Changes shown in highlighted text:

**Revision date: April 28, 2022**

**Update to 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 high risk** outpatients infected with SARS-CoV-2:

- Paxlovid (nirmatrelvir 300 mg plus ritonavir 100 mg) orally twice daily for 5 days.

**Paxlovid is available only by prescription. To locate a pharmacy that has Paxlovid, the following website can be searched:** [https://covid-19-therapeutics-locator-dhhs.hub.arcgis.com/](https://covid-19-therapeutics-locator-dhhs.hub.arcgis.com/)

If Paxlovid is not available or is contraindicated, additional treatment options can be found at: [https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/nonhospitalized-adults--therapeutic-management/](https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/nonhospitalized-adults--therapeutic-management/)

For hospitalized patients infected with SARS-CoV-2:

- Dexamethasone (systemic steroids) for patients meeting specific criteria
- Remdesivir treatment for patients meeting specific criteria
- Baricitinib (or tofacitinib if baricitinib is not available), with or without remdesivir, for patients meeting specific criteria
- Tocilizumab (or sarilumab if tocilizumab is not available), 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, and are recommended by National Institute of Health COVID-19 treatment guidelines.

** For definition of high risk patient see: [https://www.covid19treatmentguidelines.nih.gov/therapies/statement-on-patient-prioritization-for-outpatient-therapies/](https://www.covid19treatmentguidelines.nih.gov/therapies/statement-on-patient-prioritization-for-outpatient-therapies/)

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**Revision date: April 8, 2022**

**Addition of 4.14**

A second booster dose of the Pfizer-BioNTech COVID-19 vaccine or Moderna COVID-19 vaccine may be administered to individuals 50 years of age and older at least 4 months after receipt of a first booster dose of any authorized or approved COVID-19 vaccine (see 4.12 for recommendations for a first booster). The original booster/3rd vaccine dose continues to offer strong protection against hospitalization and death from COVID-19, although there is some evidence that this protection wanes over time, particularly in people 60 years of age or older.
New safety signals have not been identified in patients receiving a second booster, however, patients who had rare serious side effects from previous COVID-19 vaccines may consider deferring a second booster. Shared decision making is recommended when considering a second booster (see recommendation 2.5 regarding shared decision making).

The following patients with psoriatic disease are most likely to BENEFIT from a second COVID-19 booster vaccine:

- People 60 years of age or older
- People taking abatacept, cyclosporine, leflunomide, glucocorticoids (e.g., prednisone), methotrexate, upadacitinib, or tofacitinib
- People with underlying co-morbidities known to increase the risk of severe COVID-19, such as being overweight, being a current or former smoker, or having diabetes, cardiovascular disease, chronic lung, liver, or kidney disease.
- People who are at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting; or who have routine contact with unvaccinated individuals (i.e., children) or routine contact with those at high risk for severe COVID-19 or infection (i.e., an elderly or immunocompromised household member).

It is recommended that patients who are to receive COVID-19 booster vaccine continue their biologic or oral therapies for psoriasis and/or psoriatic arthritis in most cases. Patients who are taking methotrexate with well-controlled psoriatic disease, may, in consultation with their prescriber, consider holding it for 2 weeks after receiving a booster vaccine in order to potentially improve vaccine response.

References:


Revision date: January 8, 2022
Updates to 4.8, 4.12, and 5.2

4.8
In most cases, patients should take the first mRNA-based 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).

4.12

**Patients 18 and older** with psoriatic disease who received a second dose of the Pfizer-BioNTech or a Moderna COVID-19 vaccine **five** or more months ago* **SHOULD get a booster shot.**

Individuals who are eligible for a booster dose may choose which vaccine they receive as a booster. Some people may prefer the vaccine type that they originally received, and others may prefer to get a different booster. In most situations, Pfizer-BioNTech or Moderna COVID-19 vaccines are preferred over the Johnson & Johnson COVID-19 vaccine for primary and booster vaccination.

If receiving a booster dose with a Moderna vaccine, this should be half of the dose that is given for the primary series (i.e., first 2 doses).

