Psoriasis treatment options, impact on the workplace and the tremendous return of improving ONE LIFE
SWIFT ACTION NEEDED ON A DISEASE THAT’S MORE THAN SKIN DEEP

Nearly one million Canadians suffer from psoriasis, which means there’s a good chance you have an employee with the disease in your workplace.¹ An autoimmune condition that affects the whole body but is known primarily for its effects on the skin, psoriasis torments its sufferers with raised, itchy, crusty scales that can form anywhere. Because it causes widespread inflammation in the body, having the disease raises one’s risk of developing heart disease, arthritis, diabetes and Crohn’s disease.

Mental fallout can also be severe. The risk of clinical depression is 39% higher among people with psoriasis. They are also at an increased risk of anxiety (31%) and suicide (44%), compared with those who do not have this potentially debilitating disease.²

Life with psoriasis is a daily ordeal, especially during flare-ups, a period when symptoms become worse. Though sufferers can go through symptom-free periods that vary in duration from person to person, a third of sufferers report the disease has a severe impact on their quality of life—at home and at work. Many sufferers with moderate to severe psoriasis spend their days slathering on lubricating or topical ointments and creams during lunch breaks, forgoing social situations that require handshakes, or withdrawing completely during flare-ups. When symptoms get worse, they may be more likely to call in sick, or to show up for work but be unable to perform their duties fully, due to their physical discomfort and experiences of stigma among co-workers. A 2012 study found that lost productivity costs due to work absences or an inability to perform effectively were $3,442 per person annually.³

Many fear the reactions of co-workers and managers upon seeing the skin lesions they try desperately to hide. Others fear discrimination: being shunned, or even passed over for promotions.

Employers have the power to change the lives of these individuals—and avoid future costs that could otherwise profoundly affect their bottom line. By bringing awareness to the condition, they can reduce the stigma of this disease. By supporting employee efforts to manage their own symptoms, employers can improve employee quality of life and reduce presenteeism, absenteeism and short-term disability claims, while potentially staving off early retirements.⁴ And, by ensuring that their drug plans cover the full range of medications that can alleviate symptoms—such as topical agents, oral medications or systemic medications such as biologics—employers can improve productivity while decreasing the risk of employees developing another condition, such as diabetes or heart disease. It’s a question of pay now or pay later.
Talk to Brenda Spinozzi for a few minutes, and it’s easy to understand why the World Health Organization recently urged countries to take action on psoriasis, a “chronic, non-communicable, painful, disfiguring and disabling disease for which there is no cure.”

Spinozzi has suffered from severe plaque psoriasis for all but the first five of her 53 years. Until nine years ago, red, scaly, itchy plaques covered 90% of her body and prevented her from participating in many activities. Sports were out. So were beach vacations with her husband and two children.

“Living with psoriasis is no easy task,” says the pharmacy technician. “I looked like a third-degree burn patient. I had to keep myself covered up all the time.”

Spinozzi stoically endured her disease while working full time. “I didn’t want to take short-term disability or long-term disability because I was so stubborn. I didn’t want it to run my life.”

But working with such a severe disease meant Spinozzi had to take emergency bathroom breaks to manage the intense itching. “I would undress at work, apply the creams, get dressed and go back to work.”

Having psoriasis also meant frequent hospitalizations. “I’ve been in hospital six to seven times over the years. The skin was so bad, they had to try to get it under control.”

Yet Spinozzi’s absences pale in comparison to those of many patients. Flare-ups can force some to go on short-term disability. Others even end up on long-term disability, unable to return to work. Gooderham
Psoriasis certainly appears to solely affect the skin—at first glance. “People think it’s a skin disease. But it’s so many more things than that,” says Dr. Melinda Gooderham, a Peterborough, Ont.-based dermatologist. “There’s discomfort physically, there’s discomfort emotionally. And then you have this deeper systemic inflammation. It can be pretty bad.”

Chronic and incurable, psoriasis is an autoimmune condition. The body’s immune system believes skin cells are invaders and attacks them, causing skin cells to die and slough off at a very rapid rate. For an average person, skin cells generally turn over every 28 days. For a psoriasis sufferer, skin cell turnover can occur in three to six days, according to the Canadian Psoriasis Network. The rapid skin turnover causes raised, red, itchy patches to appear on the skin that are covered by silvery scales of excess skin.

