UPDATES ON EMERGING THERAPIES IN PSORIASIS MANAGEMENT

November 13, 2025

MED LEARNING GROUP

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Updates on Emerging Therapies in Psoriasis Management

PROGRAM FACULTY

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PROGRAM OVERVIEW

This educational symposium is designed to equip healthcare professionals with the skills and knowledge necessary to optimize the management of patients with psoriasis (PsO). Attendees will learn to implement comprehensive assessment tools to evaluate disease severity and determine eligibility for systemic therapy accurately. The symposium will also explore current guideline recommendations alongside efficacy and safety data to support evidence-based selection among a broad and evolving array of treatment options, including emerging oral therapies. Additionally, attendees will be guided in designing individualized treatment plans through effective shared decision-making strategies that align with patient preferences and clinical goals.

TARGET AUDIENCE

This educational activity is specifically designed for dermatology NPs and PAs, and dermatologists involved in the management of patients with plaque psoriasis.

LEARNING OBJECTIVES

Upon the completion of this program, attendees should be able to:

- Implement comprehensive assessment tools in practice to determine disease severity and systemic therapy eligibility of patients with PsO
- Analyze guideline recommendations and efficacy and safety data supporting the numerous options within the evolving PsO treatment landscape, including emerging oral options
- Design individualized PsO treatment plans utilizing shared decision-making

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Laura Bush	**Consulting Fees**: Amgen, Arcutis Biotherapeutics, Boehringer Ingelheim, Bristol Myers Squibb, Dermavant Sciences, Janssen Pharmaceuticals, Johnson & Johnson, L'Oréal, Ortho Dermatologics, Sanofi, and Takeda Pharmaceuticals **Speakers Bureaus**: Boehringer Ingelheim, Ferndale Laboratories, and UCB **Stock**: Bristol Myers Squibb, and Vertex Pharmaceuticals

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Disclosures

- **Linda Stein Gold, MD** discloses the following:
  - **Consulting Fees, Speakers Bureaus and Contracted Research:** AbbVie, Amgen, Bristol Myers Squibb, Johnson & Johnson, Lilly, and Takeda Pharmaceuticals
- **Laura Bush, DMSc, PA-C, DFAAPA** discloses the following:
  - **Consulting Fees:** Amgen, Arcutis Biotherapeutics, Boehringer Ingelheim, Bristol Myers Squibb, Dermavant Sciences, Janssen Pharmaceuticals, Johnson & Johnson, L'Oréal, Ortho Dermatologics, Sanofi, and Takeda Pharmaceuticals
  - **Speakers Bureaus:** Boehringer Ingelheim, Ferndale Laboratories, and UCB
  - **Stock:** Bristol Myers Squibb, and Vertex Pharmaceuticals
- During the course of this lecture, faculty may mention the use of medications for both US Food and Drug Administration (FDA)-approved and non-FDA-approved indications
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Learning Objectives

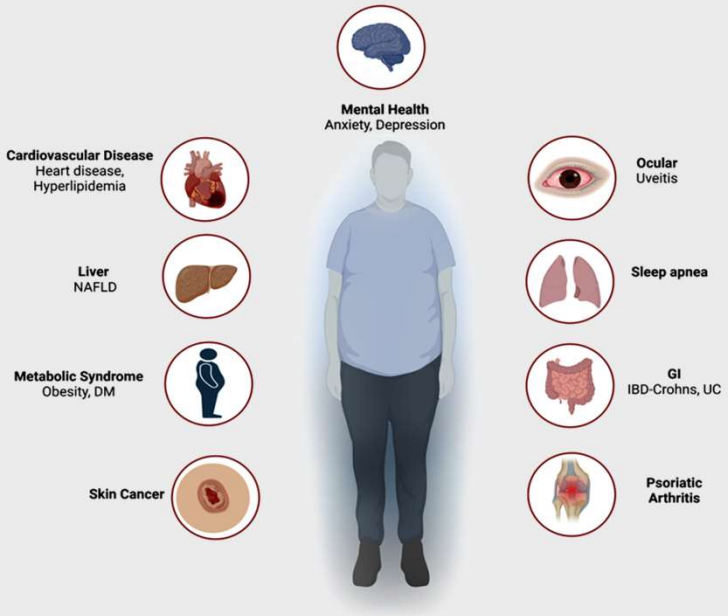
- Implement comprehensive assessment tools in practice to determine disease severity and systemic therapy eligibility of patients with psoriasis (PsO)
- Analyze guideline recommendations and efficacy and safety data supporting the numerous options within the evolving PsO treatment landscape, including emerging oral options
- Design individualized PsO treatment plans utilizing shared decision-making

We will now watch a brief animation on
the Inflammatory Pathology of Psoriasis

Understanding Psoriasis: Beyond the Skin

Inflammatory pathophysiology | Systemic comorbidities

Comorbidities of Psoriasis



Early recognition =↓ risk.

Created in https://BioRender.com

Patient-Specific Comorbidity Factors to Consider

Domain	Screening	Red flags/referral/management
Musculoskeletal/ psoriatic arthritis	Regular Psoriasis Epidemiology Screening Tool (PEST) screen Joint pain, morning stiffness, swelling, nail changes, dactylitis	New inflammatory joint symptom, >30-minute morning stiffness, nail involvement, functional limitation Comanage rheumatology
Gastrointestinal (IBD)	Personal/family history of Crohn's disease or UC Symptoms: Chronic diarrhea, abdominal pain, blood in stool, weight loss	Active GI symptoms, family history. Coordinate with GI, use dual-indication biologics
Ocular (uveitis)	Ophthalmology screen Eye pain, redness, photophobia, vision changes, history of uveitis	Acute eye symptoms, recurrent inflammation, unexplained vision deficits
Cardiovascular	Risk factors: Blood pressure (BP), lipids, smoking cessation, activity, weight	Uncontrolled risk factors, severe psoriasis, decreased exercise tolerance, smoking—refer primary care provider (PCP)
Metabolic (obesity, DM, NAFLD)	Screen glucose/lipids, monitor liver enzymes History of diabetes, obesity, liver issues; metabolic syndrome Diet/exercise	Elevated body mass index (BMI), abnormal lab test results, suspicion of fatty liver Coordinate endocrine/hepatology
Sleep apnea	Screen for high risk, weight management Snoring, witnessed apneas, daytime fatigue, or nonrestorative sleep	Obesity, hypertension (HTN), high-risk sleep symptoms CPAP, treat obesity
Mental health	Routine screening (Patient Health Questionnaire-9 [PHQ-9]) Anxiety, depression, social withdrawal, sleep/appetite changes	Persistent mood symptom, functional impairment, suicidal thoughts Therapy, support groups, coordinate care for pharmacotherapy

Taliercio M, Lebwohl M. *Dermatol Clin*. 2024;42(3):405-416.

Considerations for Selecting Treatment for Patients With Psoriasis

	Coexisting conditions						
	PsA	CD	Obesity	CV	CHF	MS	Lupus
TNF inhibitor	++	Mostly ++	Mostly +	++	–/+	X	–/+
Anti-IL-23/12	+	++	++	+	++	+	+
Anti-IL-23	+ (GIS, RIS)	+ (RIS)	++	?	++	?/+	?/+
Anti-IL-17	Mostly ++	–	++	?	++	+	?/+
Oral apremilast	+	+	Apremilast: ++	Apremilast: ?	++	Apremilast: ?/+	+
Oral MTX	+	+	MTX: X	MTX: ++	++	MTX: +	+
Anti-TYK2	+	?	?	?	?	?	+
Cyclosporine	–/+	+	+	?/-	++	+	–/+
Acetretin	–/+	+	+	?/-	++	+	+

Key: ++ = preferred agent; **+ =** can be used; **+/– =** can be used but is controversial; **?/+ =** not enough data but safe to use; **–/+ =** not preferred but can be used; **? =** not enough data; **– =** use is controversial because not enough data; **x =** contraindicated.

CD = Crohn's disease; CHF = congestive heart failure; CV = cardiovascular; GIS = Geographic Information Systems; MS = multiple sclerosis; MTX = methotrexate; PsA = psoriatic arthritis; RIS = Relative Importance Score; TNF = tumor necrosis factor; TYK2 = tyrosine kinase 2.

Modified from Kaushik SB, Lebwohl MG. *J Am Acad Dermatol*. 2019;80:27-40. Morand E, et al. *Arthritis Rheumatol*. 2023;75:242-522.

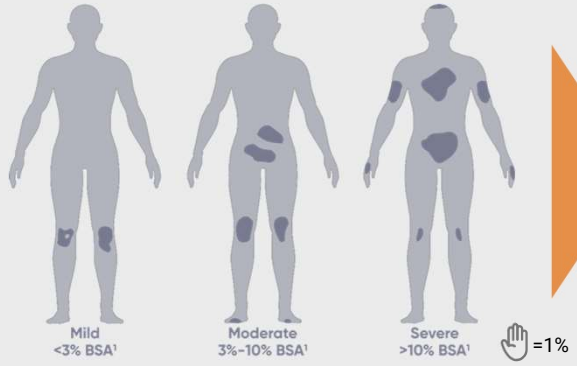
Assessment of Disease Severity and Therapeutic Management of PsO

Psoriasis Severity

A small area doesn't always mean a small burden.

