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Tildrakizumab In Everyday Dermatology: Clinical Insights From Challenging Psoriasis Cases

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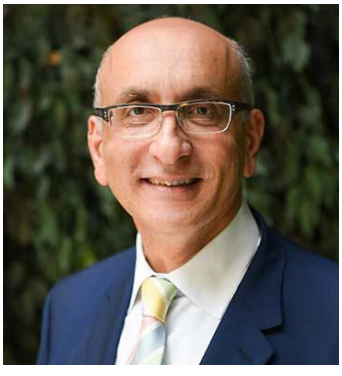
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Journal of Drugs in Dermatology

Tildrakizumab: In Office Administration for Elderly Patients



Leon Kircik MD

The evolution of biologic therapies for the treatment of psoriatic disease has led to the emergence of therapies that inhibit interleukin-23 (IL-23), a cytokine that has relatively recently been implicated in the pathogenesis of psoriasis.[1] Among this class of agents, tildrakizumab, a humanized immunoglobulin G1 (IgG1) monoclonal antibody that selectively binds the p19 subunit of IL-23, was shown in pivotal phase 3 trials to achieve high rates of clearance from baseline at week 12.[1,2]

The phase 3 trials and subsequent long-term extension studies, summarized ahead, establish both efficacy and long-term durability of response for tildrakizumab. Among responders at week 28, at least 88% maintained PASI-75, 65% maintained PASI-90, and 32% maintained PASI-100 at week 244.[3,4] Additionally, tildrakizumab has demonstrated a favorable long-term safety profile.[1-4]

Among biologic therapies broadly and IL-23 inhibitors specifically, there are differences in dosing and administration. After initial loading doses at weeks 0 and 4, tildrakizumab is administered every 12 weeks or approximately four times per year. Furthermore, tildrakizumab is typically administered within a healthcare setting, in which case it may be billed under Medicare Part B, rather than Medicare Part D, which primarily covers self-administered prescription drugs. For patients in the Medicare population, this can result in reduced out-of-pocket costs and easier access to treatment and less hurdles for biologic coordinators.

The patient cases presented in the pages ahead demonstrate how the documented durable efficacy and long-term safety of tildrakizumab, coupled with its dosing profile, provide unique clinical utility. Importantly, real-world experience echoes the treatment outcomes seen in controlled trials.

Particularly among our older patients with psoriasis, there may be concern about implementing long-term systemic, immunomodulatory therapy. The real-world cases presented here demonstrate that tildrakizumab can be confidently used in individuals with cardiometabolic disease and complex comorbidities.

In-office administration of treatment in the older population, potentially associated with better access and coverage, may also support better therapeutic adherence and, theoretically by extension, therapeutic outcomes. With maintenance dosing every 12 weeks, scheduling injections is not onerous for patients. Even individuals who are hesitant to receive injections due to needle phobia may be persuaded to undergo just four shots per year by a health care professional.

With demonstrated efficacy and safety both in controlled trials and in the clinical practice setting, the IL-23 inhibitor tildrakizumab may be a suitable treatment option for a wide range of psoriasis patients across all age groups. Although psoriasis develops in patients of all ages, the incidence of onset has been suggested to peak between ages 15 and 25 and ages 50 and 60.[5] Particularly in this latter population, the option to treat moderate to severe psoriasis with tildrakizumab may offer real-world advantages for safe, accessible long-term disease management.

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DISCLOSURE

Leon Kircik MD has received compensation from JDD for his editorial efforts.

REFERENCES

1. Näslund-Koch C, Zachariae C, Skov L. Tildrakizumab: an evidence-based review of its use in the treatment of moderate-to-severe chronic plaque psoriasis. *Ther Clin Risk Manag*. 2020;16:903-916. doi:10.2147/TCRM.S227880
2. Reich K, Papp KA, Blauvelt A, et al. Tildrakizumab versus placebo or etanercept for chronic plaque psoriasis (reSURFACE 1 and reSURFACE 2): results from two randomised controlled, phase 3 trials. *Lancet Lond Engl*. 2017;390(10091):276-288. doi:10.1016/S0140-6736(17)31279-5
3. Thaci D, Piaserico S, Warren RB, Gupta AK, et al. Five-year efficacy and safety of tildrakizumab in patients with moderate-to-severe psoriasis who respond at week 28: pooled analyses of two randomized phase III clinical trials (reSURFACE 1 and reSURFACE 2). *Br J Dermatol*. 2021;185(2):323-334. doi: 10.1111/bjd.19866. Epub 2021 May 4. PMID: 33544883.
4. Egeberg A, Jullien D, Gaarn Du Jardin K, et al. Five-year safety of tildrakizumab in patients with moderate-to-severe psoriasis from two phase 3 trials (reSURFACE 1 and reSURFACE 2): number needed to harm for occurrence of adverse events of special interest. J Dermatolog Treat. 2023;34(1):2220447. doi: 10.1080/09546634.2023.2220447. PMID: 37341303.
5. Henseler T, Christophers E. Psoriasis of early and late onset: characterization of two types of psoriasis vulgaris. *J Am Acad Dermatol*. 1985;13(3):450-6.

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ORIGINAL ARTICLE Journal of Drugs in Dermatology

Tildrakizumab for Real-World Psoriasis Care: Clinical Lessons From Medically Complex and Underserved Patient Populations

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ABSTRACT

Tildrakizumab, a humanized monoclonal antibody targeting the p19 subunit of interleukin-23, has demonstrated durable efficacy and a favorable long-term safety profile in moderate-to-severe plaque psoriasis. However, patients encountered in clinical practice frequently have comorbidities, treatment barriers, and social circumstances that are underrepresented in randomized clinical trials. This case review describes 16 patients treated with tildrakizumab across clinically relevant populations, including older adults, patients with cardiometabolic disease or complex medical comorbidities, and individuals with unique treatment considerations. Across these cases, tildrakizumab was associated with substantial improvement in psoriasis, including involvement of high-impact sites such as the scalp, nails and intertriginous regions. Durable disease control was observed in patients with prior malignancy, chronic infection, hepatic disease, cardiovascular comorbidities, polypharmacy, and prior biologic failure, without treatment-limiting adverse events attributed to tildrakizumab. In-office administration and every-12-week maintenance dosing also offered practical advantages for patients facing Medicare-related access considerations, self-injection aversion, inconsistent healthcare access, or adherence challenges. These cases demonstrate how tildrakizumab may be integrated into individualized psoriasis management and highlight its potential as a practical, effective, and well-tolerated treatment option across diverse real-world clinical settings.