**# Children 12-17 years old can get a Pfizer-BioNTech COVID-19 vaccine booster 5 months after completing their primary COVID-19 vaccination series with a Pfizer-BioNTech COVID-19 vaccine.**

*Patients with psoriatic disease treated with immunosuppressive or immune-modulating therapies such as corticosteroids, leflunomide, methotrexate, tofacitinib, upadacitinib, apremilast, and biologics that target the cytokines TNF, IL-12/23, IL-17, and IL-23 or T cells (e.g., abatacept), are ELIGIBLE for a 3rd dose “mRNA COVID-19 vaccine as per the CDC, as soon as 28 days after the second dose of an mRNA vaccine. This eligibility applies to patients ages 5 and older (Pfizer-BioNTech vaccine) or in patients ages 18 and older (Moderna vaccine and Pfizer-BioNTech vaccine). Most patients receiving systemic treatment for psoriatic disease are not moderately to severely immunocompromised and would not require a 3rd dose at 28-days. Patients taking abatacept, cyclosporine, leflunomide, glucocorticoids (e.g., prednisone), methotrexate, upadacitinib or tofacitinib who have additional risk factors for poor COVID-19 outcomes may benefit from a 3rd dose of a mRNA COVID-19 vaccine. Patients who elect to get a 3rd dose of an mRNA vaccine may then receive a booster dose **5 months after the 3rd dose.** Shared decision-making between clinician and patient is recommended to guide discussions about use of 3rd doses of mRNA COVID-19 vaccines and booster doses of COVID-19 vaccines.

**Patients 18 and older with psoriatic disease who received a single dose of the Johnson & Johnson COVID-19 vaccine two or more months ago** **SHOULD get a booster shot.** This booster vaccine can be a Pfizer-BioNTech COVID-19 vaccine or a Moderna (half dose) COVID-19 vaccine **which are preferred over the Johnson & Johnson COVID-19 vaccine.**

The following patients most likely to **BENEFIT** from a COVID-19 booster vaccine:

- People aged 50 or older
- People taking abatacept, cyclosporine, leflunomide, glucocorticoids (e.g., prednisone), methotrexate, upadacitinib or tofacitinib
- People who received their second dose of an mRNA vaccine over 5 months ago
- People who received a single dose of the Johnson & Johnson vaccine over 2 months ago
- People with underlying co-morbidities known to increase the risk of severe COVID-19, such as being overweight, being a current or former smoker, or having diabetes, cardiovascular disease, chronic lung, liver, or kidney disease.
- People who are at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting; or who have routine contact with unvaccinated individuals (i.e., children) or routine contact with those at high risk for severe COVID-19 or
infection (i.e., an elderly or immunocompromised household member). It is recommended that patients who are to receive COVID-19 booster vaccine continue their biologic or oral therapies for psoriasis and/or psoriatic arthritis in most cases. Patients who are taking methotrexate with well-controlled psoriatic disease, may, in consultation with their prescriber, consider holding it for 2 weeks after receiving a booster vaccine in order to potentially improve vaccine response.

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 high risk** outpatients infected with SARS-CoV-2:

- Paxlovid (nirmatrelvir 300 mg plus ritonavir 100 mg) orally twice daily for 5 days
- Sotrovimab 500 mg, administered as a single intravenous (IV) infusion
- Remdesivir 200 mg IV on Day 1, followed by remdesivir 100 mg IV on Days 2 and 3
- Molnupiravir 800 mg orally twice daily for 5 days

For hospitalized patients infected with SARS-CoV-2:
- Dexamethasone (systemic steroids) for patients meeting specific criteria
- Remdesivir treatment for patients meeting specific criteria
- Baricitinib (or tofacitinib if baricitinib is not available), with or without remdesivir, for patients meeting specific criteria
- Tocilizumab (or sarilumab if tocilizumab is not available), 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, and are recommended by National Institute of Health COVID-19 treatment guidelines.

** For definition of high risk patient see: https://www.covid19treatmentguidelines.nih.gov/therapies/statement-on-patient-prioritization-for-outpatient-therapies/

