Real-World Clinician- and Patient-Reported Outcomes and Treatment Persistence Following Bimekizumab Initiation in Patients with Psoriasis: 6-Month Results from the PPD CorEvitas Psoriasis Registry

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Objective

To describe clinical and patient-reported outcomes (PROs) and treatment persistence 6 months after bimekizumab (BKZ) initiation in patients with psoriasis (PSO)

Synopsis

- BKZ is a monoclonal antibody inhibiting interleukin (IL)-17A and IL-17F with demonstrated efficacy in clinical trials for PSO.[1–4]
- Real-world data are needed to evaluate BKZ in routine clinical practice in the United States (US).

Methods

- Real-world patient data were sourced from the PPD™ CorEvitas™ Psoriasis Registry – a US prospective, multicenter, observational registry.
- Eligible patients were ≥18 years old, had a PSO diagnosis, and initiated BKZ with ≥9 months of follow-up, or had 6-month follow-up visit, between October 2023–March 2025 (**Figure 1**).
- Six-month outcomes (range: 5–9) included clinician-reported measures (Psoriasis Area Severity Index [PASI], body surface area [BSA], Investigator Global Assessment [IGA]) and PROs (Dermatology Life Quality Index [DLQI]; pain, fatigue, itch 100-point visual analog scale [VAS]; and joint pain and overall wellness VAS for patients with dermatologist-diagnosed psoriatic arthritis [PsA]). Lower VAS scores indicate less severe itch, fatigue, and pain, as well as greater wellness.
- Treatment patterns were characterized by persistence, discontinuation, and switching at or before a follow-up visit within the 9-month window.
- Results were stratified by biologic-naïve and -experienced status at initiation.
- Continuous variables were reported as means with standard deviation (SD) or 95% confidence interval (CI), and categorical variables as counts and percentages.

Results

- Baseline characteristics in the overall cohort and among patients with 6-month outcomes are described in **Table 1**.
  - The overall cohort included 173 patients with PSO; 67.6% had PsA, and 86.1% were biologic-experienced, with 69.4% having used ≥2 prior biologics.
  - Mean PSO duration since diagnosis was 18.5 years.
- Among 113 patients with 6-month follow-up, 69.9% remained on BKZ and 8.8% switched therapies at 6 months.
  - Of 34 (30.1%) patients who discontinued, 52.9% discontinued due to safety reasons (minor or serious side effects) or efficacy reasons (inadequate initial response or failure to maintain initial response).
- Among patients with 6-month outcomes, mean PASI decreased from 6.8 at baseline to 2.5 at follow-up (mean difference: −4.3; 95% CI: −5.6, −3.1). Mean BSA decreased from 14.5 to 5.4 (mean difference: −9.2; 95% CI: −11.7, −6.6), and mean IGA decreased from 2.5 to 1.3 (mean difference: −1.3; 95% CI: −1.6, −1.0) (**Table 2**).
- At 6 months, 47.6% (95% CI: 38.3, 57.1) of patients had ≥90% reduction in PASI (PASI90), which was achieved by 66.7% (95% CI: 41.7, 84.8) of biologic-naïve and 44.4% (95% CI: 34.6, 54.7) of biologic-experienced patients (**Figure 2**).
- Mean DLQI decreased from 6.4 at baseline to 3.4 at follow-up (mean difference: −3.0; 95% CI: −4.1, −1.9) (**Table 2**).
- Among patients with dermatologist-diagnosed PsA, mean joint pain severity decreased from 47.8 at baseline to 40.3 at follow-up (mean difference: −7.5; 95% CI: −13.9, −1.1), and mean overall wellness improved from 41.6 to 33.4 (mean difference: −8.2; 95% CI: −14.9, −1.6) (**Table 2**).

Limitations

- Point estimates for the stratified analysis by biologic experience were unadjusted, and sample sizes for the biologic-naïve and biologic-experienced cohorts were small.

Conclusion

In this early post-approval cohort of patients receiving BKZ for treatment of PSO, BKZ demonstrated clinically meaningful 6-month skin clearance, PRO improvement, and persistence.