The disease, often characterized by flare-ups followed by periods of remission, takes many forms:

1. **Plaque psoriasis** is the most common, affecting 80% of sufferers. It causes dry, scaly, itchy patches of skin. The scales can cover any part of the body.
2. **Guttate psoriasis** manifests as small dots on the skin that begin as pink lesions and gradually become scaly.
3. **Inverse psoriasis** usually shows up in the armpits, groin and buttocks as smooth, red lesions.
4. **Pustular psoriasis** appears as small, fluid-filled blisters that contain white blood cells.
5. **Palmoplantar pustulosis** is a form of pustular psoriasis that affects the hands and feet.
6. **Erythrodermic psoriasis** causes large areas of the skin to become red as skin cells are shed.
7. **Scalp psoriasis** shows up as red lesions covered with scales on the scalp.
8. **Nail psoriasis** causes pitting, thickening, loosening and discoloration of the nails.

Researchers point to both genetics and environment as causes of the disease, although no one knows for sure. Genetically, if one parent has psoriasis, then a child has a 25% chance of developing the disease. If both parents have it, that figure rises to over 50%. Environmental events, such as a skin injury or highly stressful situations, can also trigger an over-reaction of the immune system, leading to psoriasis.

Sources: Canadian Psoriasis Network; Psoriasis Connections Canada
says she's seen countless patients who've given up on careers and largely stay indoors. “They don't want to have to leave their houses,” she says.

From an employment perspective, this can be very expensive. According to recent Canadian research, the estimated mean annual cost of psoriasis is $7,999 per person, of which direct costs account for 57%.³ Mean lost productivity costs—which account for 43% of the costs of psoriasis—are $3,442 per person. Add this up and the total economic burden of moderate to severe psoriasis in Canada is $1.7 billion a year.

This does not take into consideration the costs of presenteeism, or the “walking wounded” who show up for work but are so distracted by physical discomfort and emotional pain that their performance lags and workload targets are not met.

Last, but not least, there is the stigma associated with an unsightly disease that looks like it might be contagious. Many psoriasis sufferers report colleagues recoiling from handshakes or avoiding them at meetings or office parties. Spinozzi recalls obsessing over what clothes to wear, opting for styles that covered every square inch of her body, save for her face. “I was so embarrassed that I would make sure people never saw [my psoriasis].”

“People who have psoriasis undergo stigmatization and embarrassment,” says Dr. Wayne Gulliver, professor of medicine and dermatology at Memorial University, St. John’s, Newfoundland and Labrador.

As a result, mental health issues go hand in hand with psoriasis, as people attempt to cope with a very visible ailment that also causes itching and pain. Many experience anxiety, depression and thoughts of suicide as they struggle to hide their skin from co-workers. People with psoriasis may also develop a condition called alexithymia, which affects their emotional health. “They have a tougher time expressing their emotions. They have higher divorce rates, have more issues at work,” says Gooderham.

People with psoriasis are four times more likely to develop associated medical and psychological problems than those in the general population, according to a 2012 survey.⁶ Those with moderate to severe psoriasis are also much more likely to contemplate suicide. While Spinozzi has never felt suicidal, she recalls her darkest moment came during the three months she had to discontinue all medication to be eligible for entry into a clinical trial. Her symptoms at their worst, Spinozzi says that life was close to unbearable. “I was raw—covered from head to toe,” she says. “Those were the worst three months of my life.”

“We know that there are plaques on the skin, but patients may also have plaques on the arteries around the heart. Psoriasis is also associated with diabetes, metabolic disease and psoriatic arthritis in a third of patients—there are so many deeper health issues than just what their skin looks like.” — Dr. Melinda Gooderham

WHAT LIES BENEATH
Dealing with skin plaques can be excruciatingly difficult. But, beneath the silvery scales of psoriasis plaques lies the real threat of the disease: systemic inflammation, which is the body’s reaction to being over-stressed. This inflammatory state means that psoriasis sufferers are more likely to develop other serious health problems that affect productivity and shorten lives.

“We know that there are plaques on the skin, but patients may also have plaques on the arteries around the heart. Psoriasis is also associated with diabetes, metabolic disease and psoriatic arthritis in a third of patients—there are so many deeper health issues than just what their skin looks like,” says Gooderham.
“People with psoriasis live an average of five years less than those without it due to heart disease,” she adds.