Psoriasis (PsO) is traditionally evaluated by body surface area (BSA), but low-BSA involvement can still have a significant symptom impact. Patients with low BSA and high-impact site involvement often remain overlooked and undertreated; BSA alone should no longer be the only trigger for systemic therapy, including biologics.[1]

Plaque PsO severity based on BSA



Current treatment recommendations[2]

Mild PsO
- Topicals

Moderate PsO
- Topicals/phototherapy/systemic medications and including biologics if appropriate

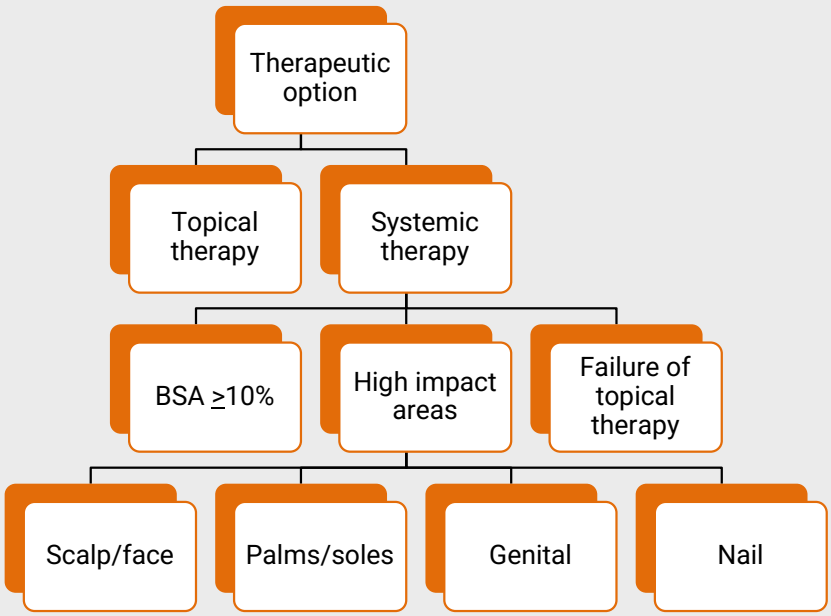
Severe PsO
- Phototherapy/systemic medications/biologics, either individually or as combination, with or without a topical agent

Plaque PsO severity is commonly determined by affected BSA.[1,2]

BSA = body surface area; PsO = psoriasis.

1. Strober B, et al. *J Am Acad Dermatol*. 2020;82(1):117-122. 2. National Psoriasis Foundation (NPF). *The Psoriasis and Psoriatic Arthritis Pocket Guide: Treatment Algorithms and Management Options.* (https://www.psoriasis.org/the-pocket-guide/). Accessed 9/26/2025.

IPC Recategorization of Psoriasis Severity



IPC = International Psoriasis Council.

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

Skin Clearance

BSA[1]

- The surface area of the hand is approximately equal to 1% of the body
- ~20% have moderate to severe plaque psoriasis

MILD	MODERATE	SEVERE
Psoriasis covers less than 3% of the body.	Psoriasis covers between 3% and 10% of the body.	Psoriasis covers more than 10% of the body.

PASI[2,3]

- Assessment of body surface area involvement and severity of plaques in 4 anatomical regions (head, trunk, arms, and legs)
- Objective measurement of treatment response
  - **PASI 75:** At least 75% improvement in PASI score from baseline
  - **PASI 90:** At least 90% improvement in PASI score from baseline
  - **PASI 100:** 100% improvement in PASI score from baseline (complete resolution of psoriasis plaques)

Increasing levels of skin clearance

PASI 75	PASI 90	PASI 100

sPGA[4]

- Physician's categorization of the patient's overall psoriatic lesions at a given time point on a 6-point scale:
- Unlike PASI, sPGA does not take BSA into account.

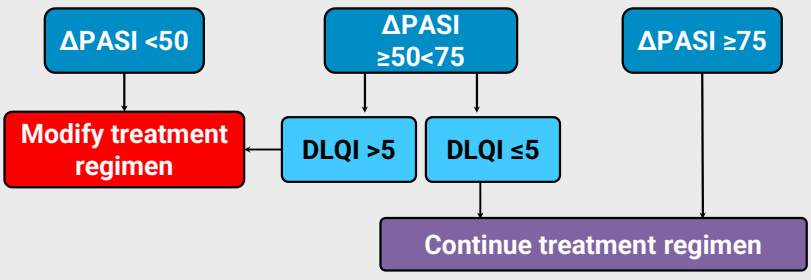
5	4	3	2	1	0
Very severe	Severe	Moderate	Mild	Minimal	Clear

BSA = Body surface area; PASI = Psoriasis Area and Severity Index; sPGA = static Physician's Global Assessment.

1. NPF. About psoriasis (https://www.psoriasis.org/about-psoriasis). Accessed 9/26/2025. 2. Menter A, et al. *J Am Acad Dermatol*. 2008;58:826-850. 3. Fredriksson T, et al. *Dermatologica*. 1978;157:238-244. 4. Chow C, et al. *J Eur Acad Dermatol Venereol*. 2015;29:1406-1414.

Nearly 20% of Almost Clear Patients in Clinical Practice Meet DLQI Criteria for Treatment Change

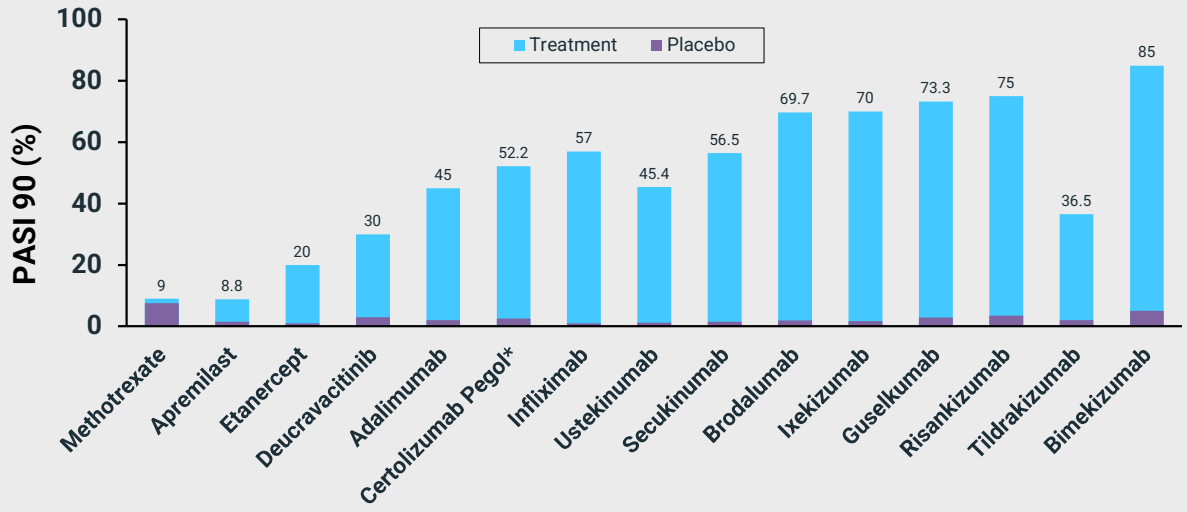
DLQI	Clear	Almost Clear	*P*-value
≥ moderate effect (DLQI >5), n (%)	2 (2.1)	85 (19.3)	< .001



DLQI = Dermatology Life Quality Index.

Takeshita J, et al. *J Am Acad Dermatol*. 2014;71:633-641. Mrowietz U, et al. *Arch Dermatol Res*. 2011;303:1-10.

Biologics and Commonly Used Oral Treatments: PASI 90 Response



*400 mg dose every 2 weeks.

Data derived from respective product labels. Saurat JH, et al. *Br J Dermatol*. 2008;158:558-566. Blauvelt A, et al. *J Am Acad Dermatol*. 2017;76:405-417. Reich K, et al. *Lancet*. 2017;390:276-288. Farahnik B, et al. *Dermatol Ther (Heidelb)*. 2016;6:111-124. Woolacott N, et al. *Health Technol Assess*. 2006;10:1-233. Reich K, et al. *Lancet*. 2005;366:1367-1374. PR Newswire. News release 10/26/2017 (www.prnewswire.com/news-releases/risankizumab-meets-all-co-primary-and-ranked-secondary-endpoints-achieving-significantly-greater-efficacy-versus-standard-biologic-therapies-in-three-pivotal-phase-3-psoriasis-studies-300543919.html). Accessed 9/26/2025. Menter A, et al. *J Am Acad Dermatol*. 2008;58:106-115. Reich K, et al. *Lancet*. 2021;397:487-498.

Selected Clinically Important Biologic AEs

Biologic	Common (> 5%)	Uncommon (0.1%–5%)	Rare (<0.1%)	Black Box
TNF inhibitors (adalimumab, etanercept, infliximab, certolizumab)	Injection-site reaction, + ANA, URTI, UTI, arthralgia, elevated AP/ cholesterol/LFT, infusion-related reactions	Neutralizing antibodies, **serious infections,** allergic reactions **malignancy,** hypersensitivity, headache, cough, herpes infection	TB, lupus-like syndrome, hepatitis B reactivation, hypersensitivity, **demyelination, CHF,** pancytopenia, severe hepatic injury, opportunistic infection, heart failure, autoantibodies	**Serious infections:** Increased risk of serious infections leading to hospitalization or death, including TB, bacterial sepsis, invasive fungal infections; **Malignancy:** Lymphoma and other malignancies; some fatal
IL-12/23 and IL-23 inhibitors (ustekinumab, guselkumab, tildrakizumab, risankizumab)	Nasopharyngitis, upper respiratory infection, headache	**Serious infections (≤0.4%)*, malignancy,** increased LFTs, migraine, mucocutaneous candida, urticaria, injection-site reactions diarrhea, dizziness, fatigue, tinea infections, folliculitis	**Reversible posterior leukoencephalopathy Noninfectious pneumonia (interstitial, eosinophilic, cryptogenic organizing)**	None

AE = adverse event; ANA = antinuclear antibody; AP = alkaline phosphatase; CHF = congestive heart failure; LFT = liver function test; TB = tuberculosis; URTI = upper respiratory tract infection. *Specific warning—serious infection from placebo-controlled period.