This real-world cohort had a higher rate of PsA, lower baseline BSA and PASI, and more biologic experience than BKZ clinical trial cohorts, reflecting post-approval use of BKZ in a difficult-to-treat population.[1–5]

These results support BKZ as an effective treatment for PSO, even in patients with high prior biologic experience and concomitant PsA.

Biologic-naïve patients had shorter time from PSO diagnosis to BKZ initiation and showed greater clinical improvements than biologic-experienced patients.

Summary

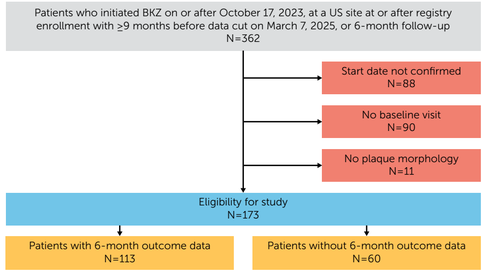
Real-world data were used to assess clinical outcomes and PROs at 6 months following initiation of **BKZ for PSO**.

Baseline demographics of this cohort suggested early **post-approval use of BKZ in difficult-to-treat populations** with higher PsA, lower BL BSA and PASI, and more biologic experience than BKZ clinical trials.

At **6 months**, BKZ demonstrated clinically meaningful improvements in skin clearance and quality of life measurements.

	Absolute mean change
PASI	Decreased from 6.8 to 2.5 (**−4.3**)
BSA	Decreased from 14.5 to 5.4 (**−9.2**)
IGA	Decreased from 2.5 to 1.3 (**−1.3**)
DLQI	Decreased from 6.4 to 3.4 (**−3.0**)

Figure 1 Patient flow diagram



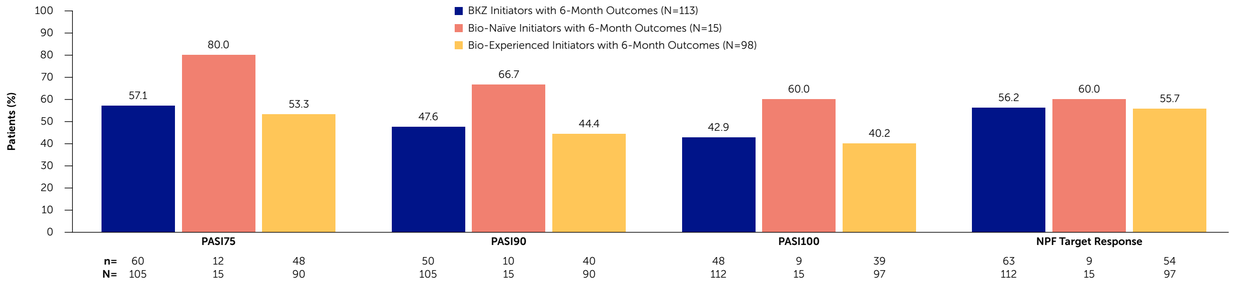
Among N=173 study-eligible patients, 107 had a 6-month follow-up visit; 6 did not have a 6-month follow-up visit but discontinued BKZ within the study period, with 6-month outcomes carried forward based on the discontinuation date. Another 60 patients did not have a 6-month follow-up visit and were not reported to have discontinued BKZ within the study period. Thus, there were 113 patients with 6-month outcomes and 60 patients without 6-month outcomes.