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INTRODUCTION

Tildrakizumab is a humanized immunoglobulin G1 (IgG1) monoclonal antibody that selectively binds the p19 subunit of interleukin-23 (IL-23), a key cytokine in the pathogenesis of psoriasis.[1-4] In the pivotal phase 3 reSURFACE 1 and 2 clinical trials, tildrakizumab demonstrated efficacy in the treatment of moderate-to-severe plaque psoriasis, with over 60% of patients achieving a 75% reduction in the Psoriasis Area and Severity Index (PASI-75) at week 12 from baseline.[5] These findings supported tildrakizumab's approval by the US Food and Drug Administration as a 100 mg subcutaneous injection at weeks 0, 4, and every 12 weeks thereafter.[6]

The long-term safety and efficacy of tildrakizumab have been further demonstrated in long-term extension studies over 5 years. Among responders to tildrakizumab at week 28, at least 88% maintained PASI-75, 65% maintained PASI-90, and 32% achieved PASI-100 at week 244.[7-8] Taken together, these findings support the durability of response and favorable long-term safety profile of tildrakizumab in the treatment of patients with moderate-to-severe plaque psoriasis.

Unlike many biologic therapies, tildrakizumab is typically administered within a healthcare setting. As a result, tildrakizumab may be billed under Medicare Part B, which generally covers physician-administered medications, rather than Medicare Part D, which primarily covers self-administered prescription drugs, potentially reducing out-of-pocket costs and improving access in the Medicare population.[9-11] These features make tildrakizumab well-suited for populations frequently underrepresented in clinical trials, but commonly encountered in real-world clinical practice. In particular, tildrakizumab may be an important therapeutic option for elderly patients and especially for those with complex medical comorbidities, cardiometabolic disease, or unique social circumstances.

TABLE 1.

Summary of Clinical Characteristics and Outcomes of Patients Treated With Tildrakizumab

Case	Age/Sex	Key Comorbidities	Psoriasis Features	Rationale for Tildrakizumab	Outcome
Case 1 - Elderly 1	69/Female	Hypertension, hyperlipidemia	BSA 70%, PsA	First-line biologic, cost	Clearance; sustained ~3 years
Case 2 - Elderly 2	65/Female	Hypertension	BSA 7%, scalp	Quality of life impact (scalp)	Clearance; marked improvement in quality of life
Case 3 - Elderly 3	71/Male	Tobacco use	BSA 14%, scalp, nails, PsA	Skin + joint control	Clearance; sustained >5 years
Case 4 - Elderly 4	81/Female	Chronic obstructive pulmonary disease, hypertension, hyperlipidemia	BSA 17%, scalp, nails	Medicare access, high-impact sites	Marked improvement at 2 months and gradual clearance; sustained > 5 years
Case 5 - Elderly 5	65/Male	--	Previously controlled psoriasis on guselkumab	Medicare transition	Maintained clearance
Case 6 - Cardiometabolic 1	67/Male	Elevated BMI, diabetes, myocardial infarction, hypertension	BSA 6%, inverse	Cardiovascular safety, adherence	Clearance after 6 months; improved irritation
Case 7 - Cardiometabolic 2	78/Female	Metabolic syndrome	BSA 15%, nails	Comorbidity, Medicare access, high-impact disease	Clearance; sustained >3 years
Case 8 - Cardiometabolic 3	69/Male	Arrhythmia, hypertension	BSA 10%, PsA	Cardiovascular safety, adherence	BSA ~1%; sustained 3 years despite inconsistent adherence
Case 9 - Complex Comorbidities 1	78/Male	Malignancy, recurrent infections, venous thrombosis	BSA 9%, nails, face, hands	Safety, nail disease, infrequent dosing	Complete clearance in 4 months; sustained > 4 years
Case 10 - Complex Comorbidities 2	76/Female	Cirrhosis, metabolic syndrome, elevated BMI	BSA 4%, inverse regions, severe pain	Hepatic safety, intolerance to prior therapy	75% improved; sustained > 2 years
Case 11 - Complex Comorbidities 3	71/Male	Malignancy, chronic obstructive pulmonary disease, hypertension, polypharmacy	BSA 10%, scalp, arthralgia	Comorbidity, medication burden, cost	Near-clearance and sustained >5 years
Case 12 - Complex Comorbidities 4	48/Female	Hypertension, hyperlipidemia	BSA 40%, scalp, inverse	Multi-drug failure, durability	Complete clearance; sustained >5 years
Case 13 - Unique 1	62/Male	Hypertension, hyperlipidemia	BSA 20%	Cost, provider transition	Clearance after 1 year
Case 14 - Unique 2	36/Female	--	Psoriasis	Injection aversion	Clearance
Case 15 - Unique 3	57/Male	--	BSA 20%	In-office preference	Sustained control >3 years
Case 16 - Unique 4	52/Female	Hepatitis C	BSA 12%, scalp	Insurance appeal	BSA ~1% after 1 year

BSA, body surface area; PsA, psoriatic arthritis

Accordingly, this case review aims to highlight real-world clinical evidence supporting tildrakizumab's efficacy in the treatment of moderate-to-severe plaque psoriasis across populations that may particularly benefit from its therapeutic profile, including the elderly, patients with cardiometabolic disease, those with complex comorbidities, and those with unique treatment barriers that may complicate the selection or continuation of systemic therapy. Through these cases, we seek to illustrate how tildrakizumab may be effectively integrated into real-world psoriasis management across a range of clinically relevant contexts (Table 1).

CASE REVIEW

Tildrakizumab in the Elderly Population

Case 1: 69-year-old Woman With Severe Psoriasis

A 69-year-old woman with hypertension, hyperlipidemia, and prior tobacco use presented with a 3-year history of severe psoriasis. At presentation, the patient's disease involved approximately 70% body surface area (BSA) and affected the scalp, trunk, buttocks, and extremities, and was associated with severe symptoms including 10 out of 10 itch and pain. The patient also had a formal diagnosis of psoriatic arthritis. Prior treatment with methotrexate 15mg weekly along with topical corticosteroids and vitamin D analogues resulted in inadequate disease control. Secukinumab was considered, but the out-of-pocket cost was prohibitive for the patient.

