National Psoriasis Foundation COVID-19 Task Force: Schedule of Updates to Guidelines

Changes shown in highlighted text:

Revision date: April 27, 2021

Category 4: Reinstatement of Guidance Statements 4.8 & 4.9

4.8
In most cases, patients should take the first COVID-19 vaccine currently approved by emergency use authorization for which they are eligible and offered based on federal, state, and local guidance. Currently available vaccines include the mRNA vaccines (manufactured by Pfizer and Moderna, see recommendation 4.5) and a replication-incompetent adenovirus type 26-vectored vaccine encoding a stabilized variant of the SARS-CoV-2 S protein (Ad26.COV2.S, manufactured by Johnson & Johnson). Systemic medications for psoriasis or psoriatic arthritis are not a contraindication to any currently available COVID-19 vaccines (be they mRNA-based or adenovirus vectored vaccine).

4.9
It is recommended that patients who are to receive an Ad26.COV2.S vaccine continue their biologic or oral therapies for psoriasis and/or psoriatic arthritis in most cases. Patients 60 or older who have at least one comorbidity associated with an increased risk for poor COVID-19 outcomes,* and who are taking methotrexate with well-controlled psoriatic disease, may, in consultation with their prescriber, consider holding it for 2 weeks after receiving the Ad26.COV2.S vaccine in order to potentially improve vaccine response. Holding methotrexate for 2 weeks following influenza vaccination in patients with rheumatoid arthritis resulted in a modest improvement in antibody titer response, with unknown clinical significance. It is not known if holding methotrexate for 2 weeks following the Ad26.COV2.S vaccine will result in clinically meaningful benefits for vaccine efficacy. Shared decision-making between clinician and patient is recommended to guide discussions about use of systemic therapies during the pandemic (see guidance 2.5 for definition of shared decision making, see guidance 4.6 for continuation of biologic or oral therapies during mRNA vaccine administration).

* https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

Revision date: April 13, 2021

Category 4 revisions: Suspension of Guidance Statements 4.8 and 4.9

The NPF COVID-19 task force is suspending guidance statements 4.8 and 4.9 in light of recent guidance from FDA and CDC recommending a pause in the use of the J&J COVID-19 vaccine

while a safety signal of an extremely rare type of severe blood clot is being investigated. The event was reported in 6 patients out of the more than 6.8 million who have received this vaccine to date (https://www.cdc.gov/media/releases/2021/s0413-JJ-vaccine.html).
Please see recommendations 4.5 and 4.6 regarding use of mRNA-based vaccines.

Revision date: April 1, 2021

Category 5 revisions
5.2

Patients with psoriatic disease who become infected with SARS-CoV-2 should be prescribed and adhere to evidence-based COVID-19 therapies. Evidence-based therapies* currently include supportive care for all patients with consideration of the following:

For outpatients:

• Casirivimab and imdevimab to be administered together for patients meeting specific criteria and who are at high risk for progressing to severe COVID-19 and/or hospitalization

• Bamlanivimab and Etesevimab to be administered together for patients meeting specific criteria and who are at high risk for progressing to severe COVID-19 and/or hospitalization

For hospitalized patients:

- Dexamethasone (systemic steroids) for patients meeting specific criteria
- Remdesivir treatment for patients meeting specific criteria
- Baricitinib, in combination with remdesivir, for patients meeting specific criteria
- Tocilizumab, in combination with dexamethasone, for patients meeting specific criteria

The care of the hospitalized patient should include consultation with rheumatologists, dermatologists, and/or infectious disease specialists as medically necessary.

* Evidence based therapies are those that have been tested in well-conducted randomized controlled clinical trials, and have proven benefit on clinically relevant COVID-19 outcomes.

Revision date: March 4, 2021

Category 4 additions

4.8
In most cases, patients should take the first COVID-19 vaccine currently approved by emergency use authorization for which they are eligible and offered based on federal, state, and local guidance. Currently available vaccines include the mRNA vaccines (manufactured by Pfizer and Moderna, see recommendation 4.5) and a replication-incompetent adenovirus type 26-vectored vaccine encoding a stabilized variant of the SARS-CoV-2 S protein (Ad26.COV2.S, manufactured by Johnson & Johnson). Systemic medications for psoriasis or psoriatic arthritis are not a contraindication to any currently available COVID-19 vaccines (be they mRNA-based or adenovirus vectored vaccine).