Revision date: December 17, 2021
Update to 4.12

Patients 18 and older# with psoriatic disease who received a second dose of the Pfizer-BioNTech or a Moderna COVID-19 vaccine six or more months ago* SHOULD get a booster shot.
Individuals who are eligible for a booster dose may choose which vaccine they receive as
a booster. Some people may prefer the vaccine type that they originally received, and
others may prefer to get a different booster.
If receiving a booster dose with a Moderna vaccine, this should be half of the dose that is
given for the primary series (i.e., first 2 doses).
* Teens 16-17 years old can get a Pfizer-BioNTech COVID-19 vaccine booster 6 months
  after completing their primary COVID-19 vaccination series with a Pfizer-BioNTech
  COVID-19 vaccine.
  *Patients with psoriatic disease treated with immunosuppressive or immune-modulating
  therapies such as corticosteroids, leflunomide, methotrexate, tofacitinib, apremilast, and
  biologics that target the cytokines TNF, IL-12/23, IL-17, and IL-23 or T cells (e.g.,
  abatacept), are ELIGIBLE for a 3rd dose “mRNA COVID-19 vaccine as per the CDC, as
  soon as 28 days after the second dose of an mRNA vaccine. This eligibility applies to
  patients ages 12 and older (Pfizer-BioNTech vaccine) or in patients ages 18 and older
  (Moderna vaccine and Pfizer-BioNTech vaccine). Most patients receiving systemic
  treatment for psoriatic disease are not moderately to severely immunocompromised and
  would not require a 3rd dose at 28-days. Patients taking abatacept, cyclosporine,
  leflunomide, glucocorticoids (e.g., prednisone), methotrexate, or tofacitinib who have
  additional risk factors for poor COVID-19 outcomes may benefit from a 3rd dose of a
  mRNA COVID-19 vaccine. Patients who elect to get a 3rd dose of an mRNA vaccine may
  then receive a booster dose 6 months after the 3rd dose. Shared decision-making
  between clinician and patient is recommended to guide discussions about use of 3rd

Patients 18 and older with psoriatic disease who received a single dose of the
Johnson & Johnson COVID-19 vaccine two or more months ago SHOULD get a
booster shot. This booster vaccine can be a Johnson & Johnson COVID-19 vaccine,
a Pfizer-BioNTech COVID-19 vaccine, or a Moderna (half dose) COVID-19 vaccine.
The following patients most likely to BENEFIT from a COVID-19 booster vaccine:
• People aged 50 or older
• People taking abatacept, cyclosporine, leflunomide, glucocorticoids (e.g., prednisone),
  methotrexate, or tofacitinib
• People who received their second dose of an mRNA vaccine over 6 months ago
• People who received a single dose of the Johnson & Johnson vaccine over 2 months
  ago
• People with underlying co-morbidities known to increase the risk of severe COVID-19,
such as being overweight, being a current or former smoker, or having diabetes,
cardiovascular disease, chronic lung, liver, or kidney disease.
• People who are at increased risk for COVID-19 exposure and transmission because of
  occupational or institutional setting; or who have routine contact with unvaccinated
  individuals (i.e., children) or routine contact with those at high risk for severe COVID-19 or
  infection (i.e., an elderly or immunocompromised household member).
It is recommended that patients who are to receive COVID-19 booster vaccine continue
their biologic or oral therapies for psoriasis and/or psoriatic arthritis in most cases.
Patients who are taking methotrexate with well-controlled psoriatic disease, may, in
consultation with their prescriber, consider holding it for 2 weeks after receiving a booster
vaccine in order to potentially improve vaccine response.
Patients with psoriatic disease who received a second dose of the Pfizer-BioNTech or a Moderna COVID-19 vaccine six or more months ago* are ELIGIBLE for a booster shot if they are in one of the following groups:

- 65 years and older
- Age 18+ who live in long-term care settings
- Age 18+ who have underlying medical conditions
- Age 18+ who work or live in high-risk settings

Individuals who are eligible for a booster dose may choose which vaccine they receive as a booster. Some people may prefer the vaccine type that they originally received, and others may prefer to get a different booster.

If receiving a booster dose with a Moderna vaccine, this should be half of the dose that is given for the primary series (i.e., first 2 doses).

*Patients with psoriatic disease treated with immunosuppressive or immune-modulating therapies such as corticosteroids, leflunomide, methotrexate, tofacitinib, apremilast, and biologics that target the cytokines TNF, IL-12/23, IL-17, and IL-23 or T cells (e.g., abatacept), are ELIGIBLE for a 3rd dose *mRNA COVID-19 vaccine as per the CDC, as soon as 28 days after the second dose of an mRNA vaccine. This eligibility applies to patients ages 12 and older (Pfizer-BioNTech vaccine) or in patients ages 18 and older (Moderna vaccine and Pfizer-BioNTech vaccine). Most patients receiving systemic treatment for psoriatic disease are not moderately to severely immunocompromised and would not require a 3rd dose at 28-days. Patients taking abatacept, cyclosporine, leflunomide, glucocorticoids (e.g., prednisone), methotrexate, or tofacitinib who have additional risk factors for poor COVID-19 outcomes may benefit from a 3rd dose of a mRNA COVID-19 vaccine. Patients who elect to get a 3rd dose of an mRNA vaccine may then receive a booster dose 6 months after the 3rd dose. Shared decision-making between clinician and patient is recommended to guide discussions about use of 3rd doses of mRNA COVID-19 vaccines and booster doses of COVID-19 vaccines.