Given the need for an effective yet well-tolerated systemic therapy in the setting of advanced age and comorbidities, tildrakizumab was initiated. The patient achieved complete clearance of cutaneous psoriasis with only occasional mild scalp flaring over nearly 3 years of treatment. Symptoms of itch and pain resolved, and her arthritic symptoms remained quiescent. Therapy was well tolerated without treatment-limiting adverse events.

This case highlights the role of tildrakizumab as a first-line biologic option in older patients with severe psoriasis, particularly when cost and tolerability are key considerations.

Case 2: 65-year-old Woman With Significant Quality of Life Impairment

A 65-year-old woman with hypertension presented with a 30-year history of psoriasis. Her disease had previously been limited to mild plaques on the elbows and knees but progressed to involve the scalp, significantly affecting her quality of life and limiting engagement with her social support system at the hair salon. At presentation, her psoriasis involved 7% BSA (Physician's Global Assessment (PGA) 3). Previously, the patient had tried topical corticosteroids along with ketoconazole shampoo with minimal improvement.

Given the disproportionate impact the patient's scalp psoriasis had on her daily functioning and social well-being, tildrakizumab was initiated to achieve effective clearance of high-impact sites. After 6 months of therapy with tildrakizumab, the patient achieved complete resolution of psoriasis with minimal need for adjunctive topical therapies. She has maintained this response for over 14 months, with marked improvement in quality of life and restoration of social engagement.

This case highlights the effectiveness of tildrakizumab in treating high-impact scalp psoriasis, demonstrating meaningful improvement in patient-centered outcomes beyond skin clearance.

Case 3: 71-year-old Man With Cutaneous and Joint Involvement

A 71-year-old man with prior tobacco use and a 25-year history of psoriasis and psoriatic arthritis presented with persistent disease. At presentation, the patient's psoriasis involved approximately 14% BSA (PGA 3), including the scalp and nails, and was accompanied by significant joint symptoms affecting the hands, ankles, and hips. Prior treatments included phototherapy, adalimumab, tofacitinib, and combination methotrexate with apremilast, all of which failed to achieve adequate control.

Given the need for effective management of both cutaneous and joint manifestations, tildrakizumab was initiated. The patient achieved complete control of psoriasis with resolution of joint symptoms and has maintained this response for over 5 years of continuous therapy. Although the patient was diagnosed with nonmelanoma skin cancer and actinic keratoses during follow-up, no treatment-related safety concerns or additional adverse effects were observed.

This case highlights the potential for tildrakizumab to provide sustained control of both skin and joint symptoms in older patients with longstanding psoriatic disease.

Case 4: 81-year-old Woman With Gradual Response to Tildrakizumab

An 81-year-old woman with chronic obstructive pulmonary disease, prior nicotine use, hypertension, and hyperlipidemia presented with a 5-year history of psoriasis. At presentation, the patient's psoriasis involved approximately 17% BSA (PGA 4), including high-impact areas such as the scalp and nails. Prior treatment was limited to topical therapies, which provided inadequate control.

Given the patient's Medicare coverage and involvement of high-impact sites, tildrakizumab was initiated due to its accessibility and demonstrated effectiveness in treating scalp and nail disease. The patient exhibited progressive improvement over time, with reduction to 7% BSA (PGA 1) at two months, further improvement to 2% BSA at 8 months, and complete clearance by 1 year. This response has been sustained over 5 years of continuous therapy.

This case highlights the potential for gradual yet durable disease control with tildrakizumab in older patients, as well as its accessibility within the Medicare population.

Case 5: 65-year-old Man undergoing Transition to Medicare

A 65-year-old man with plaque psoriasis previously well controlled on guselkumab underwent a transition to Medicare insurance, after which guselkumab therapy became financially prohibitive. Given the need for a cost-accessible alternative, he was transitioned to tildrakizumab due to its availability under Medicare coverage with supplemental insurance. The patient maintained complete disease control following the switch, without loss of efficacy. This case highlights the role of tildrakizumab as a practical therapeutic option in patients transitioning to Medicare, demonstrating preserved efficacy following in-class IL-23 inhibitor switching.

Tildrakizumab in Patients With Cardiometabolic Disease

Case 6: 67-year-old Man With Prior Myocardial Infarction, Diabetes, Hypertension, Hyperlipidemia, and Elevated Body Mass Index

A 67-year-old man with elevated body mass index (BMI), type 2 diabetes mellitus, hypertension, hyperlipidemia, prior colorectal malignancy, and a history of myocardial infarction requiring coronary artery bypass grafting presented with a long-standing history of psoriasis. At baseline, the patient's disease involved approximately 6% BSA (PGA 3) and primarily involved intertriginous areas including the axillae, inguinal folds, scrotum, and intergluteal cleft. The patient's psoriasis was frequently irritated by excess bodily perspiration. Prior therapies included topical corticosteroids and calcineurin inhibitors, but the patient reported infrequent adherence due to dissatisfaction with the greasy texture of these medications.

Given the patient's extensive cardiometabolic comorbidities, involvement of sensitive inverse areas, and need for a more practical treatment approach, tildrakizumab was initiated due to its efficacy and cardiovascular safety profile with convenient maintenance dosing. After 6 months of therapy with tildrakizumab, the patient achieved complete skin clearance with resolution of irritation and no longer required adjunctive topical treatments. He has maintained this response over 9 months of continued therapy.

This case highlights the effectiveness of tildrakizumab in patients with cardiometabolic disease, particularly in the management of inverse psoriasis where adherence to topical therapy may be challenging.

Case 7: 78-year-old Woman With Metabolic Syndrome

A 78-year-old woman with metabolic syndrome and a history of breast cancer presented with a lifelong history of psoriasis. At age 64, she was initiated on certolizumab with initial improvement followed by gradual loss of efficacy over time. At presentation, the patient's psoriasis involved approximately 15% BSA with prominent involvement of all 10 fingernails. Prior treatments also included topical and intralesional corticosteroids with minimal benefit.

Given the patient's metabolic comorbidities, high-impact nail disease, and need for an affordable therapy within the Medicare system, tildrakizumab was initiated due to its favorable tolerability, efficacy in nail psoriasis, and accessibility through Medicare Part B coverage. The patient achieved complete clearance of both cutaneous and nail disease and has maintained this response for over 3 years of therapy without tolerability concerns.

This case highlights the effectiveness of tildrakizumab in patients with metabolic comorbidities, demonstrating durable disease control and treatment accessibility in an older population following secondary biologic failure.

