Table 1. Additional Efficacy Outcomes at Week 56 Stratified by Severity of Skin Involvement at Baseline

	SELECT-PsA 1	
n/N (%) [95% CI]	**UPA 15 mg**	**ADA**
sIGA 0/1 w/at least 2 point improvement from BL[a]		
≥3%-<10%	71/128 (55.5) [46.9, 64.1]	53/124 (42.7) [34.0, 51.4]
≥10%	29/76 (38.2) [27.2, 49.1]	33/77 (42.9) [31.8, 53.9]
MDA + skin[b]		
≥3%-<10%	58/138 (42.0) [33.8, 50.3]	56/132 (42.4) [34.0, 50.9]
≥10%	19/76 (25.0) [15.3, 34.7]	28/79 (35.4) [24.9, 46.0]
SELECT-PsA 2		
n/N (%) [95% CI]	**UPA 15 mg**	
sIGA 0/1 w/at least 2 point improvement from BL[a]		
≥3%-<10%	24/71 (33.8) [22.8, 44.8]	
≥10%	18/50 (36.0) [22.7, 49.3]	
MDA + skin[b]		
≥3%-<10%	22/80 (27.5) [17.7, 37.3]	
≥10%	9/50 (18.0) [7.4, 28.6]	

[a] defined as achieving an sIGA score of 0 or 1 and at least a 2 point improvement from BL, evaluated in pts with BL sIGA ≥2.

[b] defined as achieving 5 of the 7 criteria, with PASI ≤1 or BSA-psoriasis ≤3 as a required component.

ADA, adalimumab; BL, baseline; CI, confidence interval; MDA, minimal disease activity; sIGA, Static Investigator Global Assessment of psoriasis; UPA, upadacitinib

skin endpoints. The achievement of MDA was generally consistent across skin severity subgroups; when pts were required to achieve the skin component of MDA, results were numerically better in the ≥3-<10% skin severity group (Table 1). In non-biologic DMARD-IR pts, results were similar between UPA 15 mg and ADA.

Conclusion: UPA is a viable treatment option for pts with active PsA regardless of the extent of psoriasis at baseline. Although these results are of interest and hypothesis-generating, they should be interpreted with caution due to low sample size.

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POS1031

LOW INCIDENCE OF GASTROINTESTINAL-RELATED AND OVERALL SERIOUS ADVERSE EVENTS AMONG GUSELKUMAB-TREATED PATIENTS: POOLED ANALYSES OF VOYAGE 1 & 2 AND DISCOVER 1 & 2 THROUGH 1-YEAR

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Background: Guselkumab (GUS), a human monoclonal antibody that specifically binds to the p19-subunit of interleukin (IL)-23, demonstrated efficacy in the Phase 3 VOYAGE 1&2 trials of patients (pts) with moderate to severe plaque psoriasis (PsO)[1,2] and in the DISCOVER 1&2 trials of pts with active psoriatic arthritis (PsA).[3,4] IL-17 inhibitors used to treat PsO and PsA have been associated with exacerbation or new onset of inflammatory bowel disease (IBD) (e.g., Crohn's disease or ulcerative colitis).[5]

Objectives: Evaluate the incidence of gastrointestinal (GI)-related and overall serious adverse events (SAEs) from pooled safety data through 1-year of GUS 100 mg treatment from the VOYAGE 1&2 and DISCOVER 1&2 trials.

Methods: Using pooled safety data from the VOYAGE 1&2 PsO trials and DISCOVER 1&2 PsA trials, SAEs related to GI disorders were identified using the Medical Dictionary for Regulatory Activities (MedDRA) system-organ class "GI disorders". Pts with a previous history of IBD were not excluded in these trials; medical history of IBD was collected at baseline in DISCOVER 1&2. Rates of overall SAEs and GI-related SAEs were calculated as the number of SAEs per 100 pt-years (PY) of follow-up (95% confidence intervals). Data are presented for the placebo (PBO)-controlled period (Weeks 0-16 for VOYAGE 1&2; Weeks 0-24 for DISCOVER 1&2) and through 1-year (defined as through Week 48 for VOYAGE 1&2; through Week 60 for DISCOVER 1, and through Week 52 for DISCOVER 2). Events of uveitis and opportunistic infections were also analyzed.