Booster shots are RECOMMENDED for patients with psoriatic disease 18 or older who received a single dose of the Johnson & Johnson COVID-19 vaccine two or more months ago. This booster vaccine can be a Johnson & Johnson COVID-19 vaccine, a Pfizer-BioNTech COVID-19 vaccine, or a Moderna (half dose) COVID-19 vaccine.

The following patients most likely to BENEFIT from a COVID-19 booster vaccine:

- People aged 50 or older
- People taking abatacept, cyclosporine, leflunomide, glucocorticoids (e.g., prednisone), methotrexate, or tofacitinib
- People who received their second dose of an mRNA vaccine over 6 months ago
- People who received a single dose of the Johnson & Johnson vaccine over 2 months ago
- People with underlying co-morbidities known to increase the risk of severe COVID-19, such as being overweight, being a current or former smoker, or having diabetes, cardiovascular disease, chronic lung, liver, or kidney disease.
- People who are at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting; or who have routine contact with unvaccinated individuals (i.e., children) or routine contact with those at high risk for severe COVID-19 or infection (i.e., an elderly or immunocompromised household member).

It is recommended that patients who are to receive COVID-19 booster vaccine continue their biologic or oral therapies for psoriasis and/or psoriatic arthritis in most cases. Patients who are taking methotrexate with well-controlled psoriatic disease, may, in consultation with their prescriber, consider holding it for 2 weeks after receiving a booster vaccine in order to potentially improve vaccine response.

Revision date: October 20, 2021
Category 4 add

New recommendation 4.14
Patients 18 or older with psoriatic disease who received the Pfizer-BioNTech COVID-19 vaccine primary series who are at least 6 months from the second dose are ELIGIBLE for a 3rd booster shot of the Pfizer-BioNTech’s COVID-19 vaccine regardless of use of immunosuppressive or immune-modulating therapies.
- people 65 years and older and residents in long-term care settings should receive a booster shot of Pfizer-BioNTech’s COVID-19 vaccine at least 6 months after their Pfizer-BioNTech primary series,
- people aged 50–64 years with underlying comorbidities known to increase the risk of severe COVID-19, such as being overweight, being a current or former smoker, or having diabetes, cardiovascular disease, chronic lung, liver, or kidney disease) should receive a booster shot of Pfizer-BioNTech’s COVID-19 vaccine at least 6 months after their Pfizer-BioNTech primary series,
- people aged 18–49 years with underlying comorbidities known to increase the risk of severe COVID-19, such as being overweight, being a current or former smoker, or having diabetes, cardiovascular disease, chronic lung, liver, or kidney disease) may receive a booster shot of Pfizer-BioNTech’s COVID-19 vaccine at least 6 months after their Pfizer-BioNTech primary series, based on their individual benefits and risks, and
- people aged 18-64 years who are at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting may receive a booster shot of Pfizer-BioNTech’s COVID-19 vaccine at least 6 months after their Pfizer-BioNTech primary series, based on their individual benefits and risks.

Supporting language:
https://www.cdc.gov/media/releases/2021/p0924-booster-recommendations-.html

Revision date: October 11, 2021
4.12 update

Revision date: September 23, 2021
Category 2 sunset

Remove 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.


Revision Date: August 20, 2021

Category 4 additions

New recommendation 4.12

Patients with psoriatic disease treated with immunosuppressive or immune-modulating therapies that affect the immune system in a manner that may make a patient more susceptible to infection, such as corticosteroids, leflunomide, methotrexate, tofacitinib, apremilast, and biologics that target the cytokines TNF, IL-12/23, IL-17, and IL-23 or T cells (e.g., abatacept), are ELIGIBLE for a 3rd dose “booster” mRNA COVID-19 vaccine as per the CDC. This booster vaccine should be administered at least 28 days following the two-dose regimen of the SAME vaccine, and only to patients ages 12 and older (Pfizer-BioNTech vaccine) or in patients ages 18 and older (Moderna vaccine and Pfizer-BioNTech vaccine). CDC has not issued recommendations for boosters in patients who received the one dose Ad26.COV2.S vaccine manufactured by Johnson & Johnson.

At this time, it is not known whether these treatments for psoriatic disease affect the benefits of COVID-19 vaccines, which are proven to be highly effective in preventing severe COVID-19 illness in the general population. The COVID-19 vaccines are safe and, to date, neither the CDC nor the FDA have seen evidence of a safety signal for these vaccines in terms of flaring existing psoriasis. Shared decision-making between clinicians and patients is recommended to guide discussions about the use of a 3rd booster dose of an mRNA vaccine.