Table 1 Baseline characteristics of BKZ initiators

Characteristic	N	All BKZ Initiators (N=173)	N	BKZ Initiators with 6-Month Outcomes (N=113)	N	Biologic-Naïve (All Initiators) (N=24)	N	Biologic-Experienced (All Initiators) (N=149)
Demographic Characteristics								
Sex, n (%)	173		113		24		149	
Female		95 (54.9)		56 (49.6)		14 (58.3)		81 (54.4)
Age (years), mean (SD)	173	53.3 (14.9)	113	52.8 (15.4)	24	52.2 (15.8)	149	53.4 (14.7)
Race,[a] n (%)	173		113		24		149	
White		148 (85.5)		92 (81.4)		24 (100)		124 (83.2)
Lifestyle Characteristics								
BMI (kg/m^2), mean (SD)	150	32.2 (7.8)	101	31.8 (7.2)	22	30.0 (6.9)	128	32.6 (7.9)
BMI category, n (%)	150		101		22		128	
Obese: ≥30 kg/m^2		85 (56.7)		57 (56.4)		11 (50.0)		74 (57.8)
Overweight (25–<30 kg/m^2)		37 (24.7)		23 (22.8)		5 (22.7)		32 (25.0)
Underweight/normal (<25 kg/m^2)		28 (18.7)		21 (20.8)		6 (27.3)		22 (17.2)
Disease Characteristics								
PSO duration since diagnosis (years), mean (SD)	171	18.5 (15.5)	112	18.1 (15.9)	23	4.3 (6.8)	148	20.7 (15.3)
Involvement of difficult-to-treat areas, n (%)	173		113		24		149	
Scalp		88 (50.9)		59 (52.2)		6 (25.0)		82 (55.0)
Nail		43 (24.9)		31 (27.4)		2 (8.3)		41 (27.5)
Palmoplantar		21 (12.1)		17 (15.0)		2 (8.3)		19 (12.8)
Genital		22 (12.7)		20 (17.7)		1 (4.2)		21 (14.1)
Dermatologist-diagnosed PsA, n (%)	173	117 (67.6)	113	77 (68.1)	24	5 (20.8)	149	112 (75.2)
PsA duration (years),[b] mean (SD)	117	10.8 (9.6)	77	10.5 (9.1)	5	3.4 (1.1)	112	11.1 (9.7)
Treatment Characteristics								
Non-biologic-experienced at BKZ initiation, n (%)	173	149 (86.1)	113	98 (86.7)	24	0 (0)	149	149 (100)
Number of prior biologics,[c] n (%)	173		113		24		149	
0		24 (13.9)		15 (13.3)		24 (100)		0 (0)
1		29 (16.8)		21 (18.6)		0 (0)		29 (19.5)
2+		120 (69.4)		77 (68.1)		0 (0)		120 (80.5)
Biologic-naïve at BKZ initiation, n (%)	173	103 (59.5)	113	66 (58.4)	24	4 (16.7)	149	99 (66.4)
Number of prior non-biologics,[d] n (%)	173		113		24		149	
0		70 (40.5)		47 (41.6)		20 (83.3)		50 (33.6)
1		55 (31.8)		36 (31.9)		2 (8.3)		53 (35.6)
2+		48 (27.7)		30 (26.5)		2 (8.3)		46 (30.9)

[a] Other race categories included Asian, Black, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, multiracial, and other; **[b]** Restricted to patients with dermatologist-diagnosed PsA; **[c]** Prior biologics count did not include patient's current index biologic (i.e., BKZ); **[d]** Prior non-biologic use count did not include current non-biologic therapy, if applicable.

Figure 2 Proportion of patients achieving PASI responses at 6-month follow-up



NPF Target Response was defined as BSA ≤1%. BKZ initiators with PASI of 0 at baseline were excluded as PASI75, PASI90, and PASI100 responses were undefined for these initiators. BKZ initiators with unreported BL PASI or BSA were excluded from the analysis for that particular outcome.

Table 2 Change from baseline to follow-up in clinical and patient-reported outcomes for BKZ initiators with 6-month outcomes[a]