4.9
It is recommended that patients who are to receive an Ad26.COV2.S vaccine continue their biologic or oral therapies for psoriasis and/or psoriatic arthritis in most cases. Patients 60 or older who have at least one comorbidity associated with an increased risk for poor COVID-19 outcomes,* and who are taking methotrexate with well-controlled psoriatic disease, may, in consultation with their prescriber, consider holding it for 2 weeks after receiving the Ad26.COV2.S vaccine in order to potentially improve vaccine response. Holding methotrexate for 2 weeks following influenza vaccination in patients with rheumatoid arthritis resulted in a modest improvement in antibody titer response, with unknown clinical significance. It is not known if holding methotrexate for 2 weeks following the Ad26.COV2.S vaccine will result in clinically meaningful benefits for vaccine efficacy. Shared decision-making between clinician and patient is recommended to guide discussions about use of systemic therapies during the pandemic (see guidance 2.5 for definition of shared decision making, see guidance 4.6 for continuation of biologic or oral therapies during mRNA vaccine administration).

* https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

Revision date: February 10, 2021

Category 2 additions

2.6: TB Tests and mRNA COVID-19 Vaccines:

Until more data are available, decisions about the timing of latent tuberculosis infection (LTBI) screening to facilitate initiation of oral or biologic therapy should involve a risk-benefit discussion between individual patients and their prescribers, which should consider individual epidemiologic risk factors for LTBI, treatment-related risk of LTBI reactivation (e.g., higher with TNFi), and urgency to initiate therapy. If TST or IGRA is done within 6 weeks after the first COVID-19 mRNA vaccine dose and there is a concern for a false negative result*, the test can be repeated ≥ 4 weeks after the second COVID-19 mRNA vaccine dose.

* https://www.cdc.gov/tb/publications/letters/covid19-mrna.html

---
Supporting language:

According to the CDC, not enough is known about COVID-19 mRNA vaccines to say definitively whether mRNA vaccination could interfere with tuberculin skin test (TST) and interferon gamma release assays (IGRA, e.g., Quantiferon Gold) by causing a false negative result. Ideally, the CDC recommends waiting 4 weeks after completion of a 2-dose mRNA COVID-19 vaccine series prior to latent TB (LTBI) screening. There are no data to inform or suggest that either test will impact efficacy of COVID-19 vaccination, nor any data to suggest an impact of mRNA vaccination on reactivity of TST or IGRA.

At present, the TF does not feel there are enough data to raise concern for an interference between COVID-19 vaccines and TST/IGRA results, and that for most patients, LTBI screening for biologic planning should proceed as planned, rather than be delayed; this should not change standard of care designed to optimize disease control of patients who would benefit from an oral or biologic treatment for psoriatic disease.

Revision date: January 25, 2021

Category 4 revisions

4.5
Patients with psoriatic disease, who do not have contraindications to vaccination, should receive an mRNA-based COVID-19 vaccine as soon as it becomes available to them based on federal, state, and local guidance. Systemic medications for psoriasis or psoriatic arthritis are not a contraindication to the mRNA-based COVID-19 vaccine. If vaccine supply is limited, the TF recommends following CDC's prioritization guidelines for early vaccination for selected groups based on their comorbidities and work setting.
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations-process.html

Patients with psoriatic disease may be in a high priority group ("Phase 1c: Persons aged 16–64 years with high-risk medical conditions") due to psoriasis associated comorbidities (such as those known to increase COVID-19 risk, e.g., chronic kidney disease, COPD, heart disease, obesity, type 2 diabetes, or smoking or might increase COVID-19 risk, e.g., hypertension, liver disease, or overweight*) or treatments that CDC classifies as making them more susceptible to infection. Examples of medications that may make a patient more susceptible to infection provided by CDC include use of oral (e.g., prednisone) or intravenous corticosteroids or other medicines that lower the body's ability to fight some infections (e.g., mycophenolate, sirolimus, cyclosporine, tacrolimus, etanercept, rituximab**). Based on prescribing information, additional medications for psoriasis and/or psoriatic arthritis which may be classified as possibly lowering the body's ability to fight some infections include apremilast, leflunomide, methotrexate, tofacitinib, and biologics which target cytokines TNF, IL12/23, IL17, and IL23 or T cells (e.g., abatacept).

* https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

**
https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/immunocompromised.html

Revision date: December 12, 2020

Category 4 additions

4.5:
Patients with psoriatic disease, who do not have contraindications to vaccination, should receive a mRNA-based COVID-19 vaccine as soon as it becomes available to them based on federal, state and local guidance. Systemic medications for psoriasis or psoriatic arthritis are not a contraindication to the mRNA-based COVID19 vaccine. If vaccine supply is limited, the TF recommends following CDC's prioritization guidelines for early vaccination for selected groups based on their comorbidities and work setting.

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations-process.html

4.6:
It is recommended that patients who are to receive a mRNA-based COVID-19 vaccine continue their biologic or oral therapies for psoriasis and/or psoriatic arthritis in most cases. Shared

decision-making between clinician and patient is recommended to guide discussions about use of systemic therapies during the pandemic (see guidance 2.5 for definition of shared decision making).