Adalimumab (Humira®) Prescribing information (PI) 2024 (www.rxabbvie.com/pdf/humira.pdf). Etanercept (Enbrel®) PI 2022 (https://www.enbrel.com). Infliximab (Remicade®) PI 2021 (www.janssenlabels.com/package-insert/product-monograph/prescribing-information/REMICADE-pi.pdf). Certolizumab (Cimzia®) PI 2024 (www.cimzia.com/themes/custom/cimzia/docs/CIMZIA_full_prescribing_information.pdf). Ustekinumab (Stelara®) PI 2019 (www.janssenlabels.com/package-insert/product-monograph/prescribing-information/STELARA-pi.pdf). Guselkumab (Tremfya®) PI 2025 (www.janssenlabels.com/package-insert/product-monograph/prescribing-information/TREMFYA-pi.pdf). Tildrakizumab (Ilumya®) PI 2024 (www.ilumyapro.com). Risankizumab (Skyrizi®) PI 2025 (www.rxabbvie.com/pdf/skyrizi_pi.pdf). URLs accessed 9/26/2025.

Selected Clinically Important Biologic AEs

Biologic	Common (>5%)	Uncommon (0.1%–5%)	Rare (<0.1%)	Black Box (brodalumab)
IL-17 Inhibitors (secukinumab, ixekizumab, brodalumab, bimekizumab)	Nasopharyngitis, upper respiratory tract infection (URTI), eczematous eruptions, injection-site reactions, oral candidiasis	**Serious infections (0.14–0.5%)*** Mucocutaneous candida, URTI, **IBD*,** nausea, tinea infection, arthralgia, headache, neutropenia, herpes simplex, gastroenteritis, fatigue	**Exacerbation/new onset IBD*, Crohn's disease***	**Suicidal ideation and behavior:** Evaluate history of depression/suicidal behavior; brodalumab only available through REMS program

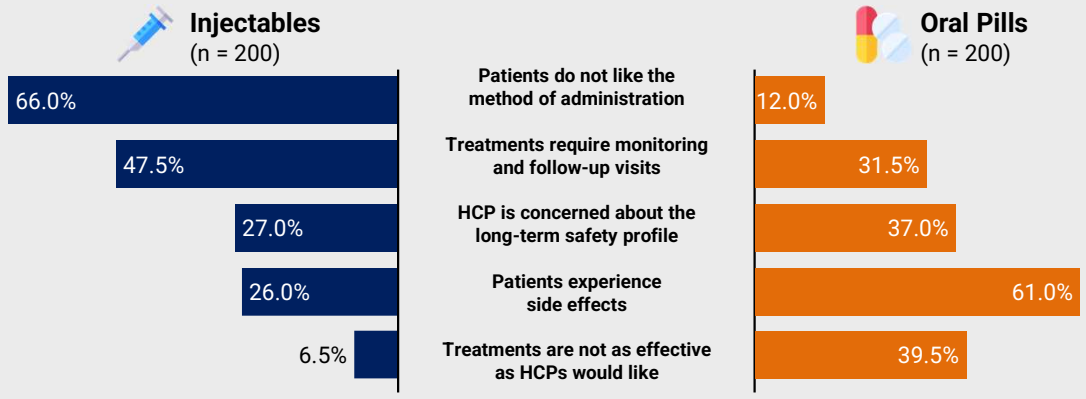
*Specific warning—serious infection from placebo-controlled period.

IBD = inflammatory bowel disease; REMS = Risk Evaluation and Mitigation Strategy.

Secukinumab (Cosentyx®) PI 2020 (www.novartis.com/us-en/sites/novartis_us/files/cosentyx.pdf). Ixekizumab (Talz®) PI 2024 (https://uspl.lilly.com/taltz/taltz.html#pi). Brodalumab (Siliq®) PI 2024 (https://www.siliq.com). URLs accessed 9/26/2025.

Unmet Needs of Adults With Psoriasis and Clinicians Treating Psoriasis in the US

HCP-Reported Clinical Disadvantages: Injectables vs Newer Oral Therapies*



"Lack of Affordability/Insurance Coverage" was the TOP overall disadvantage (not shown on graph) across both treatment types

Answers were not mutually exclusive. 'Newer Oral Treatments' included apremilast, deucravacitinib, or others.
HCP = healthcare provider.

Stein Gold, et al. Poster presented at 2025 American Academy of Dermatology (AAD) Innovation Academy. July 10–13, 2025, Chicago, Illinois, USA.

Emerging Oral Therapies: Currently Under Investigation in Clinical Trials

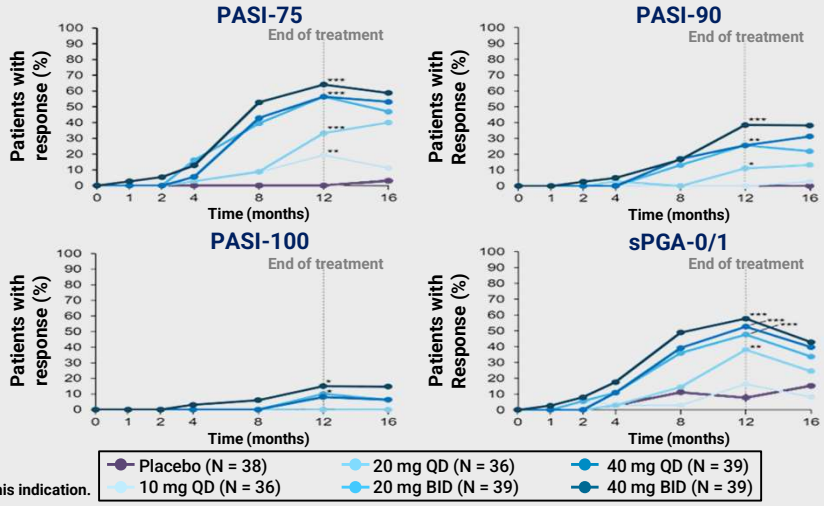
ESK-001 in Patients With Moderate to Severe Plaque Psoriasis: Results From STRIDE, a 12-Week, Randomized, Double-Blinded, Placebo-Controlled, Dose-Ranging Phase 2 Study

- Background: ESK-001, a novel allosteric, highly selective oral TYK2 inhibitor in development for treatment of immune-mediated disorders, was well-tolerated, and achieved high levels of target inhibition in phase 1 studies with healthy volunteers
- Objective: To assess the clinical efficacy, safety, and pharmacokinetics of ESK-001 compared to placebo in patients with moderate to severe plaque psoriasis
- Methods: STRIDE was a phase 2, double-blinded, 16-week study with patients randomized to 6 treatment groups for 12 weeks of placebo or ESK-001, ranging from 10 mg QD to 40 mg BID

ESK-001 is not FDA-approved for this indication.

Blauvelt A, et al. *J Am Acad Dermatol*. 2025 (https://doi.org/10.1016/j.jaad.2025.07.013). Accessed 9/26/2025.

Highly Selective, Allosteric Inhibition of TYK2 With Oral ESK-001 in Patients With Moderate to Severe Plaque Psoriasis: Results From STRIDE, a 12-Week, Randomized, Double-Blinded, Placebo-Controlled, Dose-Ranging Phase 2 Study



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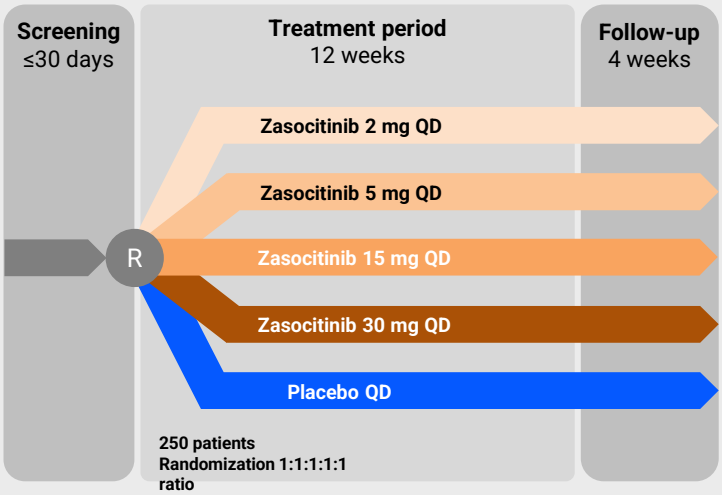
Summary of TEAEs in STRIDE study (safety analysis set)