Characteristic	N	Baseline	Follow-Up	Absolute Mean Difference (95% CI)
PASI (Range: 0–72)	111			
Mean (SD)		6.8 (8.4)	2.5 (5.7)	−4.3 (−5.6, −3.1)
Median (Q1, Q3)		4.0 (1.8, 8.4)	0.4 (0, 2.4)	–
PASI, n (%)				
0	111	7 (6.3)	47 (42.3)	36.0 (26.5, 45.2)
0 (restricted to BL >0)	104	0 (0)	41 (39.4)	39.4 (29.9, 49.0)
≤1	111	16 (14.4)	66 (59.5)	45.0 (34.4, 54.1)
≤1 (restricted to BL >1)	95	0 (0)	52 (54.7)	54.7 (44.0, 64.4)
≤2	111	36 (32.4)	78 (70.3)	37.8 (26.9, 47.2)
≤2 (restricted to BL >2)	75	0 (0)	46 (61.3)	61.3 (49.0, 71.5)
≤4	111	56 (50.5)	91 (82.0)	31.5 (21.5, 40.7)
≤4 (restricted to BL >4)	55	0 (0)	38 (69.1)	69.1 (54.4, 79.7)
BSA (% Involvement)	111			
Mean (SD)		14.5 (18.0)	5.4 (13.4)	−9.2 (−11.7, −6.6)
Median (Q1, Q3)		9.0 (4.0, 20.0)	1.0 (0, 3.5)	–
IGA (0–4)	111			
Mean (SD)		2.5 (1.0)	1.3 (1.3)	−1.3 (−1.6, −1.0)
Median (Q1, Q3)		3.0 (2.0, 3.0)	1.0 (0, 3.0)	–
IGA, n (%)				
0 (clear)	111	8 (7.2)	49 (44.1)	36.9 (26.9, 46.3)
0 (clear; restricted to BL ≥1)	103	0 (0)	43 (41.7)	41.7 (32.0, 51.4)
0 or 1 (clear/almost clear)	111	17 (15.3)	69 (62.2)	46.8 (36.5, 55.6)
0 or 1 (clear/almost clear; restricted to BL ≥1)	94	0 (0)	53 (56.4)	56.4 (45.6, 66.0)
DLQI (Range: 0–30)	112			
Mean (SD)		6.4 (6.3)	3.4 (5.3)	−3.0 (−4.1, −1.9)
Median (Q1, Q3)		4.0 (2.0, 9.0)	1.0 (0, 4.2)	–
DLQI, n (%)				
0/1 (no effect)	113	25 (22.1)	60 (53.1)	31.0 (20.7, 40.2)
0/1 (no effect; restricted to patients with BL ≥2)	88	0 (0)	39 (44.3)	44.3 (33.5, 54.7)
≤5 (no/small effect)	113	65 (57.5)	94 (83.2)	25.7 (15.3, 35.3)
≤5 (no/small effect; restricted to BL DLQI ≥6)	48	0 (0)	35 (72.9)	72.9 (57.2, 83.4)
Fatigue VAS (Range: 0–100)	112			
Mean (SD)		35.6 (28.2)	25.2 (25.9)	−10.4 (−14.7, −6.0)
Median (Q1, Q3)		32.5 (10.0, 58.5)	18.5 (1.5, 40.0)	–
Skin pain VAS (Range: 0–100)	112			
Mean (SD)		31.0 (31.7)	16.7 (24.7)	−14.3 (−19.9, −8.8)
Median (Q1, Q3)		19.0 (2.8, 51.2)	5.0 (0, 20.0)	–
Itch VAS (Range: 0–100)	112			
Mean (SD)		45.9 (33.5)	25.2 (30.3)	−20.7 (−26.8, −14.6)
Median (Q1, Q3)		50.0 (10.0, 75.0)	10.0 (0, 40.0)	–
EQ-5D VAS (Range: 0–100)[b]	111			
Mean (SD)		72.0 (20.3)	73.5 (19.8)	1.5 (−1.8, 4.7)
Median (Q1, Q3)		76.0 (65.0, 85.0)	75.0 (66.5, 90.0)	–
Joint Pain Severity (Range: 0–100)[c]	62			
Mean (SD)		47.8 (28.4)	40.3 (29.5)	−7.5 (−13.9, −1.1)
Median (Q1, Q3)		50.0 (25.0, 70.0)	40.0 (15.0, 60.0)	–
Overall Wellness (Range: 0–100)[c]	62			
Mean (SD)		41.6 (29.1)	33.4 (29.5)	−8.2 (−14.9, −1.6)
Median (Q1, Q3)		45.0 (15.0, 60.0)	25.0 (8.5, 50.0)	–

[a] The total number of BKZ initiators with 6-month outcomes was 113; **[b]** 0=worst imaginable health state, 100=best imaginable health state. A higher value on EQ-5D represents better health; a positive difference on EQ-5D at follow-up represents improvement; **[c]** Restricted to patients with dermatologist-diagnosed PsA.