A study by U.S. researchers found the more severe the disease, the higher a person’s risk of developing chronic pulmonary obstructive disorder, kidney disease, mild liver disease, heart attack, peripheral vascular disease, peptic ulcer disease and arthritis.⁷

Another 2013 study, published in the British Medical Journal, found that patients with severe psoriasis were nearly twice as likely to develop chronic kidney disease, and more than four times as likely to develop end-stage renal disease requiring dialysis.⁸

Up to 30% of psoriasis sufferers also suffer from psoriatic arthritis, an inflammatory condition that causes destruction of the joints and tendons. It also causes pitted, deformed nails, along with swelling and joint pain that reduce mobility. And it’s under-diagnosed. New research from the U.S. National Psoriasis Foundation finds that 40% of psoriasis patients may have undiagnosed psoriatic arthritis.⁹

**OBSTACLES TO EFFECTIVE TREATMENT**

Gooderham sees many desperate people in her clinic. However, the happy endings are what stay with her.

Most of those happy endings are due to the range of medications and therapies available, particularly due to innovations in recent years. And more are emerging, which will offer even more choice to doctors and patients. Yet treatment must be tailored to the individual and can be a combination of therapies, particularly among those with moderate or severe psoriasis. This requires the expert care of specialist physicians.

Unfortunately, people with psoriasis must often take a long and arduous journey before finally finding treatment—a function of misdiagnosis in some cases, long wait times for specialists, regulatory hurdles and drug plans’ patchy coverage of treatment options.

According to the Psoriasis Report Card 2014, released by the Canadian Association of Psoriasis Patients and the Canadian Skin Patient Alliance, finding a doctor who can properly diagnose the disease is the first hurdle for many patients, particularly those living outside major urban centres.¹⁰ Due to a shortage of dermatologists in Canada, wait times are usually several months long. And, the report predicts, these wait times will increase as 20% of dermatologists are expected to retire in the next five years.

In the face of lengthy waiting periods to see a dermatologist, many family physicians try to step in. “A lot of family doctors still try to treat it,” typically with a topical drug that may have little effect, says Andrew Gosse, president of the Canadian Psoriasis Network.

In some cases, psoriasis is misdiagnosed as eczema, a benign skin condition that also causes red eruptions and itching, says Gulliver. “Even for a dermatologist, sometimes it can be difficult to tell one from the other.” As a result, many patients are left to suffer. “One-third to one-half of patients are not being treated at all,” says Gulliver.

Once the right diagnosis is made, access to treatment can quickly become complicated by a number of factors, such as availability and restrictions in coverage. The Psoriasis Report Card cites the shortage of phototherapy clinics in Canada, for example, which can be a very effective treatment option for moderate psoriasis. Phototherapy involves the administration of ultraviolet-B light in a hospital, clinic or home setting. Currently, however, only 7% of psoriasis patients use phototherapy, and only 38% have tried it in the past.¹¹ Compounding the problem is the fact that many clinics do not offer phototherapy. And home phototherapy, which is relatively inexpensive, is often not covered by public or private drug plans.

Many employers also work with their insurers to create plan designs that manage the use of higher-cost specialty drugs such as biologics, notes the Report Card. Special or prior authorization is often a mandatory component of the process, which means a physician has to ensure the psoriasis patient meets specific criteria—and
complete the necessary paperwork—before being able to prescribe a biologic. Case management is also often part of the process, which involves physicians checking in regularly with a case manager to review a patient’s treatment plan and possible alternative treatments.

Plan designs also often use the step approach, which requires people with severe psoriasis to try a specified sequence of older, traditional therapies before being able to try newer, higher-cost therapies that will likely be more effective. Often, both patient and physician quickly realize the severity of the condition simply will not respond to traditional therapies, but it can be months or even years before they are “eligible” for more effective therapies.

While Gosse understands the rationale behind this approach, he feels it can lead to delays in effective treatment. “Everybody is looking for the low-cost model and that makes sense. But, realistically, the low-cost model is really a prolonged way of trying to mitigate costs. It’s not about effective treatment, it’s not about that person having fewer sick days, or an overall better quality of life.”

Gulliver agrees. “You wouldn’t deny someone treatment for their heart disease. You wouldn’t deny someone treatment for their diabetes. You wouldn’t deny someone treatment for Crohn’s or rheumatoid arthritis. So why should someone with psoriasis be denied therapy because of cost?”