	Placebo (N = 38)	ESK-001 10 mg QD (N = 36)	ESK-001 20 mg QD (N = 36)	ESK-001 20 mg BID (N = 39)	ESK-001 40 mg QD (N = 39)	ESK-001 40 mg BID (N = 39)	ESK-001 Pooled (N = 189)
TEAEs, n (%)	15 (39.5)	19 (52.8)	14 (38.9)	18 (46.2)	19 (48.7)	25 (64.1)	95 (50.3)
TEAEs leading to treatment discontinuation, n (%)*	0 (0.0)	0 (0.0)	2 (5.6)	0 (0.0)	2 (5.1)	1 (2.6)	5 (2.6)
TEAEs ≥ grade 3, n (%)	0 (0.0)	3 (8.3)	1 (2.8)	3 (7.7)	3 (7.7)	0 (0.0)	10 (5.3)
TEAEs related to study drug, n (%)	5 (13.2)	3 (8.3)	3 (8.3)	5 (12.8)	7 (17.9)	9 (23.1)	27 (14.3)
Most frequent TEAEs, n (%)†							
Headache‡	2 (5.3)	0 (0.0)	2 (5.6)	3 (7.7)	4 (10.3)	3 (7.7)	12 (6.3)
Upper respiratory tract infection§	0 (0.0)	2 (5.6)	2 (5.6)	1 (2.6)	2 (5.1)	3 (7.7)	10 (5.3)
Nasopharyngitis§	3 (7.9)	2 (5.6)	0 (0.0)	1 (2.6)	1 (2.6)	3 (7.7)	7 (3.7)
SAEs, n (%)§	0 (0.0)	1 (2.8)	0 (0.0)	3 (7.7)	1 (2.6)	0 (0.0)	5 (2.6)
Deaths, n (%)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)

† TEAEs reported by 3 or more patients in any treatment group. ‡ All events of headache were grade 1 (mild) or grade 2 (moderate) in severity and most were resolved by the end of the study. § All events of upper respiratory tract infection and nasopharyngitis were grade 1 (mild) or grade 2 (moderate) in severity and all were resolved by the end of the study. ‖ SAEs: lower limb fracture (10 mg QD), tibia fracture (20 mg BID), coronary artery occlusion (20 mg BID), enterocolitis (20 mg BID), dermatitis contact (40 mg QD); all assessed by investigators as unrelated to a study drug.
BID = twice daily; N = total number of patients; n = number of patients in specific category; QD = once daily; SAE = serious adverse event; TEAE = treatment-emergent adverse event.

Blauvelt A, et al. *J Am Acad Dermatol*. 2025 (https://doi.org/10.1016/j.jaad.2025.07.013). Accessed 9/26/2025. ESK-001 is not FDA-approved for this indication.

Phase 2b in Psoriasis Study Design: NCT04999839 (USA, Canada)



Key eligibility criteria

- Aged 18 to 70 years
- Plaque psoriasis for ≥6 months
  - PASI ≥12
  - PGA ≥3
  - BSA ≥10%
- Candidate for phototherapy or systemic therapy

Primary endpoint

- PASI 75 at Week 12

Secondary endpoints

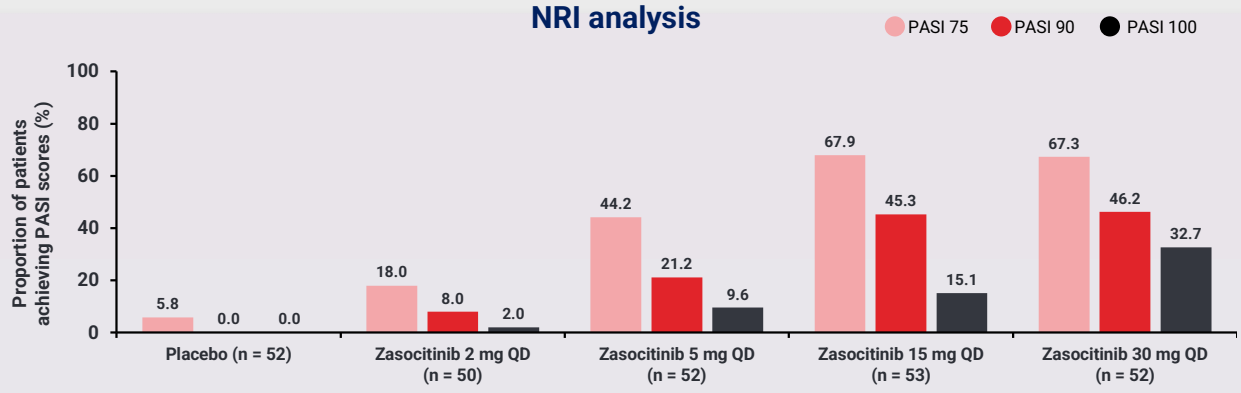
- PGA 0/1 at Week 12
- PASI 90 at Week 12
- PASI 100 at Week 12
- Change from baseline in DLQI at Week 12

Zasocitinib is not FDA-approved for this indication.

BSA = body surface area; DLQI = Dermatology Life Quality Index; PASI = psoriasis area and severity index; PGA = physician's global assessment; QD = once daily; R = randomization.

Armstrong A. American Academy of Dermatology (AAD) 2023: Abstract S025.

Phase 2b in Patients With Psoriasis Achieving PASI 75, 90, or 100 at Week 12



The primary endpoint of PASI 75 was met with the 5 mg, 15 mg, and 30 mg doses at Week 12; secondary endpoints of PASI 90 and PASI 100 at Week 12 were also met with these doses.

Zasocitinib is not FDA-approved for this indication.

P-values from a Cochran-Mantel-Haenszel test, with prior biologic treatment included as a stratification factor, comparing the proportion of patients in the treatment group versus placebo. For secondary endpoints (PASI 90 and PASI 100), *P*-values are nominal: *$p<.05$; **$p<.005$; ***$p<.001$. mITT analysis set: All patients who were randomized and received at least 1 dose of study treatment.

mITT = modified intent-to-treat; NRI = nonresponder imputation; PASI = psoriasis area and severity index; QD = once daily.

Armstrong A. AAD 2023; Abstract S025.

Phase 2b in Psoriasis Safety Summary

AE, n (%)	Placebo (n = 52)	Zasocitinib 2 mg QD (n = 50)	Zasocitinib 5 mg QD (n = 52)	Zasocitinib 15 mg QD (n = 53)	Zasocitinib 30 mg QD (n = 52)
Deaths	0	0	0	0	0
SAEs	0	0	0	1 (1.9)	0
AEs	23 (44.2)	31 (62.0)	28 (53.8)	28 (52.8)	31 (59.6)
AEs leading to discontinuation*	1 (1.9)	1 (2.0)	1 (1.9)	1 (1.9)	2 (3.8)
Most frequent AEs†					
COVID-19	1 (1.9)	6 (12.0)	4 (7.7)	6 (11.3)	7 (13.5)
Acne	0	0	1 (1.9)	3 (5.7)	2 (3.8)
Acneiform dermatitis	0	0	1 (1.9)	1 (1.9)	3 (5.8)
Diarrhea	1 (1.9)	3 (6.0)	1 (1.9)	1 (1.9)	0

The most frequent AEs (defined as those that occurred in 3 or more patients in any group) included COVID-19, acne, acneiform dermatitis, and diarrhea.

Zasocitinib is not FDA-approved for this indication.

*AEs leading to drug discontinuation and early termination in 5 patients included: Increased CPK (30 mg), pericardial effusion and pleural effusion (15 mg), tachycardia and syncope (5 mg), lymphocyte count decreased (2 mg), and atrial fibrillation (placebo); 1 additional patient (30 mg) permanently discontinued the study drug due to an AE of hypertensive urgency but remained on the study. No patients discontinued owing to COVID-19. †AEs reported by ≥3 patients in any treatment group (events elicited by laboratory testing are not included).

AE = adverse event; COVID-19 = coronavirus disease 2019; CPK = creatine kinase; QD = once daily; SAE = serious adverse event.

Armstrong A. AAD 2023; Abstract S025.

Phase 2b in Psoriasis Treatment-Emergent LABORATORY SHIFTS GRADE ≥3

Treatment-emergent laboratory shifts CTCAE Grade ≥3, n (%)*†‡[1]	Placebo (n = 52)	Zasocitinib 2 mg QD (n = 50)	Zasocitinib 5 mg QD (n = 52)	Zasocitinib 15 mg QD (n = 53)	Zasocitinib 30 mg QD (n = 52)
Neutropenia	1 (2)	1 (2)	0	0	1 (2)
Lymphopenia	1 (2)	1 (2)	0	0	0
Anemia	0	0	0	0	0
Thrombocytopenia	0	0	0	0	0
CPK elevation	1 (2)	0	0	1 (2)	1 (2)
ALT elevation	0	0	0	0	0
AST elevation	0	0	0	0	0
Creatinine elevation	0	0	0	0	0
Cholesterol elevation, Week 12	0	0	0	0	0
TG elevation, Week 12	1 (2)	1 (2)	0	1 (2)	1 (2)
Worsening of proteinuria	0	0	0	0	0

Grade ≥3 shifts occurred at a similar frequency in the placebo group compared with the active groups.

Zasocitinib is not FDA-approved for this indication.