4.7:
For patients with psoriatic disease deciding whether or not to participate in a COVID-19 therapeutic or vaccine clinical trial, the TF recommends that the decision should be made on a case-by-case basis with shared decision-making between the patient, researcher, and provider.

Category 5 revisions

5.2

Patients with psoriatic disease who become infected with SARS-CoV-2 should be prescribed and adhere to evidence-based COVID-19 therapies. Evidence-based therapies* currently include supportive care for all patients and:

For outpatients:

- Bamlanivimab for patients meeting specific criteria and who are at high risk for progressing to severe COVID-19 and/or hospitalization
- Casirivimab and imdevimab to be administered together for patients meeting specific criteria and who are at high risk for progressing to severe COVID-19 and/or hospitalization

For hospitalized patients:

- Dexamethasone (systemic steroids) for patients meeting specific criteria
- Remdesivir treatment for patients meeting specific criteria
- Baricitinib, in combination with remdesivir, for patients meeting specific criteria

The care of the hospitalized patient should include consultation with rheumatologists, dermatologists, and/or infectious disease specialists as medically necessary.

*Evidence based therapies are those that have been tested in well-conducted randomized controlled clinical trials, and have proven benefit on clinically relevant COVID19 outcomes.

https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-monoclonal-antibodies-treatment-covid-19

https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-drug-combination-treatment-covid-19

Revision date: November 30, 2020

Category 5 additions

5.4.2. At this time, due to insufficient data to recommend for or against the use of convalescent plasma for the treatment of COVID-19 in patients with psoriatic disease, the TF recommends

convalescent plasma to primarily be used in the setting of a clinical trial. Outside of a clinical trial, its use may be considered on a case-by-case basis with shared decision-making between the patient and provider.

5.4.3. Ivermectin is not recommended for the prevention or treatment of COVID-19 in patients with psoriatic disease outside of a clinical trial.

Revision date: November 17, 2020

Category 5

Patients with psoriatic disease who become infected with SARS-CoV-2 should be prescribed and adhere to evidence-based COVID-19 therapies. Evidence-based therapies* should be used, currently including supportive care for patients with mild disease, bamlanivimab for treatment of mild-to-moderate disease in adult and pediatric outpatients meeting specific criteria who are at high risk for progressing to severe COVID-19 and/or hospitalization, and dexamethasone (systemic steroids) and remdesivir treatment, if available, for hospitalized patients meeting specific criteria. The care of the hospitalized patient should include consultation with rheumatologists, dermatologists, and/or infectious disease specialists as medically necessary.

Rationale: This is based on the recent EUA https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-monoclonal-antibody-treatment-covid-19

Revision date: October 16, 2020

Category 3
How should medical care be delivered to patients with psoriatic disease to lower their risk of infection with SARS-CoV-2 while still ensuring quality of care?

3.2 The following patients should be considered for in-person care if pandemic conditions allow (i.e. the clinical practice is open to see patients in person) and Standard Operating Procedures are observed (i.e. social distancing, hand washing and masking). Patients at risk for melanoma and non-melanoma skin cancer should be seen in person at a frequency consistent with standard of care for a full skin examination. New Patients establishing care. Patients experiencing unstable psoriatic disease/flares. Patients requiring a thorough skin/or join examination and a full physical examination for rheumatology patients.

Rationale: clarifies the expectation that offices take reasonable precautions to prevent transmission of SARS-CoV-2

Category 5
What should patients with psoriatic disease do if they become infected with COVID-19?

5.2 Patients with psoriatic disease who become infected with SARS-CoV-2 should be prescribed and adhere to evidence-based COVID-19 therapies. Evidence-based therapies* should be used, currently including supportive care for patients with mild disease as well as dexamethasone (systemic corticosteroids) and remdesivir treatment, if available, for hospitalized patients meeting specific criteria. The care of the hospitalized patient should

include consultation with rheumatologists, dermatologists, and/or infectious disease specialists as medically necessary.

*Evidence based therapies are those that have been tested in well-conducted randomized controlled clinical trials, and have proven benefit on clinically relevant COVID19 outcomes.

5.4.1 Hydroxychloroquine or chloroquine are not recommended for the prevention or treatment of COVID-19 in patients with psoriatic disease outside of a clinical trial. Cases of psoriasis flare have been reported in patients on anti-malarial medications, but the clinical significance is not well understood.

Rationale: 5.2 was edited to be less specific regarding indications for remdesivir and dexamethasone as these are evolving. We also added a definition of evidence-based therapies.

Rationale 5.4.1 – Adjusting the numbering to accommodate future recommendations