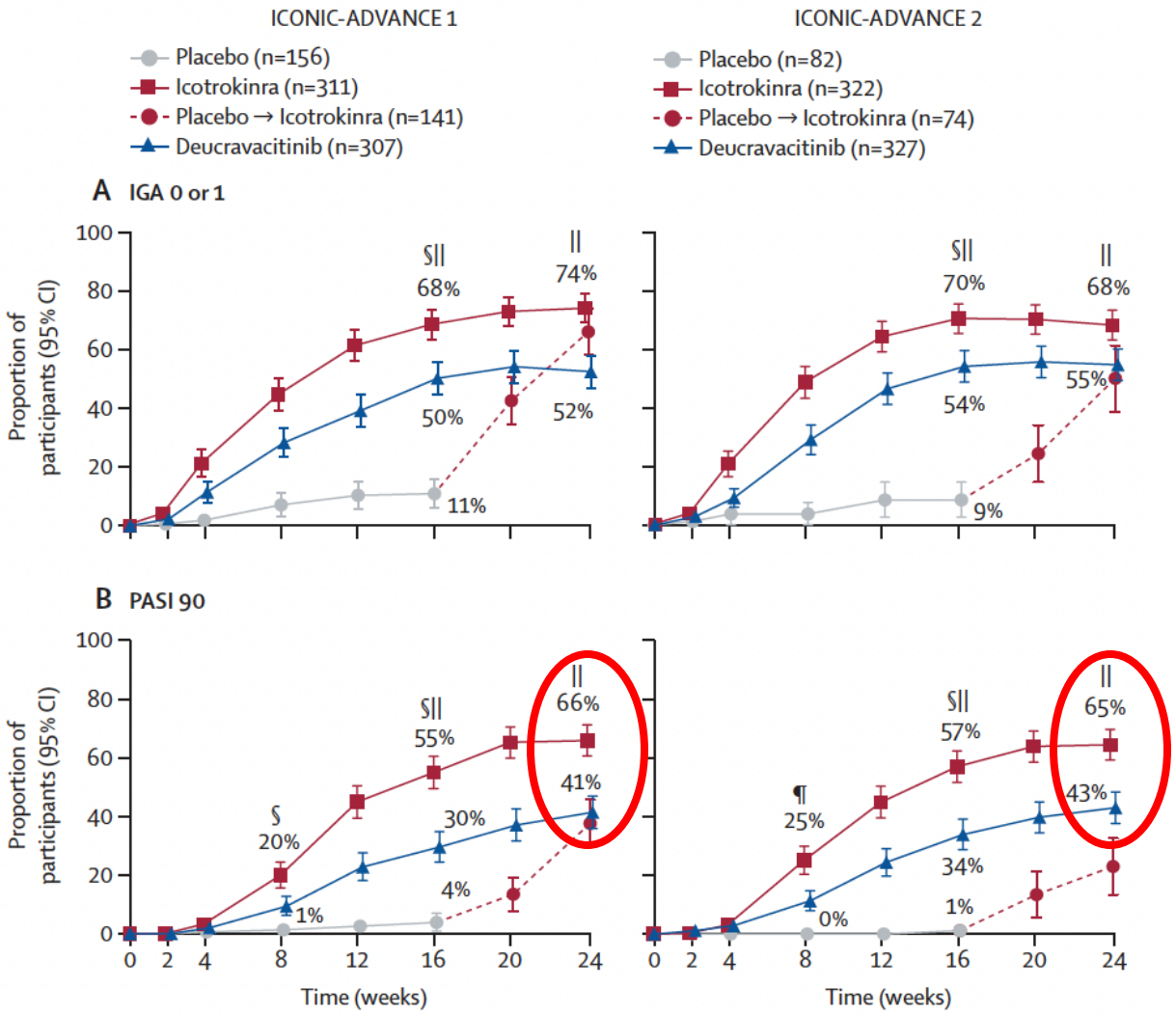

Stein Gold L, et al. *Adv Ther*. 2025;42(7):3158-3172.