Case 8: 69-year-old Man With Cardiac Arrhythmia and Inconsistent Adherence

A 69-year-old man with cardiac arrhythmia managed with diltiazem, hypertension, and prior tobacco use presented with a several-year history of psoriasis. At presentation, the patient's disease involved approximately 10% BSA and was accompanied by a recent diagnosis of psoriatic arthritis. Prior treatments included apremilast, topical corticosteroids, and vitamin D analogues, which failed to achieve adequate disease control.

Given the patient's need for improved psoriatic control in the setting of cardiovascular comorbidities, tildrakizumab was initiated with consideration of its favorable cardiovascular safety profile. Over 3 years of therapy with tildrakizumab, the patient's psoriasis has significantly improved and is limited to approximately 1% BSA. Notably, the patient experienced challenges with consistent healthcare access due to geographic distance from his provider, resulting in intermittent adherence to scheduled dosing intervals. Despite this, meaningful disease control was achieved with tildrakizumab.

This case highlights the effectiveness of tildrakizumab in patients with cardiovascular disease and demonstrates its potential to provide consistent disease control even in the setting of real-world adherence limitations.

Tildrakizumab in Patients With Complex Comorbidities

Case 9: 78-year-old Man With Prior Malignancy and Recurrent Infections

A 78-year-old man with a history of laryngeal cancer 6 years prior treated with radiation, recurrent aspiration pneumonia, venous thromboembolism, anemia, and treatment-resistant onychomycosis presented with a several-year history of moderate-to-severe plaque psoriasis. At baseline, the patient's psoriasis involved the scalp, face, hands, nails, and feet (BSA 9%, PGA 4). Despite long-standing disease, prior treatment was limited to topical corticosteroids and calcineurin inhibitors due to concern surrounding his complex past medical history. Although the patient had culture-proven onychomycosis, standard oral antifungal therapy had resulted in only partial improvement, leading to concern for overlapping psoriatic nail disease.

Given the patient's history of malignancy, ongoing infection risk, significant nail involvement, and preference for infrequent dosing, tildrakizumab was initiated given its safety profile, efficacy in nail psoriasis, and quarterly maintenance schedule. Within 4 months, the patient achieved complete skin and nail clearance. Importantly, no increase in infection frequency was observed during treatment, and pulmonary infections were subsequently better controlled with adjunctive speech therapy. The patient has maintained therapy for 5 years with sustained disease control and no treatment-limiting toxicity. This case demonstrates durable disease control and good tolerability of tildrakizumab in a patient with prior malignancy, recurrent infections, and high-impact nail involvement.

Case 10: 76-year-old Woman With Cirrhosis, Sarcoidosis, and Metabolic Syndrome

A 76-year-old woman with a history of cirrhosis, metabolic syndrome, elevated BMI, sarcoidosis, and hyperthyroidism presented with a lifelong history of mild psoriasis that had acutely worsened in the months prior to evaluation. She developed severe involvement of intertriginous areas, including the inframammary folds, groin, and genital region, associated with 9/10 pain and approximately 4% BSA involvement. Previous treatments included topical hydrocortisone, which led to steroid-induced atrophy from overuse, and topical tacrolimus, which was discontinued due to intolerance. Targeted in-office narrowband ultraviolet B phototherapy was also attempted but ultimately discontinued due to inconvenience and limited adherence.
Given her underlying cirrhosis and complex metabolic and endocrine comorbidities, along with intolerance to topical therapies and difficulty maintaining phototherapy, tildrakizumab was initiated given its acceptable safety profile in the setting of hepatic disease and infrequent dosing schedule. Following treatment initiation, the patient experienced marked improvement in intertriginous plaques and associated pain, with substantial symptom relief within the first few months. She has maintained a PASI 75 response for over 2 years, with minimal reliance on adjunctive topical therapy and no reported adverse effects.

This case highlights the effectiveness of tildrakizumab in managing painful inverse psoriasis in a patient with cirrhosis and multiple comorbidities, particularly when conventional topical and phototherapy options are poorly tolerated.

Case 11: 71-year-old Man With Prior Malignancy, Pulmonary Disease, and Polypharmacy

A 71-year-old man with a history of prostate cancer, chronic obstructive pulmonary disease, hypertension, and polypharmacy presented with a 10-year history of progressively worsening psoriasis. At presentation, the patient's psoriasis involved approximately 10% BSA, including the scalp, and was accompanied by worsening arthralgia. Prior treatments included oral corticosteroids, adalimumab, apremilast, and ustekinumab, which provided inadequate disease control and were associated with increasing out-of-pocket costs.

Given the patient's multiple comorbidities, concurrent medication burden, and need for a cost-effective long-term therapy, tildrakizumab was initiated. The patient achieved near-complete resolution of psoriasis and reported marked improvement in joint symptoms, with durable disease control over more than 5 years of continuous treatment. Therapy was well tolerated without treatment-limiting toxicity.

This case highlights the utility of tildrakizumab in patients with multimorbidity and polypharmacy, demonstrating sustained disease control and good tolerability in a complex clinical setting.

Case 12: 48-year-old Woman With Multiple Biologic Exposures

A 48-year-old woman with hypertension, hyperlipidemia, and fibromyalgia presented with a 20-year history of psoriasis. The patient had previously received multiple systemic therapies, including efalizumab, adalimumab, ustekinumab, risankizumab, and ixekizumab, each of which initially improved her disease but subsequently lost efficacy over time despite appropriate adherence. At presentation, the patient's psoriasis involved approximately 40% BSA including the scalp and intertriginous areas. Although she did not have a formal diagnosis of psoriatic arthritis, the patient reported chronic intermittent arthralgias affecting the hands.

Given the patient's history of multiple prior treatment failures and need for sustained long-term disease control, tildrakizumab was selected. The patient achieved complete resolution of cutaneous psoriasis and has maintained this response for over 5 years of continuous therapy. She also reported meaningful improvement in joint symptoms during this period.

This case illustrates the potential of tildrakizumab to achieve durable disease control in patients with extensive prior biologic exposure and secondary treatment failure.

Tildrakizumab in Populations With Unique Treatment Considerations

Case 13: 62-year-old Man undergoing Care Transition

A 62-year-old man with hyperlipidemia, hypertension, and thrombocytopenia presented with a 30-year history of psoriasis. His disease had previously been well-controlled with etanercept for over a decade, followed by sustained control on ustekinumab after etanercept lost efficacy. After the retirement of his treating dermatologist, he was transitioned to risankizumab by a new provider. However, after 1 year of risankizumab therapy, the patient had persistent psoriatic disease involving approximately 20% BSA.

