

Indiana Medicaid Therapeutics Committee Therapeutic Class Review Summary

Therapeutic Class:
Antipsoriatic Agents

Overview:

Psoriasis is a chronic inflammatory skin disorder characterized by a fluctuating course of exacerbations and remissions. Psoriasis is now recognized as a T-cell-mediated immune disorder in which CD4⁺ and CD8⁺ memory T cells stimulate the hyperproliferation of keratinocytes. Normally, T cells help protect the body against infection and disease. However, in psoriasis, T cells become active in the skin and stimulate inflammation and excessive skin cell reproduction.^{9-12, 20} Additionally, tumor necrosis factor (TNF), a naturally occurring cytokine involved in normal inflammatory and immune responses, plays a role in the inflammatory process of plaque psoriasis. Elevated TNF levels have been found in involved tissues and fluids of patients with psoriatic arthritis and plaque psoriasis.

There are several different types of psoriasis. Each type has distinguishable shapes and patterns of the scales, severity, duration, and location. The most typical form of psoriasis results in patches of thick, red skin covered with silvery scales. The patches, usually referred to as plaques, may itch and burn. In addition, the skin at the joints may crack. Psoriasis most often occurs on the elbows, knees, scalp, lower back, face, palms, and soles of the feet, but can affect any skin site. Fingernails, toenails, the soft tissue inside the mouth, and genitalia may also be affected.^{9, 10}

There is no cure for psoriasis, but effective treatment may provide partial or full remission for substantial periods of time. The goal of treatment is to reduce inflammation and to control shedding of the skin.¹⁰ Several therapeutic options have been approved for the treatment and prevention of psoriasis. Topical agents, photochemotherapy, and systemic agents are discussed in this review.

Topical agents, including anthralin, calcipotriene, and tazarotene, are frequently used alone in mild-to-moderate cases of psoriasis. Anthralin is a synthesized chemical that is believed to act on psoriatic lesions by normalizing DNA activity in skin cells (keratinocytes) and reducing inflammation. Calcipotriene is a synthetic analog of vitamin D₃ that causes inhibition of cell proliferation and induction of cell differentiation in psoriatic skin. Tazarotene is a synthetic, acetylenic retinoid that modulates differentiation and proliferation of epithelial tissue and exerts some degree of anti-inflammatory and immunological activity. Clinical data suggest that calcipotriene used alone is not as efficacious in the treatment of psoriasis as the combination of calcipotriene or tazarotene with a steroid.^{5, 6} Taclonex[®], a combination of both calcipotriene and betamethasone, was approved in January 2006.

Methoxsalen is a naturally occurring photosensitivity agent (psoralen). It is used in combination with ultraviolet light A (UVA) to treat psoriasis. This combination is

referred to as photochemotherapy or psoralen + UVA (PUVA). UVA slows the rapid growth of skin cells and kills T cells in the skin. Psoralen bonds covalently to pyrimidine bases in DNA, inhibiting the synthesis of DNA and suppressing cell division, and makes the skin more sensitive to UVA rays. Patients ingest methoxsalen before being exposed to UVA rays.^{10, 11} PUVA is an option for psoriasis that does not respond to topical medications alone or for lesions that are too extensive for topical treatment.

Systemic agents are reserved for moderate to severe psoriasis. They are often combined with topical agents for better clearance of lesions. Acitretin, a retinoic acid analog, modulates the cellular differentiation of the epidermis.¹⁰⁻¹² Acitretin must not be used in females who are pregnant or those who intend to become pregnant during therapy or any time for at least 3 years following discontinuation of therapy.² Most patients will experience relapse of psoriasis after discontinuing therapy with acitretin.⁴ Biologics (ie, adalimumab, alefacept, efalizumab, etanercept, and infliximab) pinpoint precise immune responses involved with psoriasis. Alefacept interferes with the migration, activation, and proliferation of T cells resulting in relief from signs and symptoms. It is given by intramuscular or intravenous injection once weekly for 12 weeks. CD4⁺ cell counts must be monitored as circulating T cells are decreased with therapy. Efalizumab is a monoclonal antibody that inhibits the activation of the T cells and blocks T cell trafficking. This prevents T cells from entering the skin and causing inflammation. Efalizumab is given by subcutaneous injection. Common side effects are headache, flu-like symptoms, and muscle aches with the first few injections. Patients must be monitored for serious infection.^{10, 11} Adalimumab, etanercept, and infliximab inhibit tumor necrosis factor (TNF) and have been used to treat several conditions including psoriatic arthritis and plaque psoriasis. Adalimumab and etanercept are administered by subcutaneous injection. However, adalimumab is given every other week and etanercept is given twice weekly. Additionally, infliximab is administered by IV infusion every 8 weeks after three initial infusions. Common side effects for the TNF inhibitors include injection site reactions, infections, headache, and nausea. Patients must be monitored for serious infection, malignancy, and blood dyscrasias.

GENERIC NAME	TRADE NAME	MANUFACTURER	GENERIC
Acitretin	Soriatane [®]	Connectis Corporation	N
Adalimumab	Humira [®]	Abbott	N
Alefacept	Amevive [®]	Astellia Pharma	N
Anthralin	Drithocreme [®] , Psoriatec [®] , Drithro-scalp [®]	Various	Y (1% cream only)
Betamethasone; Calcipotriene	Taclonex [®]	Warner Chilcott	N
Calcipotriene	Dovonex [®]	Warner Chilcott	N
Efalizumab	Raptiva [™]	Genentech	N
Etanercept	Enbrel [®]	Amgen	N
Infliximab	Remicade [®]	Centocor Inc	N
Methoxsalen	Oxsoralen-Ultra [®]	Valeant Pharmaceuticals International	N
Tazarotene	Tazorac [®]	Allergan	N

Summary:

Calcipotriene is considered the treatment of choice by some clinicians, but clinical data and cost do not support its use before an adequate trial of topical corticosteroids.¹ Additionally, Taclonex[®], a combination of both calcipotriene and betamethasone, is also available. The literature supports the use of systemic and topical agents simultaneously as well as the use of two topical agents at the same time. The biologics (ie, adalimumab, alefacept, efalizumab, etanercept and infliximab) are the newest agents in this class and offer alternatives to immunosuppressants and chemotherapeutic agents in the treatment of moderate-to-severe plaque psoriasis. Selection of a preferred agent should be based on the ability to clear and prevent psoriatic lesions and safety.