Results: Through the PBO-controlled period, the overall rates of GI-related SAEs per 100 PY for pooled VOYAGE 1&2 were: PBO 0.78 (0.02, 4.34), GUS q8w 0; and for pooled DISCOVER 1&2: PBO 0.58 (0.01, 3.23), GUS q8w 0.58 (0.01, 3.21), GUS q4w 0. The GI-related SAEs included: gastrointestinal hemorrhage (PBO; n=1) for pooled VOYAGE 1&2; and inflammatory bowel disease (PBO; n=1) and mechanical ileus (GUS q8w; n=1) for pooled DISCOVER 1&2. Through 1-year, the overall rates of GI-related SAEs for pooled VOYAGE 1&2 were: Combined GUS group (GUS q8w and PBO→GUS groups) 0.51 (0.17, 1.20); and for pooled DISCOVER 1&2: GUS q8w 0.52 (0.06, 1.88), GUS q4w 0, Combined GUS group (GUS q8w, GUS q4w, and PBO→GUS groups) 0.21 (0.02, 0.74). The GI-related SAEs in the Combined GUS group for pooled VOYAGE 1&2 included: gastritis, hemorrhoids, inguinal hernia, pancreatitis, and umbilical hernia (0.10/100PY [0.00, 0.57]; n=1 for each); and in the Combined GUS group for pooled DISCOVER 1&2: mechanical ileus and pancreatitis chronic (0.10/100PY [0.00, 0.57]; n=1 for each). Overall, no cases of exacerbation or new onset of IBD were reported in GUS-treated pts, including 2 pts with a prior history of IBD in DISCOVER 1&2 (total PY of follow-up for the Combined GUS groups in VOYAGE and DISCOVER were 974 and 973, respectively). Through the PBO-controlled period, rates of overall SAEs for GUS-treated pts were comparable to PBO-pts and SAE rates remained low through 1-year of follow-up in the VOYAGE 1&2 and DISCOVER 1&2 trials. There were no reported cases of uveitis, opportunistic infections, or tuberculosis in GUS-treated pts through 1-year.

Conclusion: Through 1-year of follow-up with GUS treatment in pooled VOYAGE 1&2 and DISCOVER 1&2, GI-related SAE rates were low. There were no reported cases of uveitis, opportunistic infections, or new onset/exacerbation of IBD in GUS-treated pts. No new safety concerns were identified through 1-year.

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POS1032 EFFICACY OF UPADACITINIB IN PATIENTS WITH PSORIATIC ARTHRITIS STRATIFIED BY NUMBER OF PRIOR BIOLOGIC DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS

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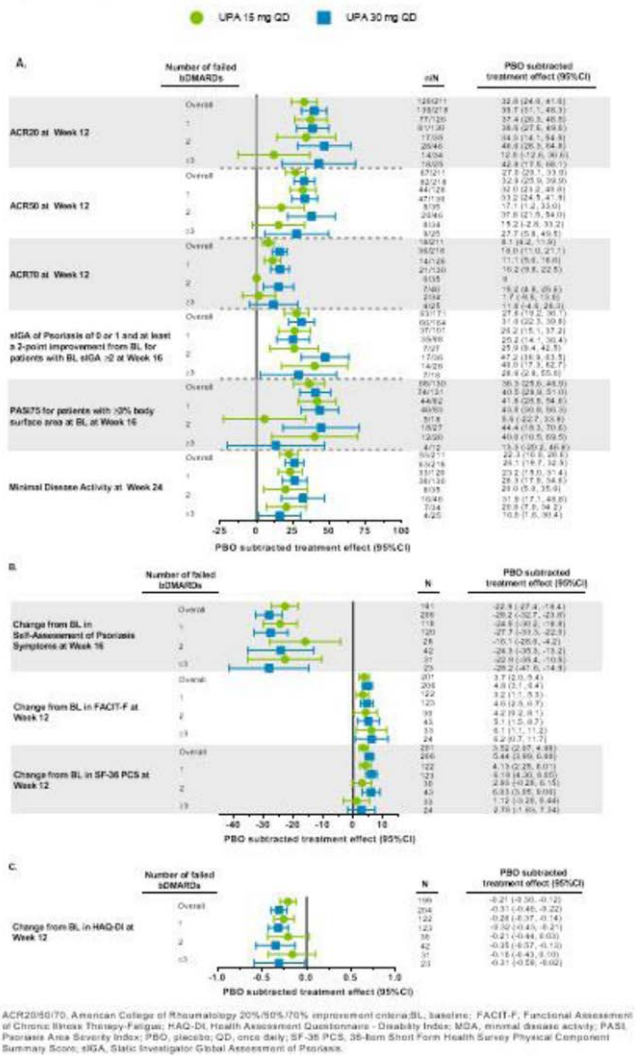
Background: Upadacitinib (UPA) has shown efficacy and safety in patients (pts) with active PsA in the Phase 3 SELECT-PsA 1 and SELECT-PsA 2 clinical trials.[1,2] Historically efficacy has been lower with second- and third-line therapy compared with first-line anti-TNF therapy in PsA;[3,4] however, clinical trial data that describe efficacy in pts who have had an inadequate response (IR) to multiple biologic DMARDs (bDMARDs) are limited.
Objectives: This analysis assessed the effects of prior bDMARD failure on UPA efficacy in the SELECT-PsA 2 trial.
Methods: The SELECT-PsA 2 study enrolled pts with prior IR or intolerance to ≥1 bDMARD (N=642). Pts were randomized to placebo (PBO), UPA 15 mg once daily (QD, UPA15), or UPA 30 mg QD (UPA30). Stable background treatment of ≤2 non-bDMARDs was permitted; background therapy was not required. Only the pts who had IR to ≥1 bDMARD were included in this analysis; pts were subgrouped based on the number of bDMARDs failed prior to enrollment (1, 2, or ≥3). This analysis includes assessment of proportion of pts achieving ACR20/50/70, and change in HAQ-DI, FACIT-Fatigue, and SF-36 Physical Component Summary at Wk 12; static Investigator Global Assessment of Psoriasis of 0 or 1 and at least a 2-point improvement from baseline, PASI75, and change in Self-Assessment of Psoriasis Symptoms at Wk 16; and proportion of pts achieving minimal disease activity (MDA) at Wk 24. Non-responder imputation was used for binary endpoints. Mixed-effects model for repeated measures was used for continuous endpoints. Point estimates and 95% confidence intervals (CIs) of the PBO subtracted treatment effect were calculated.
Results: 641 pts were randomized and received study drug; 92% were bDMARD-IR: 391 (61%) of pts failed 1 bDMARD, 116 (18%) failed 2 bDMARDs, and 83 (13%) failed ≥3 bDMARDs. In the overall study population, UPA15 and UPA30 demonstrated superiority vs placebo for all endpoints evaluated. In this post hoc analysis, the PBO subtracted treatment effect demonstrates generally consistent efficacy as compared to the overall study population for UPA15 and UPA30 across efficacy endpoints in the subgroups of pts with IR to 1, 2, or ≥3 prior bDMARDs (Figure 1). Due to limited sample sizes for pts with IR to >1 bDMARD and the pt subsets analyzed for psoriasis-related endpoints, results should be interpreted with caution.

Figure. Efficacy Outcomes by Prior bDMARD Exposure: Placebo Subtracted Treatment Effect



ACR20/50/70, American College of Rheumatology 20%/50%/70% improvement criteria; BL, baseline; FACIT-F, Functional Assessment of Chronic Illness Therapy-Fatigue; HAQ-DI, Health Assessment Questionnaire - Disability Index; MDA, minimal disease activity; PASI, Psoriasis Area Severity Index; PBO, placebo; QD, once daily; SF-36 PCS, 36-Item Short Form Health Survey Physical Component Summary Score; sIGA, Static Investigator Global Assessment of Psoriasis.

Conclusion: Upadacitinib demonstrated consistent efficacy in treating clinical manifestations of PsA including musculoskeletal symptoms, psoriasis, physical function, fatigue, and quality of life in pts with IR to 1 or multiple prior bDMARDs. In addition, comprehensive disease control as measured by MDA, was generally consistently achieved with upadacitinib regardless of number of prior bDMARDs tried.

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