Given the combination of suboptimal response to risankizumab and high out-of-pocket costs, tildrakizumab was initiated to improve disease control while reducing financial burden. After 1 year of tildrakizumab therapy, the patient achieved complete clearance of his cutaneous disease with appropriate treatment tolerance.

This case highlights the role of tildrakizumab in managing psoriasis in the context of care transitions, demonstrating effective disease control following in-class biologic switching while addressing cost-related barriers.

Case 14: 36-year-old Woman With Needle Aversion

A 36-year-old healthy woman presented with a history of psoriasis since adolescence. Prior treatment with apremilast provided limited benefit and was discontinued due to gastrointestinal side effects. The patient reported a strong aversion to needles and was unable to perform self-injections, limiting the feasibility of most biologic therapies. Given these concerns, tildrakizumab was initiated due to its infrequent dosing schedule and administration within a healthcare setting. The patient achieved complete disease control and has maintained this response with continued adherence to therapy.

This case highlights the role of tildrakizumab in patients with barriers to self-administration, demonstrating how provider-administered therapy can support adherence and enable effective disease control.

Case 15: 57-year-old Man With Preference for In-Office Treatment

A 57-year-old healthy man presented with a 30-year history of psoriasis. At presentation, the patient's psoriasis involved approximately 20% BSA (moderate PGA). Prior treatments included adalimumab, etanercept, and multiple topical therapies, all of which failed to achieve adequate disease control. The patient expressed a preference for receiving treatment within a healthcare setting rather than self-administering injections at home. Accordingly, tildrakizumab was selected due to its provider-administered dosing schedule. The patient achieved sustained disease control and has maintained this response for over 3 years with consistent adherence to treatment.

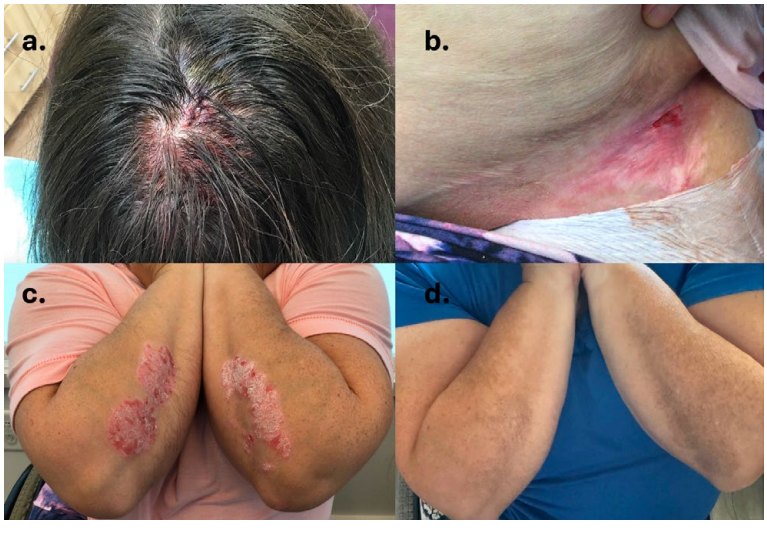
This case highlights the role of tildrakizumab in accommodating patient preferences for in-office therapy, demonstrating how treatment delivery models can influence adherence and long-term disease control.

Case 16: 52-year-old Woman With Chronic Infection

A 52-year-old woman with a history of hepatitis C presented with severely symptomatic psoriasis involving approximately 12% BSA and including the scalp and inguinal folds (Figure 1A-C). Prior treatments included methotrexate, topical corticosteroids, and calcineurin inhibitors, all of which failed to achieve adequate disease control. Initial insurance coverage was limited to infliximab and ustekinumab, but tildrakizumab was successfully obtained following an appeal and submission of a letter of medical necessity. After approximately 1 year of treatment, the patient experienced marked improvement, with psoriasis reduced to approximately 1% BSA (Figure 1D).

This case highlights the role of tildrakizumab in patients with chronic infection and demonstrates how insurance appeals can facilitate access to appropriate therapy, enabling effective disease control in complex clinical scenarios.

FIGURE 1. Severe Plaque Psoriasis involving the (A) Scalp, (B) Inguinal Folds, and (C) Elbows at Presentation, and (D) Elbows after 1 Year of Tildrakizumab Therapy.