Second-step drugs—which insurers mandate patients try before trying biologics—can also have unwanted effects. According to the Report Card, the older, traditional drugs typically prescribed in the second “step” of therapy, such as methotrexate and cyclosporine, run the risk of side effects that can be toxic to some patients, affecting blood-cell function and possibly causing liver damage. “Second-level drugs have significant toxicities and, because psoriasis is a chronic systemic condition and is associated with other medical conditions, such as depression, obesity, heart disease and stroke, there is increased risk to patients [of suffering from these toxicities],” reads the report.

**ADDING UP THE COST OF INFLAMMATION**

Delays in access to the right treatment, whether due to wait times or coverage requirements, can lead to significant additional costs, on top of the direct costs of psoriasis. Three conditions in particular, which are already consuming significant shares of drug-plan spend—cardiovascular disease, diabetes and mental illness—have been linked to, and can be exacerbated by, poorly treated psoriasis.

When you look at the highest-cost claimants for drug plans—or the 20% of plan members who account for 75% of costs—just 9% are taking a
biologic to treat an autoimmune condition such as psoriasis, severe rheumatoid arthritis or Crohn’s disease, according to a 2011 analysis of claims data by Green Shield Canada and IMS Brogan.¹² However, a staggering 61% of these claimants are also submitting claims for hypertension medications. Among these claimants, 51% are also treating mental illnesses and 34%, diabetes.

Cardiovascular disease
People with untreated psoriasis have a higher risk of cardiovascular disease, which can lead to hospitalizations and short-term and long-term disability costs, as patients recover from heart attacks and surgeries. A study of 3,600 psoriasis patients found they had a 57% increased incidence of a cardiovascular event compared with people without psoriasis.¹³

Conversely, a 2012 study by the Montreal Heart Institute found that successfully treating psoriasis patients—in this case, with a biologic—decreased vascular inflammation and lowered levels of C-reactive protein, which is known to be associated with an increased risk of heart attack and stroke, by 51%.¹⁴ Another 2012 study showed that certain biologic drugs may reduce heart attack risk in people with psoriasis by almost 75%.¹⁵

Diabetes
People with psoriasis are 27% more likely to develop diabetes than the average population, according to research in 2013.¹⁶

Diabetes cost the Canadian healthcare system and economy $11.7 billion in 2010, an increase of nearly 70% since 2000. Costs are forecast to reach $13.5 billion by the end of 2014, and $17 billion in 2024. A workplace survey conducted across Canada determined that employees with type 2 diabetes cost employers an estimated $412 annually due to reduced productivity (presenteeism), and $1,042 due to missed work (absenteeism).¹⁷

Mental illness
The impact of poorly treated psoriasis on a person’s mental health has been well-documented. According to the Canadian Association of Psoriasis Patients, 75% of people with psoriasis on short-term disability also have a mental illness, as do 79% of those on long-term disability.

Mental illness is the second-leading cause of short-term disability (STD), and the average cost per STD leave per person is $18,000, compared to $9,000, on average, for the top five leading causes.¹⁸

Claims data show that mental health–related claims accounted for 26.2% of all claims in 2011, up from 24.6% in 2006.¹⁹
“LIFE-CHANGING DRUGS”

Gulliver estimates that the older, traditional therapies fail for 10% to 15% of his patients. For these patients, who are especially at risk of associated illnesses such as cardiovascular disease, biologic therapies can be very effective. Gulliver is also looking forward to adding new oral medications to his range of treatment options, recently approved by Health Canada. (see Emerging Therapies, page 12, and Q&A, page 13).

Biologics, also known as biologic response modifiers, are drugs derived through the metabolic activity of living organisms, and are structurally much more complex than chemically synthesized drugs. Usually reserved for moderate to severe cases when other treatments have failed, these drugs treat the whole body rather than just the skin; that is, they suppress the immune response that causes the skin plaques and inflammation in the body.

Gooderham cites the case of a patient whose life changed dramatically after treatment with biologics. “He was 35 and still living at home with his mom, never had a girlfriend.” After starting a biologic, “he moved out, found a girlfriend, they have a child now. His life is completely different.”

Spinozzi has a similar tale. She began taking a biologic 11 years ago, after decades of trying every possible combination of traditional topical creams, UV light treatment and traditional prescription drugs. “After 12 weeks on a biologic, you would not believe the difference,” says Spinozzi, who says her skin was clear for the first time in her life. “I don’t think people really know how life-changing these drugs are.”