Studies demonstrate that a third dose of an mRNA vaccine increases immunogenicity in transplant recipients, but it is not known whether a 3rd booster dose of an mRNA vaccine will result in additional clinically important benefits for patients with psoriatic disease taking immunosuppressive or immune-modulating treatments. Patients taking an immunosuppressive or immune-modulating treatment for psoriatic disease are predicted to be more likely to benefit from a 3rd booster mRNA-based COVID-19 vaccine in the following circumstances:

1. People aged 50 or older, based on data from Israel.*
2. People taking abatacept, cyclosporine, leflunomide, glucocorticoids (e.g., prednisone), methotrexate, or tofacitinib, based on evidence of modest reduction in antibody responses to mRNA-based vaccines for some of these treatments, or theoretical concerns based on their mechanism of action.
3. People who received their second dose of an mRNA vaccine over 6 months ago.*
4. People with underlying comorbidities known to increase the risk of severe COVID-19, such as being overweight, being a current or former smoker, or having diabetes, cardiovascular disease, chronic lung, liver, or kidney disease)*
*Based on data from the general population

**New recommendation 4.13**

Patients who are taking methotrexate with well-controlled psoriatic disease, may, in consultation with their prescriber, consider holding it for 2 weeks after receiving a 3rd “booster” mRNA 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 a booster dose of a mRNA 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).

**CDC Links:**


**FDA Link:**


References regarding benefits of a 3rd dose mRNA vaccine:

https://www.acpjournals.org/doi/10.7326/L21-0282
DOI: 10.1056/NEJMc2111462; PMCID: PMC8262620


References regarding subgroups likely to benefit from a 3rd dose of a mRNA vaccine:

https://www.thelancet.com/journals/lanrhe/article/PIIS2665-9913(21)00212-5/fulltext
https://www.acpjournals.org/doi/10.7326/M21-1451
https://ard.bmj.com/content/early/2021/08/09/annrheumdis-2021-220597
https://jamanetwork.com/journals/jama/fullarticle/2779852
https://www.medrxiv.org/content/10.1101/2021.04.05.21254656v2
https://www.kidneyinternational.org/article/S0085-2538(21)00348-3/fulltext
https://ard.bmj.com/content/early/2021/08/09/annrheumdis-2021-220272
https://ard.bmj.com/content/80/8/1098
https://gut.bmj.com/content/early/2021/04/25/gutjnl-2021-324789

**Revision date: August 4, 2021**
5.2 Patients with psoriatic disease who become exposed to or 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 post-exposure prophylaxis: Casirivimab and imdevimab to be administered together for patients meeting specific criteria and who are at high risk for progression to severe COVID-19 and/or hospitalization and have been exposed to an individual infected with SARS-CoV-2 or who are at high risk of exposure to an individual infected with SARS-CoV-2 (for example, a resident of a nursing home where an outbreak may be occurring).

For outpatients infected with SARS-CoV-2:
• Sotrovimab 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 infected with SARS-CoV-2:
• Dexamethasone (systemic steroids) for patients meeting specific criteria
• Remdesivir treatment for patients meeting specific criteria
• Baricitinib, with or without 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: July 1, 2021

Category 5 revision

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:
• Sotrovimab 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
• 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.
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 COVID19 vaccine.

Patients with psoriasis and or psoriatic arthritis who are taking certain medications that affect the immune system in a manner that may increase the risk of infections may not be fully protected even if fully vaccinated against COVID-19. Out of an abundance of caution, and until more data emerge, we recommend that patients with psoriatic disease taking abatacept, cyclosporine, leflunomide, glucocorticoids (e.g., prednisone), methotrexate, or tofacitinib continue masking and social distancing precautions (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html) when they are in contact with people who are not vaccinated against COVID-19 or whose vaccination status is not verifiable.

Antibody testing is currently not recommended to assess immunity after COVID-19 vaccination or to inform medical decision making related to individual precautions. The accuracy of antibody testing to predict protection from SARS-CoV-2 infection and COVID-19 illness is not known. Individuals who are concerned about the efficacy of the COVID-19 vaccines due to their unique circumstances are referred to guidance 4.10 and 5.2 for additional strategies to lower their risk of COVID-19.
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).


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).


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.


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.


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).
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.


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.


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.
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/flare. 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