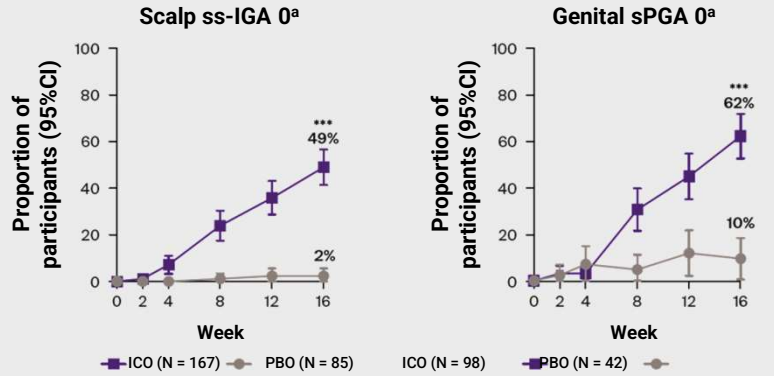
*Post hoc analysis; percent rounded up to nearest integer. †Treatment-emergent and ≥1-grade increase from baseline. ‡Per the protocol, all AEs were graded according to the National Cancer Institute CTCAE, version 5. AEs were graded 1–5. A Grade 3 event was classified as severe or medically significant but not immediately life-threatening; hospitalization indicated; disabling; limiting self-care activities of daily living (referring to bathing, dressing and undressing, feeding self, using the toilet, taking medications, and not bedridden).[2]

AE = adverse event; ALT = alanine aminotransferase; AST = aspartate aminotransferase; CPK = creatine kinase; CTCAE = Common Terminology Criteria for Adverse Events; QD = once daily; TG = triglyceride.

1. Armstrong AW, Gooderham M, Lynde C, et al. *JAMA Dermatol*. 2024;160(10):1066-1074. doi:10.1001/jamadermatol.2024.27012. National Institutes of Health (NIH). Common terminology criteria for adverse events (CTCAE), version 5.0. (https://ctep.cancer.gov/protocoldevelopment/ electronicapplications/docs/ctcae_v5_quick_reference_5x7.pdf). Accessed 9/26/2025.

Icotrokinra (JNJ-2113): Phase 3 ICONIC-TOTAL Efficacy in Special Sites at Week 16

Clearance of scalp and genital psoriasis



Higher rates of completely clear scalp and genital psoriasis were achieved with icotrokinra vs placebo.

Similar trend was seen in hand/foot clearance.

Icotrokinra is not FDA-approved for this indication.

***Nominal *P*< .001 vs PBO.[b]

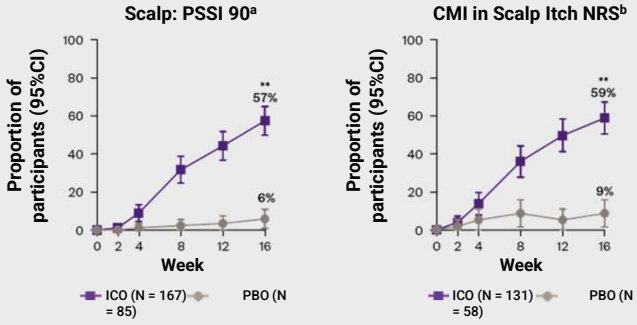
[a]Among patients with a baseline ss-IGA score, SPGA-G score, or hf-PGA score 23. [b]*P*-values were based on Cochran-Mantel-Haenszel chi-square test stratified by geographic region and/or BSA category.

hf-PGA = Physician's Global Assessment of hands and feet; ICO = icotrokinra; PBO = placebo; ss-IGA = scalp-specific Investigator's Global Assessment; sPGA-G = static Physician's Global Assessment of Genitalia

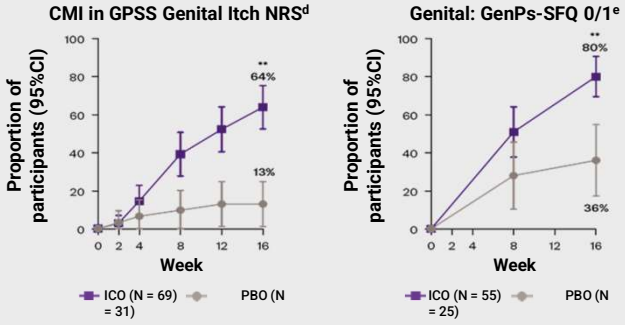
Gooderham MJ, et al. Society for Investigative Dermatology (SID) 2025; Abstract LB1142 (later published in Gooderham MJ, et al. *J Invest Dermatol*. 2025;145(8)(suppl):S199).

Icotrokinra (JNJ-2113): Phase 3 ICONIC-TOTAL Efficacy in Special Sites at Week 16

Scalp psoriasis severity and itch



Genital itch and impact on sexual activity



Early separation between icotrokinra and placebo

Significant improvements in itch and sexual activity

**Multiplicity-adjusted *P*< .01 vs PBO.*

[a]Among patients with a baseline ss-IGA score ≥3. [b]Among patients with baseline Scalp Itch NRS score 24 and a ss-IGA score ≥3. [c]*P*-values were based on Cochran-Mantel-Haenszel chi-square test stratified by geographic region and BSA category. [d]Among patients with a baseline GPSS Genital Itch NRS score (Item 1) 24 and a sPGA-G score 23. [e]Among patients with a baseline GenPs-SFQ score (Item 2) ≥2 and a sPGA-G score ≥3. [f]*P*-values were based on Cochran-Mantel-Haenszel chi-square test stratified by BSA category.

CMI = clinically meaningful improvement (≥4-point improvement from baseline); GenPs-SFQ = Genital Psoriasis Sexual Frequency Questionnaire; GPSS = Genital Psoriasis Symptoms Score; ICO = icotrokinra; NRS = numeric rating scale; PBO = placebo; PSSI 90 = reduction from baseline of ≥90% in the Psoriasis Scalp Severity Index score.

Gooderham MJ, et al. SID 2025; Abstract LB1142 (later published Gooderham MJ, et al. *J Invest Dermatol*. 2025;145(8)(suppl):S199).

Icotrokinra is not FDA-approved for this indication.

ICONIC-ADVANCE 1 and ICONIC-ADVANCE 2 – Study Design

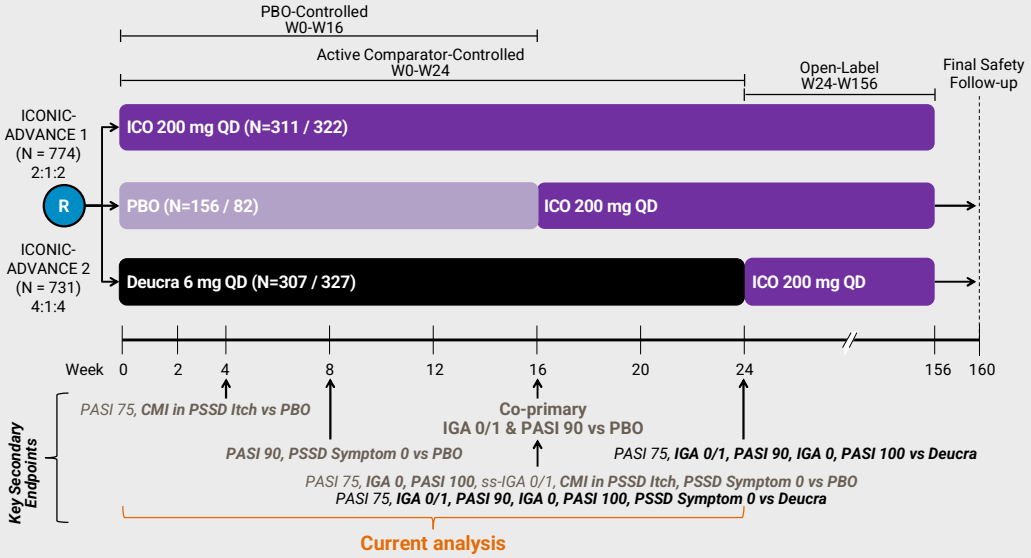
Moderate-to-severe plaque PsO

Key inclusion criteria

- ≥18 years
- Plaque PsO for ≥26 weeks
- BSA ≥10%; PASI score ≥12; IGA score ≥3
- Candidate for phototherapy or systemic treatment for plaque PsO
- Suitable candidate for Deucra per approved product labeling

Co-primary endpoints

- IGA score 0/1 and ≥2-grade improvement from baseline (IGA 0/1) vs PBO at W16
- PASI 90 vs PBO at W16



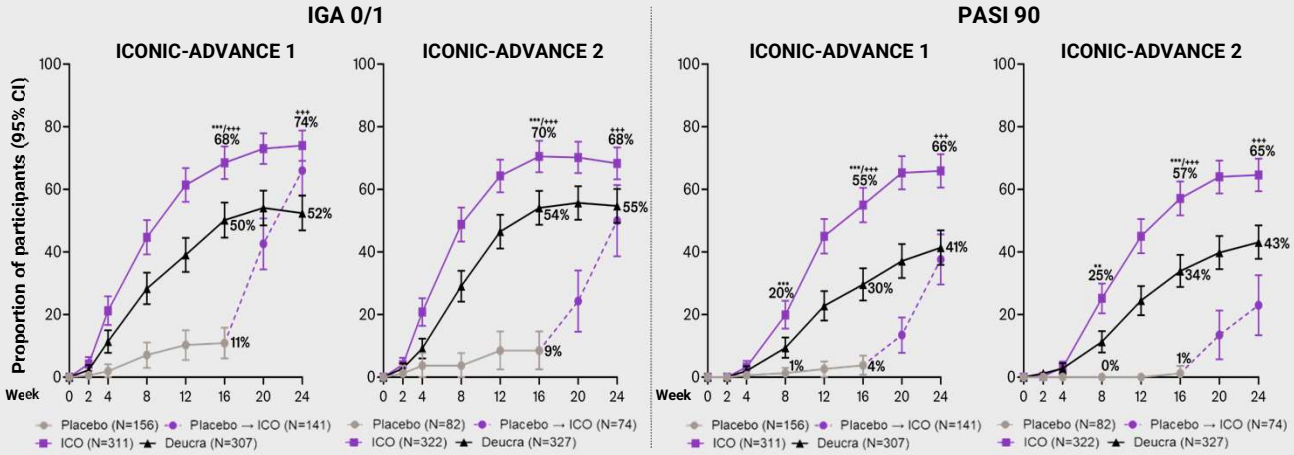
Bolded co-primary and key secondary endpoints presented in results. Participants (pts) with the following intercurrent events were considered as nonresponders: discontinued study drug due to a lack of efficacy or AE of worsening PsO, or initiated prohibited medication that could impact PsO. After accounting for these intercurrent events, nonresponder imputation was applied to pts with missing data.