Gooderham adds that new medications such as biologics, which can be effective when nothing else is, can also lead to more fulfilling careers. “Patients would be more productive at work—they would be less distracted and have fewer doctors’ appointments. People can actually focus on their jobs.”

Not to mention employees “will be more loyal,” notes Gooderham. She recalls one patient, a young woman in her 20s, who experienced clear skin for the first time after taking a biologic. She was considering a career move, but knew that leaving her firm—with a drug plan that covers her medication—would interrupt treatment and likely trigger the return of her symptoms. Rather than run that risk—and possibly not get coverage in her next job—she decided to take a closer look at career options with her current employer.

“It’s pay now or pay later. If you pay it now, people get to stay employed, they get to stay healthy. If you pay later, they can’t work, they have to go on welfare and they’re no longer contributing to the system.” — Andrew Gosse

COVERAGE STRATEGIES FOR THE WORKPLACE

Biologics can give people with severe psoriasis their lives back—yet there is no question they cost more. In 2012, the average cost of a specialty prescription covered by a private plan was $1,240 per month, compared with $46 for all other drugs, according to Express Scripts Canada.²⁰ Collectively, biologics account for 22% of private drug spending but only 1.2% of the number of claims.²¹ In the case of psoriasis in particular, the average cost per patient is $20,000 to $30,000 a year. This number drops to $13,000 annually for patients taking small molecule drugs.

If these costs are foremost in the minds of plan sponsors, coverage is usually conditional upon

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²⁰ North American Drug Utilization Database
²¹ Express Scripts Canada
prior authorization criteria, and can be restricted. “There’s a multipronged obstacle course to get on biologics. First you have to be diagnosed properly by the right specialist. Then you have to find someone who’s willing to treat you. Then you have to get access to it,” says Gosse, who takes a biologic to manage his own psoriasis. But he insists that the savings associated with absenteeism, presenteeism, and short-term and long-term disability point to an investment with many positive returns.

“It’s pay now or pay later. If you pay it now, people get to stay employed, they get to stay healthy. If you pay later, they can’t work, they have to go on welfare and they’re no longer contributing to the system.”

Limited coverage often results in patients trying to make their case to insurers directly, which takes time away from work and can be very stressful. Both Gooderham and Gosse regularly see patients who are frustrated and upset by the apparent barriers to treatment, particularly when that treatment is their best, and often last, hope for a relatively normal life. Some even walk away from any treatment, which inevitably leads to a worsening of their condition and possible complications.

Gosse urges employers to ensure that HR staff are trained to help affected plan members navigate coverage by facilitating communications with the insurer and, ideally, a patient assistance program (PAP).

PAPs are available through pharmaceutical companies, as well as not-for-profit health charities, hospitals and government health agencies. PAPs can not only navigate coverage from private drug plans, but they can also co-ordinate additional coverage from public ones. They may also offer direct financial assistance in cases of need (e.g., to help cover a high out-of-pocket cost for co-insurance, or to provide bridge financing until public coverage kicks in). They can also assist physicians to complete the steps required as part of insurance carriers’ prior authorization process, and can co-ordinate additional education and training for patients to learn how to administer their medications.

A plan may not only limit the dollar amount of coverage; it may also limit eligibility to one drug in a given category, particularly among biologics. This can significantly limit the likelihood of positive health outcomes—and plan sponsors may spend tens of thousands on a medication that does not work and that the physician did not want to prescribe in the first place. ”The body has different receptors and tolerances. What works for one person doesn’t work for another,” says Gosse, who tried three biologics himself before finding the one that works best for him.

“Some biologics work better for some patients, so you need a range of medications available to properly treat your patients,” emphasizes Gooderham.

There is also the emerging issue of subsequent entry biologics (SEBs), which are becoming available as patents expire for original biologics. While SEBs are similar to biologics, they can never be identical due to manufacturing processes that are much more complex than those for traditional chemical pharmaceuticals. While plan designs may outline substituting an originator biologic with a lower-cost SEB, much as they already do using the generic versions of brand-name traditional pharmaceuticals, such substitutions may negatively affect health outcomes and therefore should be made by the physician to ensure patient safety. Indeed, Health Canada has advised provincial regulators that it does not support the automatic substitution of an SEB for its originator biologic.²²

If someone has been taking a biologic that works, which is then replaced with an SEB that fails, that person runs the risk of not being able to go back to his or her original biologic due to an immune response, explains Gosse. “Once you get off it, you can’t go back,” he warns. “It’s a point of no return.”