Clinical images for Figure 1 provided by *Dr. Todd Schlesinger.*

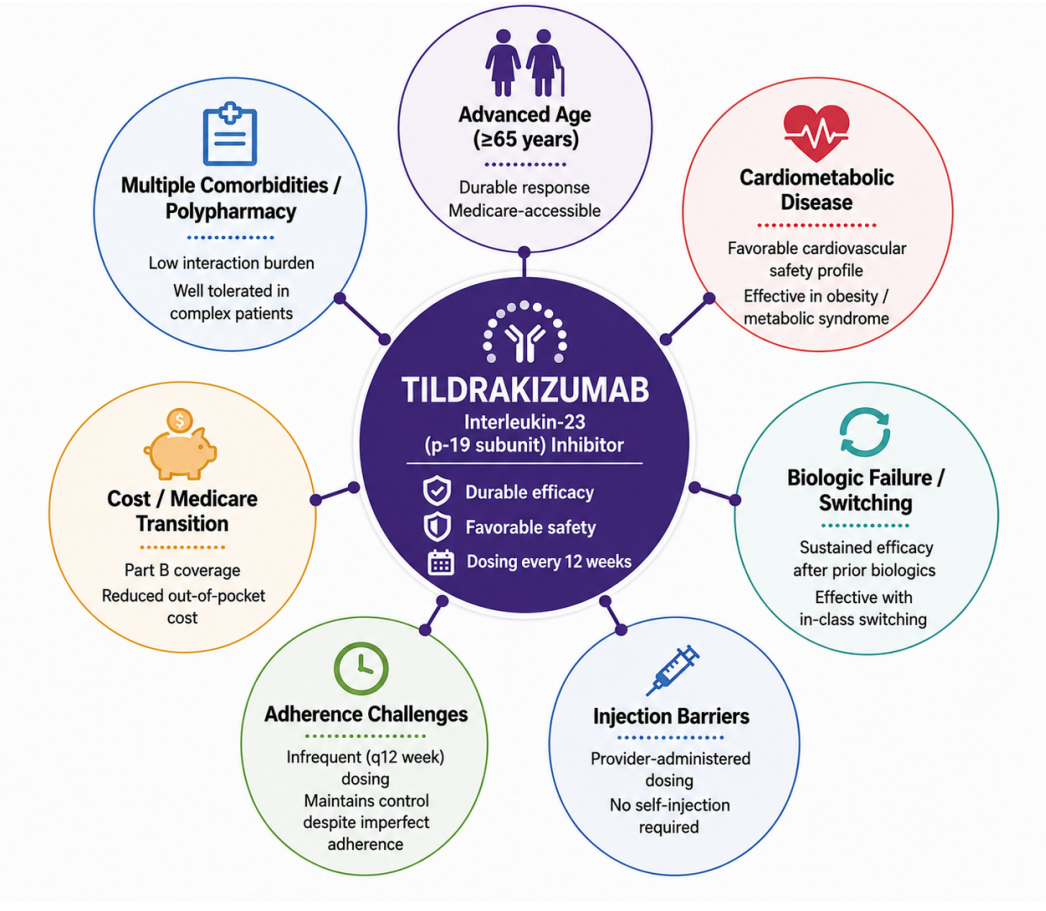
DISCUSSION

This case review highlights the role of tildrakizumab across clinically relevant real-world scenarios that extend beyond the populations typically represented in randomized clinical trials. Across diverse patient groups, including those with advanced age, cardiometabolic disease, complex comorbidities, and unique treatment barriers, tildrakizumab was associated with sustained disease control, consistent tolerability, and meaningful improvements in patient-centered outcomes within the limitations inherent to observational case-based evidence. Notably, effective disease management with tildrakizumab was observed in populations often underrepresented in clinical trials, including patients with prior malignancy, chronic infection, polypharmacy, and barriers to consistent adherence. Collectively, these cases underscore the versatility of tildrakizumab across diverse clinical contexts and reinforce its applicability in routine dermatologic practice (Figure 2). While some patients reported improvement in joint symptoms, tildrakizumab is not approved for the treatment of psoriatic arthritis, and these observations should be interpreted cautiously.

Importantly, this case series highlighted the long-term efficacy and tolerability of tildrakizumab in medically complex patients at increased risk of treatment-related complications. Durable responses were observed in individuals with prior malignancy, pulmonary disease, hepatic dysfunction, and significant medication burden without evidence of treatment-limiting adverse events related to tildrakizumab. These observations are consistent with prior real-world and pooled clinical trial data demonstrating a stable long-term safety profile in patients with multiple comorbidities or prior oncologic history.[12-14] In particular, tildrakizumab was well tolerated in patients with recent malignancy, consistent with a recent surveillance study suggesting that biologics may not affect oncologic outcomes in psoriasis patients.[15] Given the challenges associated with selecting systemic therapies in these populations, these findings support the use of tildrakizumab as a well-tolerated therapeutic option in medically complex patients.

Consistent efficacy was also observed in patients with cardiometabolic disease. In this series, patients with elevated BMI, type 2 diabetes mellitus, hypertension, and prior cardiovascular events achieved meaningful and sustained improvements in their psoriatic disease.These findings align with pooled post-hoc analyses of the reSURFACE 1 and 2 trials demonstrating durable responses across weight categories.[16-17] Additional analyses of the reSURFACE trials have suggested numerical decreases in fasting glucose, triglycerides, and systolic blood pressure among patients with metabolic syndrome,[18] though these findings were exploratory and not powered for cardiometabolic outcomes, while other smaller studies suggest that tildrakizumab 200 mg may lead to further metabolic benefits in this population.[19-20] Additionally, the long-term favorable safety profile observed across these cases aligns with emerging data suggesting no increased signal for cardiovascular adverse events with tildrakizumab.[21] Together, these findings suggest that tildrakizumab may be a strong therapeutic option in patients with overlapping cardiometabolic disease.

FIGURE 2. Real-World Clinical Scenarios for Tildrakizumab's Use in Moderate-to-Severe Plaque Psoriasis.



Similar patterns of efficacy and tolerability were observed among elderly patients, an especially important population given both their increased comorbidity burden and the accessibility of tildrakizumab through Medicare Part B coverage.[9-11] Prior pooled analyses of the reSURFACE trials demonstrated comparable efficacy between patients aged ≥65 years and younger cohorts, including similar rates of achieving absolute PASI <3 and Dermatology Life Quality Index scores of 0 or 1.[22] Additional prospective and retrospective studies have further supported these findings, demonstrating high rates of skin clearance and favorable safety outcomes in older populations.[23-25] In clinical practice, older patients often present with additional challenges including polypharmacy, increased comorbidity burden, and reduced tolerance of traditional systemic therapies. The cases presented in this review not only reinforce the well-established efficacy and safety profile of tildrakizumab in this population, but they also highlight the practical advantages of its dosing schedule and coverage structure under Medicare.

Beyond comorbidity subgroups, these cases also emphasize the importance of tailoring biologic therapy to individual patient circumstances and disease phenotypes. Tildrakizumab demonstrated particular utility in patients with involvement of high-impact sites such as the scalp, nails, and intertriginous regions. These findings are consistent with prior studies demonstrating strong efficacy of tildrakizumab in complex disease presentations, including high-impact site involvement, long-standing disease, and patients with concomitant joint symptoms.[26-31]

Additionally, tildrakizumab provided meaningful benefit in patients with unique treatment considerations, including aversion to self-injections or preference for in-office therapy, transitions in care, and inconsistent healthcare access. Selecting an appropriate biologic therapy that aligns with each patient's preferences is critical to optimizing disease control, improving quality of life, and supporting long-term adherence.[32-34] Real-world data further suggest that tildrakizumab is

associated with favorable persistence and adherence, while additional studies have demonstrated improvements in quality of life and work productivity among tildrakizumab-treated patients.[35-37] Additionally, our cases support prior literature suggesting that tildrakizumab may be an effective therapeutic option following failure of alternative biologic treatments, including both within-class and between-class switching.[38-40] These findings highlight the importance of integrating patient-centered factors into therapeutic decision-making and position tildrakizumab as a practical option across a wide range of real-world clinical scenarios.

Ultimately, the cases presented in this review support the use of tildrakizumab as a practical and effective therapeutic option for the long-term management of moderate-to-severe psoriasis across a broad spectrum of real-world clinical contexts. By combining durable efficacy, favorable tolerability, convenient dosing schedules, and high accessibility, tildrakizumab represents an effective biologic therapy that may be considered a practical and adaptable treatment option within the complexities of real-world psoriasis care.