AE = adverse event, BSA = body surface area, CMI = clinically meaningful improvement (≥4-point improvement from baseline), Deucra = deucravacitinib, ICO = icotrokinra, IGA = Investigator's Global Assessment, PASI = Psoriasis Area and Severity Index, PBO = placebo, PsO = psoriasis, PSSD = Psoriasis Symptoms and Signs Diary, QD = once daily, R = randomization, ss-IGA 0/1 = scalp-specific IGA score 0/1 & ≥2-grade improvement from baseline, W = week. Gold LS, et al. *Lancet*. 2025;406(10510):1363-1374.

Icotrokinra is not FDA-approved for this indication.

ICO Demonstrated Significantly Higher Rates of IGA 0/1 and PASI 90 vs PBO at W16 (co-primary endpoints) and vs Deucra at W16 and W24

Co-primary and *Key Secondary Endpoints*



Multiplicity-adjusted **p*<0.05, ***p*<0.01, ****p*<0.001 vs PBO; multiplicity-adjusted †*p*<0.05, ††*p*<0.01, †††*p*<0.001 vs Deucra

ICO showed early separation from PBO for achievement of PASI 90 at W8

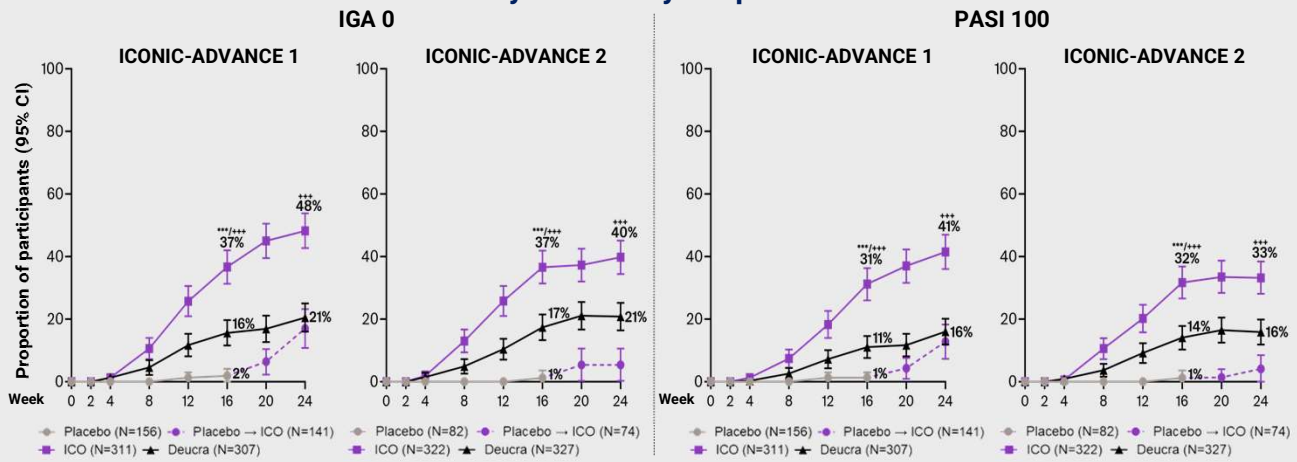
P-values based on Cochran-Mantel-Haenszel chi-square test stratified by baseline weight category (≤90 kg, >90 kg) and geographic region. CI = confidence interval, Deucra = deucravacitinib, ICO = icotrokinra, IGA = Investigator's Global Assessment, IGA 0/1 = IGA score 0/1 & ≥2-grade improvement from baseline, PASI = Psoriasis Area and Severity Index, PBO = placebo, W = week.

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

Icotrokinra is not FDA-approved for this indication.

ICO Demonstrated Significantly Higher Rates of Complete Skin Clearance vs PBO at W16 and vs Deucra at W16 and W24

Key Secondary Endpoints



Multiplicity-adjusted *$p<0.05$, **$p<0.01$, ***$p<0.001$ vs PBO; multiplicity-adjusted $^{+}p<0.05$, $^{++}p<0.01$, $^{+++}p<0.001$ vs Deucra

Rates of completely clear skin were ~2-fold or greater for ICO- vs Deucra-treated participants at W16 and W24

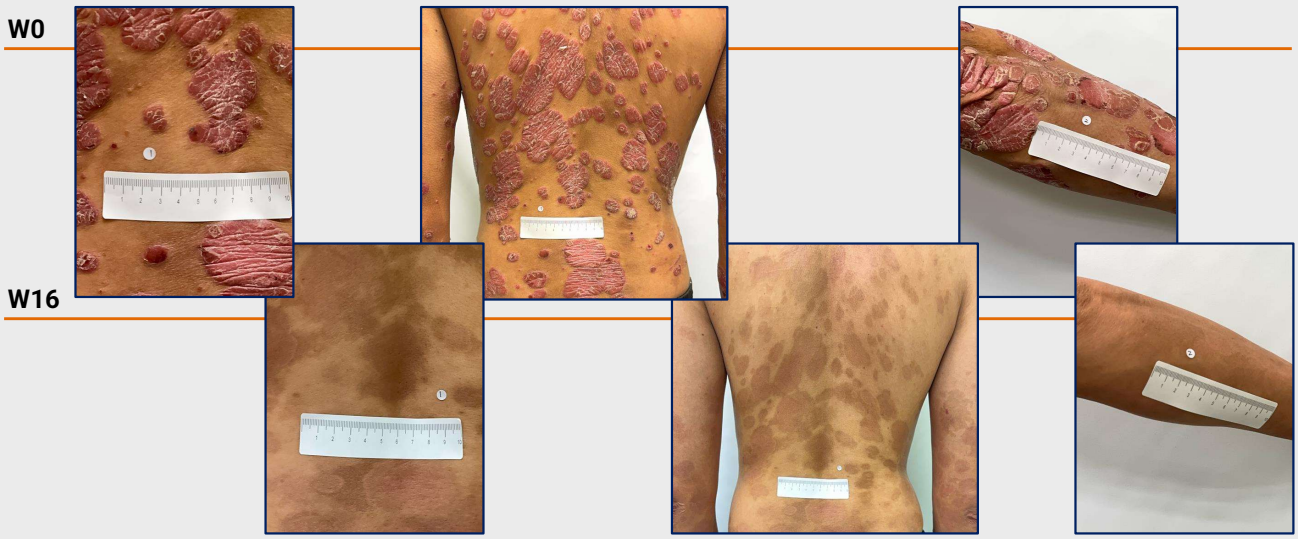
P-values based on Cochran-Mantel-Haenszel chi-square test stratified by baseline weight category (≤90 kg, >90 kg) and geographic region. CI = confidence interval, Deucra = deucravacitinib, ICO = icotrokinra, IGA = Investigator's Global Assessment, PASI = Psoriasis Area and Severity Index, PBO = placebo, W = week.

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

Icotrokinra is not FDA-approved for this indication.

ICO-treated Participant With PASI 100 Response at W16

ICONIC-ADVANCE 1 participant with PASI 28.5 and IGA score 4 at baseline



IGA = Investigator's Global Assessment; PASI = Psoriasis Area and Severity Index; W = week.

Gold LS, et al. *Lancet*. 2025;406(10510):1363-1374. Images courtesy of Dr. Stein Gold.

Icotrokinra is not FDA-approved for this indication.

No ICO Safety Signal Was Observed Through W24

Combined ICONIC-ADVANCE 1 & 2 AEs[a]	PBO-Controlled (W0-16)			Active Comparator-Controlled (W0-24)	
	PBO (N = 237)	ICO (N = 632)	Deucra (N = 634)	ICO (N = 632)	Deucra (N = 634)
Mean weeks/total PY of follow-up	15.5 / 70.5	15.9 / 192.7	15.8 / 191.6	23.6 / 285.2	23.3 / 283.1
Most common AEs (≥5%[b])					
Infection	73 (31%)	145 (23%)	202 (32%)	**190 (30%)**	**253 (40%)**
Incidence/100 PY (95% CI)[c]	128 (94, 151)	86 (72, 100)	130 (111, 147)	**80 (69, 92)**	**118 (104, 133)**
Nasopharyngitis	13 (5%)	37 (6%)	58 (9%)	56 (9%)	77 (12%)
Upper respiratory tract infection	8 (3%)	23 (4%)	33 (5%)	32 (5%)	49 (8%)
Headache	11 (5%)	26 (4%)	19 (3%)	28 (4%)	20 (3%)
Gastrointestinal Aes[d]	15 (6%)	45 (7%)	63 (10%)	55 (9%)	80 (13%)
Incidence/100 PY (95% CI)[c]	22 (12, 38)	24 (17, 32)	35 (26, 44)	20 (15, 26)	31 (24, 37)
Other AEs of Interest					
Acne[e]	0	4 (1%)	27 (4%)	5 (1%)	30 (5%)
Herpes[f]	6 (3%)	5 (1%)	13 (2%)	6 (1%)	18 (3%)