# Icotrokinra: Phase 3, Short-Term Efficacy




**Bissonnette R, et al. *N Engl J Med*. 2025;393(18):1784-1795.**

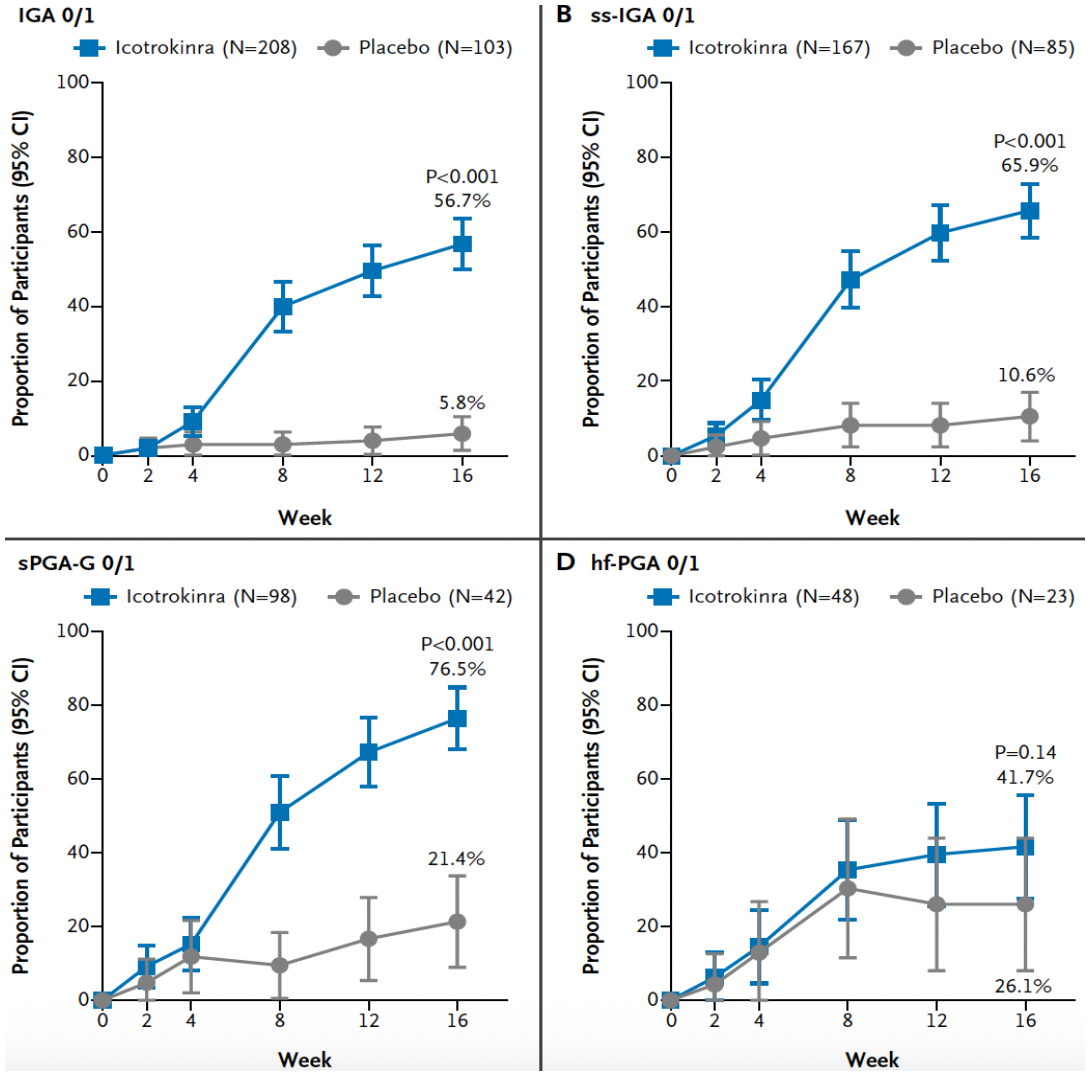
# Icotrokinra: Phase 3, Short-Term Efficacy vs Deucravacitinib




**Icotrokinra was statistically superior to deucravacitinib for both IGA 0/1 and PASI 90 in both studies**

Gold LS, et al. *Lancet*. 2025;406(10510):1363-1374.

# Icotrokinra: Efficacy in High-Impact Sites




**Gooderham M, et al. *NEJM Evid*. 2025;4(12):EVIDoa2500155.**

# Icotrokinra: Summary

- Novel oral drug
- **Targeted peptide** that binds and **blocks the IL-23 receptor**
- **Once daily** dosing on empty stomach
- **Best efficacy for oral agent** to date
- Efficacy established in **high-impact sites**
- No major safety issues
- **Approval in late 2026?**

# Key Learning Points

- Psoriasis has a huge impact on **overall quality of life**
  - About 25% of patients with psoriasis have cases that are moderate to severe
- Don’t undertreat it; **treat to clearance** or near clearance
- **Benefits of treating** psoriasis go beyond the skin
- Current **biologic choices are excellent**, especially IL-23 inhibitors
- **Emerging oral IL-23 inhibitors** provide excellent efficacy, safety, and convenience for patients

**My mentors:**
**Chuck Ellis, Bill Eaglstein, Steve Katz, Maria Turner, Fran Storrs, Bob Matheson**

masterclasses in dermatology annual meeting

PRESENTED BY THE dermatologist

# Thank you!

blauveltconsults@gmail.com