Whether it’s a topical drug for mild psoriasis or a biologic for severe psoriasis, plan sponsors are best served by plan designs that “fund all drugs deemed to be the standard of care without restrictions,” recommends the Report Card.
“Psoriasis is a whole-life disease,” says Andrew Gosse, president of the Canadian Psoriasis Network. Each patient’s journey is unique, with different challenges and outcomes—and the key is finding the right treatment at the right time. “These drugs are not in competition,” says Dr. Wayne Gulliver, professor of medicine and dermatology at Memorial University, St. John’s, Newfoundland and Labrador. “It’s whatever works for the patient.”

CURRENT THERAPIES

**Mild psoriasis**

Mild psoriasis involves the trunk, limbs and neck, and affects less than 5% of the body’s surface. Treatment can include corticosteroids, which are administered orally, via injection, or topically, followed by vitamin D-3 analogues that reduce the speed of the skin’s turnover. Topical drugs such as retinoids, anthralin and tar can also help manage symptoms. Combination therapy, which involves multiple therapies taken together—such as steroids and retinoids—can also reduce plaques. In addition to these medications, the Canadian Dermatology Association recommends emollients, such as creams, ointments and lotions, to restore the barrier function of the skin.
**Moderate to severe psoriasis**

Patients have moderate to severe psoriasis if plaques cover more than 5% of the skin, or lesions appear in areas such as the face, genitals, hands or feet. In addition to the topical therapies used for mild forms of psoriasis, those with moderate or severe symptoms may get positive results using a two-compound calcipotriol and betamethasone ointment, though it cannot be used on the face, genitals or skin folds around the genitals. Systemic drugs such as methotrexate, acitretin (a retinoid) and cyclosporine are mainstays of treatment. While they can be effective, they must be monitored as kidney and liver issues can arise.

Phototherapy can also be effective and involves the regular administration of UV light—usually four times a week—until patients see an improvement in their skin. Gulliver recalls one recent patient: “[One] gentleman had 25% of his body covered, had psoriasis for 10 years and was using a cream that wasn’t working, and I asked, ‘Do you get better in the summer?’ And he said: ‘Yeah, when I go to Florida or in the summertime.’ So now he’s going off for UV light, and he’s had psoriasis for 10 years. He’s never been told that UV light is effective in half of all patients.”

When traditional systemic drugs and phototherapy fail or lose their effectiveness, biologics are the next option (soon to be joined by a new small-molecule offering; see Emerging Therapies). Biologics target TNF-a and T-cells in the immune system in order to suppress the immune response that causes skin plaques and inflammation in the body. The current classes of biologics are adalimumab, etanercept and infliximab. SEBs for infliximab will soon be available in Canada.

**EMERGING THERAPIES**

**New small molecules**

A small-molecule drug can be taken orally, unlike biologics, which require injection or infusion. It can be used to treat mild to moderate psoriasis that has not responded well to methotrexate, by patients who experience frequent infections while taking a biologic or by those who do not wish to self-inject. The first small molecule for moderate to severe psoriasis, apremilast, received approval from Health Canada in November 2014. It is a selective inhibitor of phosphodiesterase 4 (PDE4), a degrading enzyme found in cells of the immune system. Currently, 200 patients are receiving this treatment in Canada. It requires no routine laboratory monitoring.

**New biologics**

The new interleukin 17A biologics target a critical molecule in the immune system called IL-17, which has been linked to the skin inflammation of psoriasis. JAK 3 (Janus kinase) inhibitors, currently in clinical trials, inhibit specific enzymes that lead to inflammation and cell growth. They are being tested in both oral and topical forms.

**Subsequent entry biologics**

Two SEBs or “biosimilars” are preparing to enter the market following the patent expiry of infliximab. These SEBs have been approved by Health Canada to treat psoriasis, among other autoimmune conditions. While pricing of SEBs is anticipated to be 15% to 30% less than the reference biologic, Health Canada does not support their interchangeability for patients already taking the originator biologic.
What’s new in psoriasis research?
Recent data suggests there’s a gene predicting a response off the biologic. What this means is that if you have this particular genetic marker, which many psoriasis patients do—especially if they have early age of onset and severe psoriasis—the response to [the biologic] is 96% versus 70%. So this gene can predict how well you’re going to respond to this drug.