BKZ: bimekizumab; **BL:** baseline; **BMI:** body mass index; **BSA:** body surface area; **CI:** confidence interval; **DLQI:** Dermatology Life Quality Index; **EQ-5D:** EuroQol 5-Dimension; **GI:** gastrointestinal; **IGA:** Investigator Global Assessment; **IL:** interleukin; **NPF:** National Psoriasis Foundation; **PASI:** Psoriasis Area Severity Index; **PASI75:** ≥75% PASI reduction; **PASI90:** ≥90% PASI reduction; **PASI100:** complete skin clearance; **PRO:** patient-reported outcome; **PsA:** psoriatic arthritis; **PSO:** psoriasis; **Q:** quartile; **QoL:** quality of life; **SD:** standard deviation; **US:** United States; **VAS:** visual analog scale.

References: [1]Reich K et al. N Engl J Med. 2021;385(2):142–152; [2]Warren RB et al. N Engl J Med. 2021;385(2):130–141; [3]Reich K et al. Lancet. 2021;397(10273):487–498; [4]Gordon KB et al. Lancet. 2021;397(10273):475–486; [5]Langley RG et al. American Association of Dermatology 2025. Presentation #63312. **Author Contributions:** Substantial contributions to study conception/design, or acquisition/analysis/interpretation of data: **BS**, **MS**, **AHL**, **RD**, **WC**, **KC**, **MP**, **PM**, **HH**, **BG**, **RL**, **JS**, drafting of the publication, or reviewing it critically for important intellectual content: **BS**, **MS**, **AHL**, **RD**, **WC**, **KC**, **MP**, **PM**, **HH**, **BG**, **RL**, **JS**, and final approval of the publication: **BS**, **MS**, **AHL**, **RD**, **WC**, **KC**, **MP**, **PM**, **HH**, **BG**, **RL**, **JS**. **Author Disclosures: BS:** Consultant (honoraria) for AbbVie, Almirall, Alumis, Amgen, Arcutis, Boehringer Ingelheim, Bristol Myers Squibb, Capital One, Dermavant, Eli Lilly and Company, Janssen, LEO Pharma, Maruho, Meiji Seika Pharma, Novartis, Oruka, Pfizer, Protagonist, Rapt, Regeneron, Sanofi, Takeda, Thermo Fisher Scientific, UCB, and Union Therapeutics; stock options from Connect Biopharma and Mindera Health; speaker for AbbVie, Arcutis, Dermavant, Eli Lilly and Company, Incyte, Janssen, Regeneron, and Sanofi; Scientific Co-Director (consulting fee): CorEvitas Psoriasis Registry; investigator for CorEvitas Psoriasis Registry; editor-in-chief (honorarium): Journal of Psoriasis and Psoriatic Arthritis. **MS, AHL, RD, WC, KC, MP:** Employees of Thermo Fisher Scientific, Inc. **PM, HH, BG, RL, JS:** Employees and shareholders of UCB. **Disclosures:** The PPD™ CorEvitas™ Psoriasis Registry was developed in collaboration with the National Psoriasis Foundation (NPF). This study is sponsored by the PPD™ clinical research business of Thermo Fisher Scientific, and funded by UCB. PPD™ CorEvitas™ Clinical Registries has been supported through contracted subscriptions in the last two years by AbbVie, Amgen, Inc., Arena, Boehringer Ingelheim, Bristol Myers Squibb, Chugai, Eli Lilly and Company, Genentech, GSK, Janssen Pharmaceuticals, Inc., LEO Pharma, Novartis, Ortho Dermatologics, Pfizer, Inc., Sun Pharmaceutical Industries Ltd., and UCB S.A. **Acknowledgments:** This study was funded by UCB. We would like to thank the patients and their caregivers in addition to the investigators and their teams who contributed to this study. The authors acknowledge Ari Navetta, BS, and Quinn Ho, PhD, of Costello Medical, Boston, MA, for medical writing, and the Costello Medical Creative team for graphic design assistance. All costs associated with development of this poster were funded by UCB.

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