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Psoriasis [2017]

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Abstracts

Will biosimilar anti-TNFs prevent novel therapies from gaining traction?

As the use of biosimilar anti-TNFs continues to expand access, and lower the costs of, biologic therapies in the treatment for psoriasis, is there room for novel products, such as the anti-interleukin-(IL)-17 mAbs and next-generation anti-IL23 mAbs? What about recently approved products, such as Siliq/Kyntheum (brodalumab), and Tremfya (guselkumab; Janssen/MorphoSys)? Clinical and commercial differentiation will become critical and as the treatment landscape becomes more crowded. Learn how KOLs see the market evolving, how current products can protect market share, and how developers can differentiate their pipeline therapies in KOL Insight: Psoriasis. Twelve North American and European KOLs provide their insight on 11 marketed products and over 15 pipeline programmes.

Take a tour of the report now:

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Find out who the 6 US and 6 European KOLs are >

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Top Takeaways

What does the future hold for branded anti-TNFs? Anti-TNFs have the most long-term safety and efficacy data to substantiate their clinical use, with Humira (adalimumab; AbbVie) being the ‘go-to’ drug in this category for many KOLs. But with several anti-TNF biosimilars scooping up market share, and more on the way, what does the future hold for branded anti-TNFs?

What impact will next-generation anti-IL23 mAbs have on the treatment landscape? KOLs are impressed with anti-IL12/23 mAbs, such as Stelara (ustekinumab; Janssen Biotech), but can newer drugs in this category, such as Tremfya (guselkumab; Janssen Biotech/MorphoSys), move things on even further? And will the lack of long-term real-world safety data hamper near-term commercial dynamics?

How do KOLs describe the anti-IL17 mAbs? Safe, effective, quick? What concerns remain, particularly for products with chequered development histories and the emergence of rare adverse effects such as IBD and Crohn’s disease? KOLs predict a future tussle between the anti-IL17 mAbs, but with which class of product?

Will payers influence the uptake of pipeline psoriasis drugs? If so, will this be based purely on cost and benefit of biosimilars, or do KOLs expect payers to look more closely at the data and allow patients to gain access to more effective treatments?

What have KOLs asked for from future treatments for psoriasis? Would KOLs prefer drugs that demonstrate long-term safety and disease remission, ones that allow for dosage flexibility and personalisation of treatment, or ones that are effective on the skin as well as joints?

Does the psoriasis treatment landscape have a differentiation problem? With many treatments available, and more on the way, what are KOLs most concerned about? What could help physicians make better treatment decisions so that patient care is optimised?

Quotes

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“Certainly there’s no direct comparison, but on paper it [brodalumab] is more effective versus placebo than compared to secukinumab and ixekizumab. It genuinely does have a different mode of action, so there is a reason to use it after secukinumab or ixekizumab has failed because it almost gives you a bit more justification, you’re not just using another IL17 blocker.”

EU Key Opinion Leader

“The more you switch the risk of immunogenicity will increase. We have no concerns with Enbrel biosimilars, but Infliximab and adalimumab have immunogenic potential, and I would not like to risk the [loss of] response of the patient. I will have no problems to initiate a drug from the beginning.”

US Key Opinion Leader

Sample of therapies covered

Marketed Therapies

Taltz (ixekizumab; Eli Lilly)

Benepali (etanercept; Biogen/Samsung Bioepis)

Remsima (infliximab; Celltrion/Napp/Mundipharma)

Inflectra (infliximab; Pfizer/Celltrion)

Cosentyx (secukinumab; Novartis)

Otezla (apremilast; Celgene)

Stelara (ustekinumab; Janssen Biotech)

Humira (adalimumab; AbbVie)

Remicade (infliximab; Janssen Biotech/Merck & Co.)

Enbrel (etanercept; Amgen/Pfizer)

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Pipeline Therapies

Siliq/Kyntheum (brodalumab; Leo Pharma/AstraZeneca)

Tremfya (guselkumab; Janssen Biotech/MorphoSys)

Amgevita/Amjevita (adalimumab; Amgen)

Erelzi (etanercept; Sandoz)

BI 695501 (adalimumab; Boehringer Ingelheim)

Tildrakizumab (Merck & Co./Sun Pharma)

Xeljanz (tofacitinib; Pfizer)

Imraldi (adalimumab; Biogen/Samsung Bioepis)

Cimzia (certolizumab pegol; UCB)

Risankizumab (Boehringer Ingelheim/AbbVie)

Piclidenoson (Can Fite Biopharma)

Mirikizumab (Eli Lilly)

Namilumab (Takeda)

Bimekizumab (UCB)

Various adalimumab and etanercept biosimilars (e.g. M923, MSB11022)

KOLs from North America

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Bryan Cho. Dermatologist and Geneticist, Department of Dermatology, University of California, San Francisco.

Craig Leonardi. Associate Clinical Professor of dermatology at St. Louis University Medical School, St. Louis, Missouri.

KOLs from Europe

Puig Sanz. Director of the Department of Dermatology, Hospital de la Santa Creu i Sant Pau, an academic hospital which is affiliated with the Autonomous University of Barcelona.

Pablo Coto-Segura. Associate Professor of Dermatology, Hospital Universitario Central Asturias, Oviedo, Spain

Andrew Pink. Consultant Dermatologist, Guys and St. Thomas Hospital NHS Foundation Trust, London.

Richard Warren. Reader and Honorary Consultant Dermatologist, Division of Musculoskeletal & Dermatological Sciences, University of Manchester, UK

Odile Picard. Consultant at Saint Antoine Hospital in Paris, Professor of Dermatology at University of Saint-Antoine, France.

Anonymous German KOL. Professors and heads of a division with a specific focus on the treatment of inflammatory conditions, including psoriasis, at leading teaching hospitals in Germany.

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