Physician Spotlight: Jeffrey M. Cohen, MD

Biologic drugs have revolutionized the care of people with psoriasis, and growing evidence suggests that these drugs may also reduce risk of psoriasis co-morbidities. Here, Jeffrey M. Cohen, MD, assistant professor of dermatology at Yale School of Medicine in New Haven, CT, discusses the role biologics play in treating psoriasis today and gives us a sneak peek into the pipeline.

With so many biologics approved for psoriasis, how do you choose?

Jeffrey M. Cohen, MD: Oftentimes the choice of treatment takes several things into account: what the psoriasis looks like, what parts of the body are affected, how much of the body surface area is covered, the subtype, and any co-morbid conditions. Only some biologics can be used in certain situations. For example, some biologics are effective for both psoriasis and psoriatic arthritis (PsA). Having a history of heart failure points us away from tumor necrosis factor-alpha inhibitors and toward another class of biologics. If a patient has a history of inflammatory bowel disease, we stay away from interleukin-17 blockers.

How have biologics revolutionized the treatment of psoriasis?

Dr. Cohen: Biologics have been an absolute game-changer for psoriasis. We now can get patients 75 percent, 90 percent, or even 100 percent clear. This is something we never could do before and has been a huge, huge, huge help. Biologics have allowed us to target what we really feel is the root cause of psoriasis: inflammation in the skin and the whole body. We also have compelling evidence that they help with some comorbidities including cardiovascular disease (CVD), and that is a big deal, as CVD is one of the most important comorbidities of psoriasis and it looks like we have a way of modifying this risk. None of the older immunosuppressant medications had this ability.

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Do access barriers still exist, and how can they be removed?

Dr. Cohen: This is still a really big problem. I struggle with it personally for my patients. Insurance companies prefer one medication and may require us to go through drugs sequentially (step therapy) before moving toward biologics. The American Academy of Dermatology has been advocating strongly on behalf of patients and dermatologists to move policy in a way that allows us to be more in control of treatment choices. Many larger medical centers now have staff to help deal with prior authorizations and fight through the system. Pharmaceutical companies also have programs for patients who don't have insurance approval, but these are not permanent solutions. There are now several biosimilars approved for the treatment of psoriasis and PsA and others in the pipeline that were expected to lower costs and improve access. I don't think that we have seen what role they can play in bringing down costs and improving access to treatment, because they are not widely used yet.

What's exciting in the pipeline for psoriasis?

Dr. Cohen: The most exciting area in the psoriasis pipeline is the JAK inhibitors. We will have topical and oral forms, which is great, and they may be as effective as or even more effective than injections or infusions. There are new biologics coming out from various companies, but most are not against a novel target. They are different monoclonal antibodies that go against targets we already have, not brand-new cytokines. ■