ICO infection rates were comparable to PBO through W16 & lower than with Deucra through W24

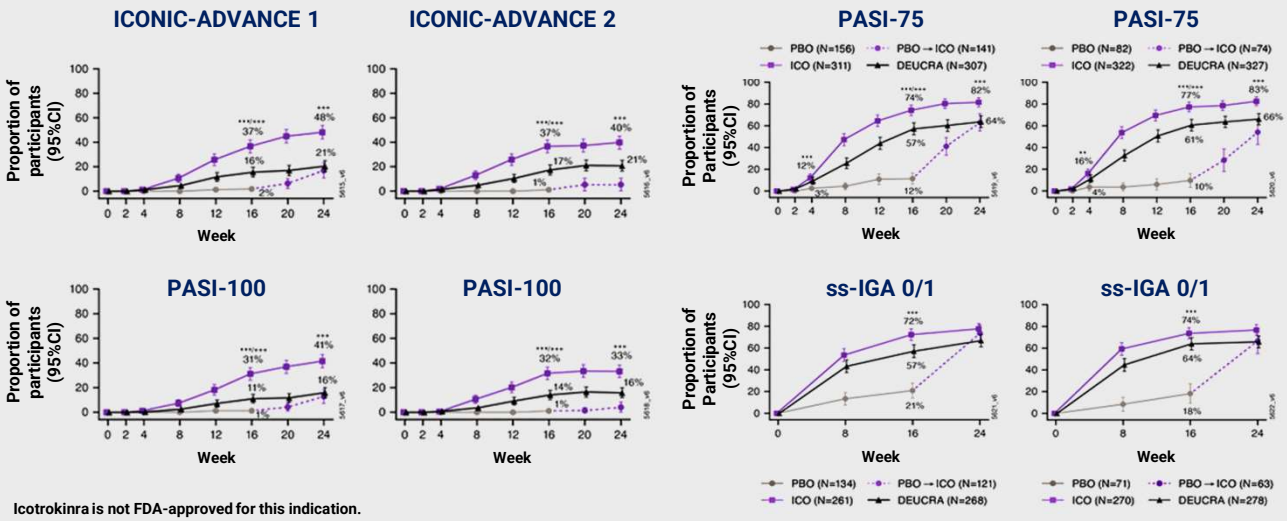
Values are n (%) unless otherwise noted. [a]Safety analysis set included all randomized and treated participants (pts); ICONIC-ADVANCE 1 & 2: PBO=155/82, ICO=310/322, Deucra=307/327. [b]Pts in any treatment group. [c]Incidence/100 PY: number of pts with AEs/total PY at risk × 100; CI based on study-size adjusted Wald statistics. [d]Based on gastrointestinal disorders SOC. [e]Included PTs acne, acne pustular, dermatitis acneiform. [f]Included PTs genital herpes simplex, herpes simplex, herpes virus infection, herpes zoster, oral herpes.

AE=adverse event, CI=confidence interval, Deucra=deucravacitinib, ICO=icotrokinra, PBO=placebo, PT=preferred term, PY=participant-years, SOC=system organ class, W=week.

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

Icotrokinra is not FDA-approved for this indication.

Phase 3: Icotrokinra vs Placebo and Deucravacitinib in Participants With Moderate to Severe Plaque Psoriasis



Icotrokinra is not FDA-approved for this indication.

ICO = icotrokinra; DEUCRA = deucravacitinib; PBO = placebo; ss-IGA = scalp-specific Investigator's Global Assessment.

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

Icotrokinra (JNJ-2113): Phase 3 ICONIC-TOTAL Efficacy in Special Sites at Week 16

	ICO 200 mg QD (N = 208)	PBO (N = 103)
Safety through Week 16		
Mean weeks of follow-up	16.0	15.7
Any AE	104 (50%)	43 (42%)
Most common AEs (≥5%)		
Nasopharyngitis	26 (12%)	11 (11%)
Upper respiratory tract infection	9 (4%)	5 (5%)
Headache	6 (3%)	6 (6%)
SAE[a]	1 (<1%)	2 (2%)
Infection	59 (28%)	22 (21%)
Serious infection	0	1 (1%)
AE leading to discontinuation[b]	4 (2%)	3 (3%)
Gastrointestinal AEs	15 (7%)	8 (8%)
Active TB	0	0
Malignancy[c]	1 (<1%)	0

Icotrokinra is not FDA-approved for this indication.

[a]SAEs through Week I6 included COVID-19 pneumonia, sepsis, sciatica, and acute respiratory failure in the PBO group; and hepatitis in the ICO group. [b]AEs leading to discontinuation through Week I6 included COVID-19 pneumonia, psoriatic arthropathy, and psoriasis in the PBO group; and vision blurred, visual field defect, laryngitis fungal, malignant melanoma in situ, and headache in the ICO group. [c]Malignancy reported in the ICO group was malignant melanoma in situ in a patient with a recent personal history of melanoma (in 2021).

COVID-19 = coronavirus disease 2019; ICO = icotrokinra; PBO = placebo; QD = daily; SAE = severe adverse events; TB = tuberculosis.

Gooderham MJ, et al. SID 2025; Abstract LB1142 (later published Gooderham MJ, et al. *J Invest Dermatol*. 2025;145(8)(suppl):S199).

Individualized Therapy Selection

Shared Decision-Making

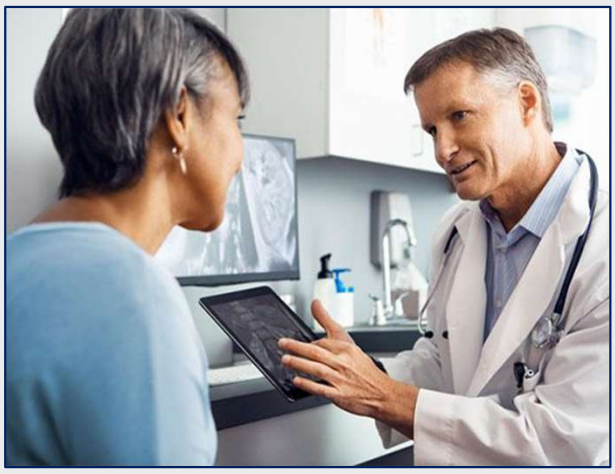
Shared decision-making (SDM) is an approach that allows the patient to serve as an active participant in their treatment plan.

An easy way to approach it is by

a) Introducing choice

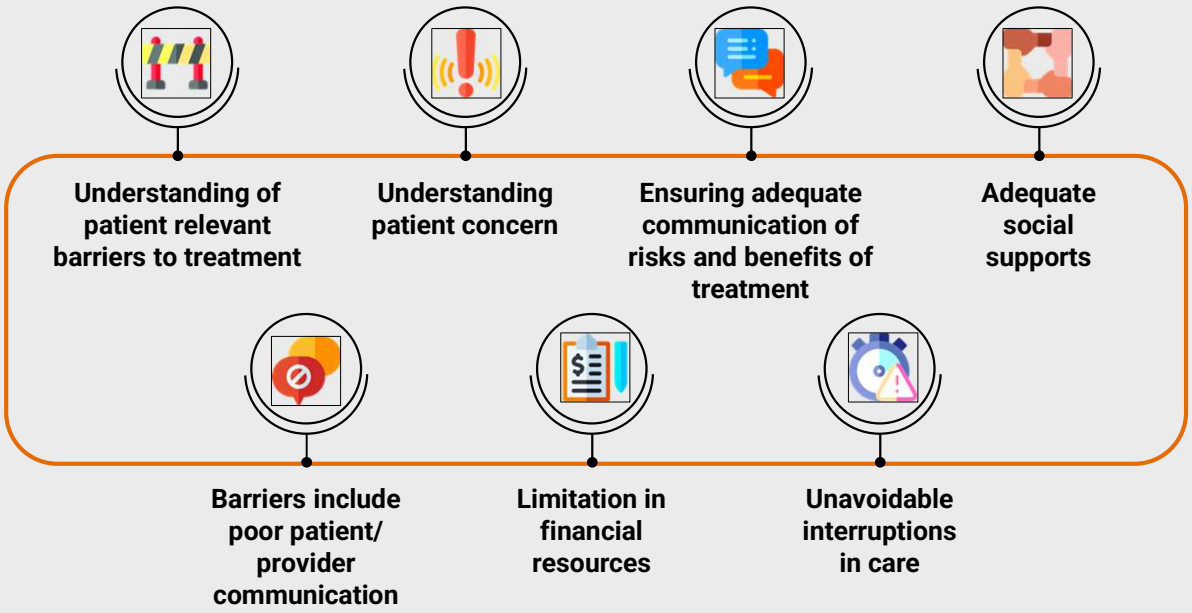
b) Describing options, often by integrating the use of patient decision support

c) Helping patients explore preferences and make decisions



Elwyn G, et al. *J Gen Intern Med*. 2012;27:1361-1367.