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REFERENCES

1. Näslund-Koch C, Zachariae C, Skov L. Tildrakizumab: an evidence-based review of its use in the treatment of moderate-to-severe chronic plaque psoriasis. *Ther Clin Risk Manag.* 2020;16:903-916. doi:10.2147/TCRM.S227880

2. Schön MP, Erpenbeck L. The interleukin-23/interleukin-17 axis links adaptive and innate immunity in psoriasis. *Front Immunol.* 2018;9:1323. doi:10.3389/fimmu.2018.01323

3. Armstrong AW, Read C. Pathophysiology, clinical presentation, and treatment of psoriasis: a review. *JAMA.* 2020;323(19):1945. doi:10.1001/jama.2020.4006

4. Hawkes JE, Chan TC, Krueger JG. Psoriasis pathogenesis and the development of novel targeted immune therapies. *J Allergy Clin Immunol.* 2017;140(3):645-653. doi:10.1016/j.jaci.2017.07.004

5. Reich K, Papp KA, Blauvelt A, et al. Tildrakizumab versus placebo or etanercept for chronic plaque psoriasis (reSURFACE 1 and reSURFACE 2): results from two randomised controlled, phase 3 trials. *Lancet Lond Engl.* 2017;390(10091):276-288. doi:10.1016/S0140-6736(17)31279-5

6. ILUMYA (tildrakizumab-asmn) injection [package insert]. Sun Pharmaceutical Industries, Inc. U.S. Food and Drug Administration.

7. Thaci D, Piaserico S, Warren RB, et al. Five-year efficacy and safety of tildrakizumab in patients with moderate-to-severe psoriasis who respond at week 28: pooled analyses of two randomized phase III clinical trials (reSURFACE 1 and reSURFACE 2). *Br J Dermatol.* 2021;185(2):323-334. doi:10.1111/bjd.19866. PMID: 33544883.

8. Egeberg A, Jullien D, Gaarn Du Jardin K, et al. Five-year safety of tildrakizumab in patients with moderate-to-severe psoriasis from two phase 3 trials (reSURFACE 1 and reSURFACE 2): number needed to harm for occurrence of adverse events of special interest. *J Dermatolog Treat.* 2023;34(1):2220447. doi:10.1080/09546634.2023.2220447. PMID: 37341303.

9. Jia X, Zhao Y, Carrico J, et al. Cost-effectiveness of tildrakizumab for the treatment of moderate-to-severe psoriasis in the United States. *J Dermatolog Treat.* 2022;33(2):740-748. doi:10.1080/09546634.2020.1773382

10. Carrico J, Zhao Y, Jia X, et al. The budget impact of introducing tildrakizumab to a United States health plan for managing moderate-to-severe plaque psoriasis. *Pharmacoecon Open.* 2020;4(4):669-677. doi:10.1007/s41669-020-00208-9. PMID: 32219733.

11. Wu JJ, Jia X, Zhao Y, et al. Comparative cost-effectiveness of tildrakizumab and other commonly used treatments for moderate-to-severe psoriasis. *J Dermatolog Treat.* 2021;32(7):693-700. doi:10.1080/09546634.2019.1698700. PMID: 32233828.

12. Bardazzi F, Viviani F, Piraccini BM, et al. Tildrakizumab in complex psoriatic patients: an experience in Emilia-Romagna (Italy). *J Cutan Med Surg.* 2023;27(2):126-132. doi:10.1177/12034754231155889. PMID: 36995351.

13. Baniandrés O, Balaguer Franch I, Vilarrasa Rull E, et al. Tildrakizumab in psoriatic patients with current or past malignancy: a real-life cohort and literature review. *Int J Dermatol.* 2026;65(2):281-288. doi:10.1111/ijd.70053. PMID: 40931458.

14. Gottlieb S, Farberg AS, Bhatia N, et al. Real-world benefit of tildrakizumab for moderate-to-severe plaque psoriasis: findings from a systematic literature review and meta-analysis. *Dermatol Ther (Heidelb).* 2026;16(2):911-936. doi:10.1007/s13555-025-01625-6. PMID: 41501565.

15. Bar D, Brilant L, Lidar M, et al. Cancer progression, recurrence, and infection outcomes in psoriasis patients with active or recent malignancy treated with biologic therapy: a cohort study showing comparable safety to conventional agents. *J Am Acad Dermatol.* 2026;94(4):1184-1192. doi:10.1016/j.jaad.2025.12.039. PMID: 41419137.

16. Lebwohl MG, Blauvelt A, Bagel J, et al. Efficacy and safety of tildrakizumab for the treatment of moderate-to-severe plaque psoriasis over 5 years in patients living with obesity. *Br J Dermatol.* 2026;194(1):172-174. doi:10.1093/bjd/ljaf392. PMID: 41092123.

17. Thaçi D, Gerdes S, Du Jardin KG, et al. Efficacy of tildrakizumab across different body weights in moderate-to-severe psoriasis over 5 years: pooled analyses from the reSURFACE pivotal studies. *Dermatol Ther (Heidelb).* 2022;12(10):2325-2341. doi:10.1007/s13555-022-00793-z. PMID: 36098877.

18. Menter MA, Mehta NN, Lebwohl MG, et al. The effect of tildrakizumab on cardiometabolic risk factors in psoriasis by metabolic syndrome status: post hoc analysis of two phase 3 trials (reSURFACE 1 and reSURFACE 2). *J Drugs Dermatol.* 2020;19(8):703-708. doi:10.36849/JDD.2020.5337. PMID: 32845115.

19. Trovato E, Bianchelli T, Odorici G, et al. Effectiveness of tildrakizumab 200 mg in moderate-to-severe plaque psoriasis: a multicenter real-world study analyzing patient outcomes by weight, PASI, BMI, and previous therapies. *Dermatol Ther (Heidelb).* 2025;15(7):1941-1952. doi:10.1007/s13555-025-01442-x. PMID: 40413278.

20. Lanna C, Rivieccio A, Cattani C, et al. Tildrakizumab 200 mg: a step forward in psoriasis treatment with added metabolic benefits. *J Dermatolog Treat.* 2025;36(1):2512159. doi:10.1080/09546634.2025.2512159. PMID: 40518438.