Would this finding be helpful from an employer standpoint?
It would, and also for the patient. If you tell the patient, “You have a 96% response rate versus 70%,” it’s pretty reassuring.

How is this gene identified?
A simple blood test that costs $25.

Anything new coming down the pipeline?
The IL 17—there are three new drugs that are going to be absolutely fantastic. Very high response rates: they say 100% of the patients are 50% better, and 60% of the patients are 90% to 100% better. They are for moderate to severe psoriasis.

There are small molecules, an oral medication just approved by Health Canada. It’s a pill that you take twice a day and it works quite well in about a third of the patients. It works on the scalp, on nails, on psoriatic arthritis. It’s a different mechanism [than a biologic] … and for all employers worried about cost, my understanding is that it will be less costly than a biologic. An oral option, this will be a very good drug for patients who are not keen to inject themselves, and who don’t want to take methotrexate because of liver toxicity. They may not want to take cyclosporine because of the hypertension and renal toxicity.

Are biologics the standard of care now?
They have been the standard of care for years. In some jurisdictions, getting access to them is the concern.

How have biologics changed the course of the disease?
It’s not if you get better, anymore—it’s when we will get you better. If you look at psoriasis compared to vitiligo, alopecia, atopic eczema … it’s night and day for what we can do for the patient.

Are there people out there with psoriasis who are undiagnosed or undertreated?
A recent article published in the Journal of the Academy of Dermatology found probably a third to half of all patients are not being treated.

Why are these patients not being treated?
One reason is that they’ve had psoriasis for a long time. And they went to see their doctors, and they got the same old, same old. People are told there’s nothing they can do, there’s nothing for them, there’s nothing new. So live with it.
What are the vast majority of patients taking? Many of them are doing nothing. Some are using phototherapy. I’ve seen about 3,500 psoriasis patients. About 300 are on biologics. I still have a few patients on cyclosporine, I have a bunch on methotrexate and I have many hundreds taking phototherapy.

What are the dangers of not treating psoriasis? One is the rate of suicide. The rate of suicide in the general population is one in 10,000; the rate of suicide—at least in our database of 1,000 patients—for those with severe psoriasis is 1 in 300. Obesity is very high. Diabetes is increased. Hypertension is increased. 20% to 30% have psoriatic arthritis.

What would you say to those balking at price tags? The thing is, they shouldn’t be. There’s a lot of absenteeism and also presenteeism. People are unemployed. People have lessened employment opportunities because of their psoriasis. There is depression and anxiety in 30% of patients. When you clear their psoriasis, you give them back their lives.

If you look at psoriasis overall, the loss of life in general from all psoriasis patients is the same as high blood pressure, diabetes and heart disease—[patients] live three to five years [less than those without this condition]. It’s a systemic inflammatory disorder that takes away years of life. Let’s get serious about the condition. We have the tools. Now let’s do something about it.

RESOURCES

Here’s a list of resources to support psoriasis patients in the workplace. This list is also available at www.benefitscanada.com/roi/psoriasis

The Arthritis Society
Spells out the signs, symptoms and treatment options for patients with psoriatic arthritis.

CAPP/ACPP Report Card
Details the costs of treatments and obstacles to treatments, while offering recommendations for patient success.

Canadian Association of Psoriasis Patients
Lists treatment options, statistics about those living with the disease, and information on where to get help.

Canadian Psoriasis Network
http://www.cpn-rcp.com
Connects patients with clinical trials, new research and support groups, and provides current information on treatments and medications.

Canadian Skin Patient Alliance
http://www.skinpatientalliance.ca/en
Offers access to Skin Deep, a report card about the treatment of skin diseases in Canada, as well as information about subsequent entry biologics.

National Psoriasis Foundation
https://www.psoriasis.org
Heavy on new research, it provides information about women with psoriasis, as well as comprehensive information about psoriatic arthritis.

Psoriasis Connect
http://www.psoriasisconnect.com
Clearly lays out details about the disease, and how to treat it effectively and live the fullest life possible. Very detailed drug treatments listed.

Psoriasis Society of Canada
http://www.psoriasissociety.org
Provides sufferers with connections to other patients. Shares stories of those affected by the disease.
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