Factors That Facilitate SDM and Potential Barriers

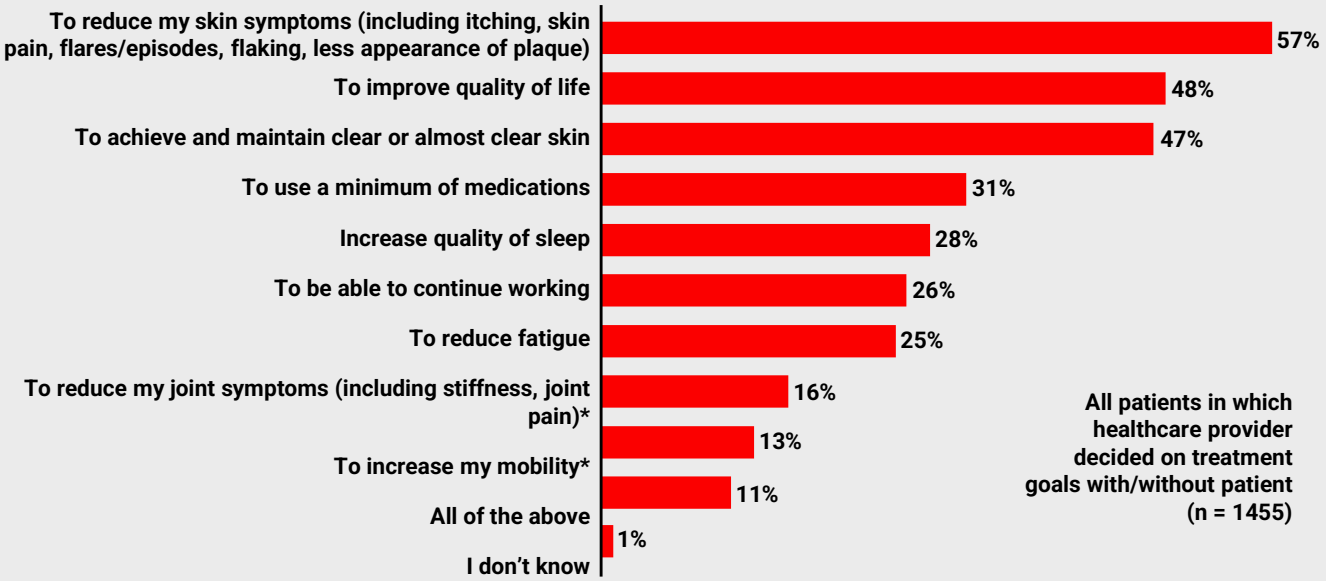


Strategies for Facilitating SDM in Clinical Practice

- An effective, relatively safe oral therapy for psoriasis exists
- Previous oral medication (ie, apremilast) is effective 30% of the time
  - Often associated with diarrhea, nausea, depression, and headaches
- TYK2 inhibitors don't include those adverse events
  - Work about twice as well

Balak DMW, et al. *Dermatol Ther (Heidelb)*. 2020;10(4):589-613. Ghislain PD, et al. *Adv Ther*. 2022;39(2):1068-1080. Armstrong AW, et al. *JAMA Dermatol*. 2024;160(10):1066-1074.

Patient-Reported Goals for Treatment



*Question addressed to patients with psoriasis and psoriatic arthritis.

Armstrong A, et al. *Dermatol Ther* (Heidelb). 2022;12(4):1055-1064.

Shared Decisions

- Discuss monitoring and patient history, including previous psoriasis medication
- Discuss patient preference for oral vs injectable medication
- History of IBD; avoid IL-17 (IBD) or PDE-4 inhibitor (diarrhea)
- History of suicide ideation; carefully choose medications after reviewing individual's risks
- If arthritis is present or psoriasis is severe, choose a medication that treats both psoriasis and psoriatic arthritis

Case Studies

Case Study 1: John

A 45-year-old male presents with ~12% BSA plaque psoriasis on hands, elbows, knees, scalp, and low back.

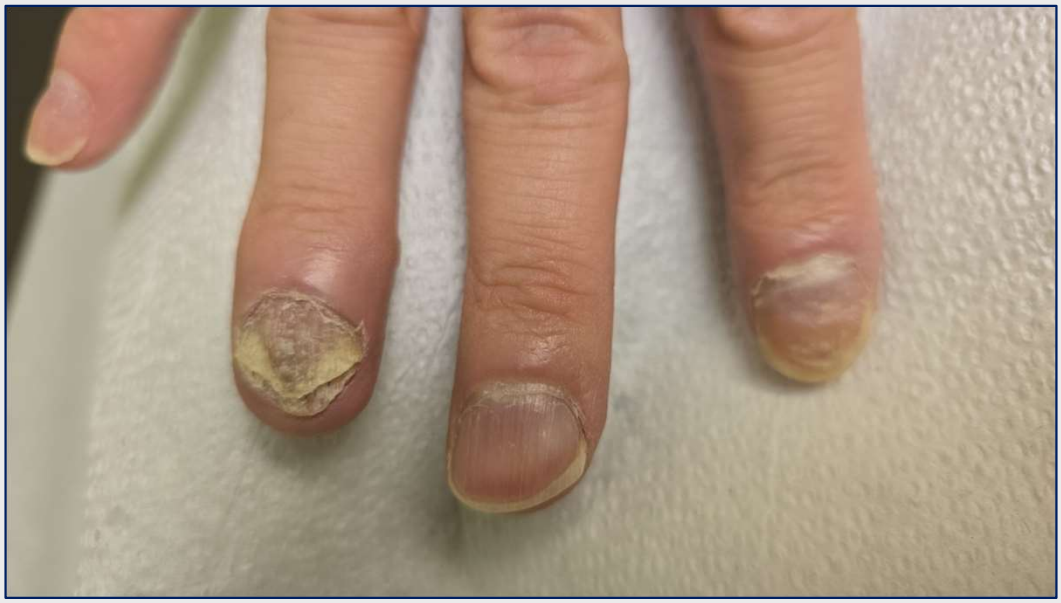
- Works evening shift as an airline mechanic
- Psoriasis has been worsening over the past 8 months
- Recently started to affect his nails, making him self-conscious around his coworkers
- Interferes with work

Medical history: Psoriasis (diagnosed at age 35 years), hypertension (well-controlled), class I obesity (BMI 32)

Social history: No tobacco; consumes alcohol on the weekend

Medicine: Lisinopril; tried and failed topical steroids/calcipotriol

Case Study 1: John (Continued)



Case Study 1: Questions for Discussion

- What systemic therapies would you consider for John with moderate plaque psoriasis and nail involvement after inadequate response to topicals?
  A. Continue topical corticosteroids and calcipotriol alone
  B. Add phototherapy as the next step
  C. Initiate systemic therapy
  D. Start oral antibiotics for secondary skin infection

- How do John's comorbidities—hypertension, obesity, and cardiovascular risk—impact your treatment selection?

- How would you engage John in shared decision-making to balance efficacy, safety, convenience, and his personal preferences when selecting therapy?
  A. Choose therapy based solely on efficacy data
  B. Present multiple evidence-based options and discuss impact
  C. Let insurance coverage determine therapy
  D. Avoid discussing side effects to prevent discouragement

Case Study 2: Lydia

A 50-year-old female presents with ~7% body surface area (BSA) plaque psoriasis on her scalp, elbows and ears.

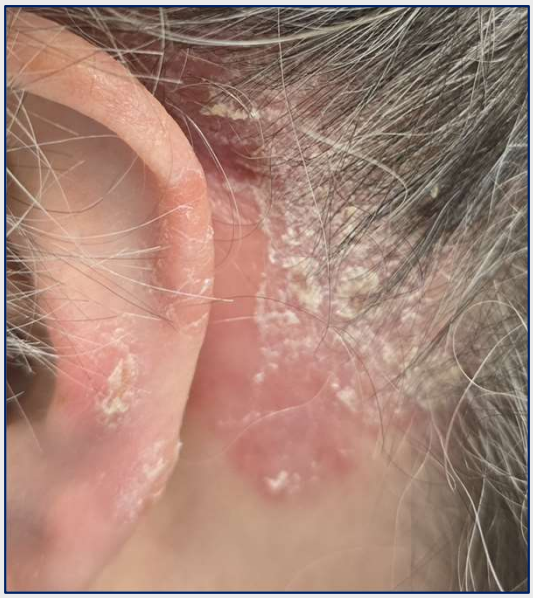
- Works as a high school teacher
- Psoriasis has been worsening over the past 2 years
- Distressing that the plaques are visible on the scalp, ears and arms, which makes her feel unkempt

Medical history: Psoriasis (diagnosed at age 42 years), diabetes (well-controlled), class 3 obesity (BMI 37), hyperlipidemia (well-controlled)

Social history: No tobacco; socially consumes alcohol

Medicines: Lisinopril, metformin, rosuvastatin; tried and failed topical steroids/calcipotriol, topical antifungal, medicated shampoos, and advanced topical therapies; failed methotrexate due to nausea and vomiting

Case 2: Lydia (continued)



Case 2: Questions for Discussion

- According to current guidelines and available efficacy and safety data, which systemic options—including newer oral therapies—would be most appropriate for Lydia, who has failed topical therapy and methotrexate?
  A. Continue topical steroids and medicated shampoos
  B. Initiate cyclosporine for long-term management
  C. Start an oral TYK2 inhibitor or biologic targeting IL-17 or IL-23 pathways
  D. Add oral corticosteroids for rapid flare control

- How do Lydia's comorbidities—hypertension, obesity, and diabetes—impact your treatment selection?

- How would you design a personalized treatment plan for Lydia, considering her comorbidities, insurance concerns, and psychosocial distress, while engaging her in shared decision-making?
  A. Choose the lowest-cost therapy regardless of efficacy
  B. Prioritize a therapy compatible with her comorbidities
  C. Use systemic corticosteroids for rapid symptom improvement
  D. Avoid all systemic therapies due to comorbidities

Concluding thoughts

Questions?

Thank you!

Updates on Emerging Therapies in Psoriasis Management

Resource	Address
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