21. Al-Yafeai Z, Sondhi M, Vadlamudi K, et al. Novel anti-psoriasis agent-associated cardiotoxicity, analysis of the FDA adverse event reporting system (FAERS). *Int J Cardiol.* 2024;402:131819. doi:10.1016/j.ijcard.2024.131819. PMID: 38301830.

22. Ter Haar ELM, Van den Reek JMPA, Gaarn Du Jardin K, et al. Efficacy and safety of tildrakizumab in older patients: pooled analyses of two randomized phase III clinical trials (reSURFACE 1 and reSURFACE 2) through 244 weeks. *Acta Derm Venereol.* 2023;103:adv17752. doi:10.2340/actadv.v103.17752. PMID: 37877618.

23. Fukasawa T, Yamashita T, Enomoto A, et al. The optimal use of tildrakizumab in the elderly via improvement of Treg function and its preventive effect of psoriatic arthritis. *Front Immunol.* 2023;14:1286251. doi:10.3389/fimmu.2023.1286251. PMID: 37928519.

24. Mastorino L, Dapavo P, Burlando M, et al. Effectiveness and safety of tildrakizumab in elderly and frail elderly psoriatic patients up to 2 years. *Psoriasis (Auckl).* 2025;15:339-350. doi:10.2147/PTT.S525256. PMID: 40791781.

25. Liu Q, Hu K, Sha Y, et al. Tildrakizumab in real-world Chinese psoriasis: efficacy-safety profiles from a 28-week retrospective cohort with geriatric, late-onset and metabolic syndrome stratification. *J Dermatolog Treat.* 2025;36(1):2598183. doi:10.1080/09546634.2025.2598183 . PMID: 41399323.

26. Gebauer K, Spelman L, Yamauchi PS, et al. Efficacy and safety of tildrakizumab for the treatment of moderate-to-severe plaque psoriasis of the scalp: a multicenter, randomized, double-blind, placebo-controlled, phase 3b study. *J Am Acad Dermatol.* 2024;91(1):91-99. doi:10.1016/j.jaad.2024.03.025. PMID: 38554938.

27. Sofen HL, Gebauer K, Spelman L, et al. Efficacy and safety of tildrakizumab for the treatment of moderate-to-severe plaque psoriasis of the scalp: week 52 results from a phase 3b, randomized, double-blind, placebo-controlled trial. *J Am Acad Dermatol.* 2025;92(4):816-824. doi:10.1016/j.jaad.2024.12.018. PMID: 39722400.

28. Trovato E, Cartocci A, Gaiani F, et al. Real-world efficacy of IL-23 inhibitors in psoriasis affecting high-impact areas: indirect comparison of tildrakizumab 200 mg, risankizumab, and gueslkumab-IL PSO (Italian Landscape Psoriasis). *Dermatol Ther (Heidelb).* 2026;16(3):1675-1692. doi:10.1007/s13555-026-01662-9. PMID: 41697632.

29. Lin TL, Fan YH, Fan KS, et al. Psoriatic arthritis risk in psoriasis patients receiving anti-IL-23 vs anti-IL-17: comparison of drug classes and individual agents. *Rheumatology (Oxford).* 2026;65(1):keaf489. doi:10.1093/rheumatology/keaf489. PMID: 41105233.

30. Galluzzo M, Talamonti M, Cioni A, et al. Efficacy of tildrakizumab for the treatment of difficult-to-treat areas: scalp, nail, palmoplantar and genital psoriasis. *J Clin Med.* 2022;11(9):2631. doi:10.3390/jcm11092631. PMID: 35566756.

31. Armstrong AW, Blauvelt A, Lebwohl M, et al. Efficacy and safety of tildrakizumab in patients with early- vs. late-onset psoriasis. *Br J Dermatol.* 2025;193(3):442-450. doi:10.1093/bjd/ljaf171. PMID: 40365708.

32. Kontzias C, Chandy R, Feldman SR. Choosing systemic agents for psoriasis. *Ann Pharmacother.* 2024;58(3):333-337. doi:10.1177/10600280231170031. PMID: 37341171.

33. Zaino M, Parks E, McNeil J, et al. Patients' preferences regarding modes of systemic psoriasis treatment - a qualitative study. *J Psoriasis Psoriatic Arthritis.* 2024;9(4):136-142. doi:10.1177/24755303241253200. PMID: 39381162.

34. Lebwohl MG, Carvalho A, Asahina A, et al. Biologics for the treatment of moderate-to-severe plaque psoriasis: a systematic review and network meta-analysis. *Dermatol Ther (Heidelb).* 2025;15(7):1633-1656. doi:10.1007/s13555-025-01423-0. PMID: 40329054.

35. Mrowietz U, Sommer R, Gerdes S, et al. Patient-reported well-being in value-based routine care using tildrakizumab: 52-week interim data of the phase IV positive study. *Psoriasis (Auckl).* 2025;15:243-259. doi:10.2147/PTT.S526748. PMID: 40605963.

36. Prajapati VH, Bellefontaine N, Gopalan D, et al. Tildrakizumab treatment patterns in adults with moderate-to-severe plaque psoriasis: a retrospective analysis from the Canadian patient support program. *Dermatol Ther (Heidelb).* 2025;15(8):2047-2059. doi:10.1007/s13555-025-01434-x. PMID: 40442565.

37. Bhutani T, Koo J, Heim J, et al. Improvements in psoriasis-related work productivity with tildrakizumab: results from a phase 4 real-world study in patients with moderate-to-severe plaque psoriasis. *Dermatol Ther (Heidelb).* 2024;14(4):1019-1025. doi:10.1007/s13555-024-01131-1. PMID: 38575729.

38. Caldarola G, De Luca E, Balato A, et al. Intraclass switching of interleukin-23 inhibitors in psoriasis: effectiveness, patterns and predictors of response - a retrospective multicentre study in Italy. *Clin Exp Dermatol.* 2026;51(3):451-456. doi:10.1093/ced/llaf476. PMID: 41161679.

39. Hren MG, Miriyala S, Khattri S. The utility of interleukin-23 intraclass switching in the treatment of plaque psoriasis: a retrospective review of 43 cases. *Clin Exp Dermatol.* 2024;50(1):137-140. doi:10.1093/ced/llae305. PMID: 39096268.

40. Zhang M, Hong S, Wang Q, et al. Biopharmaceutical switching in psoriasis treatment: a systematic review and meta-analysis. *JAMA Dermatol.* 2025;161(10):1029-1038. doi:10.1001/jamadermatol.2025.2714. PMID: 40768223.

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