multivariable models, biologic-experienced patients were more likely to discontinue treatment (HR 1.21 [95% CI 1.04–1.43]; $p=0.017$) vs. biologic-naïve patients, while PsA had no significant effect on TTD alone vs. no PsA (HR 1.12 [95% CI 0.9–1.4]; $p=0.31$). However, comorbid PsA increased the likelihood of treatment discontinuation for biologic-experienced patients (HR 1.45 [95% CI 1.06–1.97]; $p=0.018$). Obesity was a further predictor of discontinuation (HR 1.15 [95% CI 1.02–1.31]; $p=0.027$) and this was independent of comorbid PsA and prior biologic exposure (Table 1).

Conclusion: Comorbid PsA was associated with reduced time-to-discontinuation of UST in biologic-experienced patients, but not biologic-naïve patients. Obesity also impacted TTD but independently of PsA status.

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Table 1. Multivariate analysis of UST discontinuation in PsO patients (N=3,174).

Covariate	Status (n)	HR	95% CI	p-value
Comorbid PsA	No PsA	ref	-	-
	(n=2609) PsA	1.12	0.90–1.40	0.31
Biologic experience	(n=565) No prior biologic (n=2371)	ref	-	-
	Prior biologic (n=803)	1.21	1.04–1.43	0.017
PsA*prior biologic experience	No PsA, prior biologic	ref	-	-
	(n=539) PsA, prior biologic	1.45	1.06–1.97	0.018
Obesity (BMI, kg/m ²)	(n=264) <30	ref	-	-
	(n=1554) ≥30	1.15	1.02–1.31	0.027
	(n=1620)			

BMI, body mass index; CI, confidence interval; HR, hazard ratio; PsA, psoriatic arthritis; PsO, psoriasis; ref, reference; UST, ustekinumab.

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POS1053

COMPARISON OF BASELINE CHARACTERISTICS BETWEEN PATIENTS CONTINUING OR DISCONTINUING APREMILAST AT TWELVE MONTHS IN THE REWARD STUDY (THE NETHERLANDS)

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Background: Previous analysis of the REWARD study reported that patients with limited joint involvement have a considerable burden of disease¹. Recent data suggest that patients with moderately active psoriatic arthritis (PsA) and a limited joint involvement have a high likelihood of achieving treatment goals when treated with apremilast². According to EULAR recommendations a PDE4 inhibitor may be considered in patients with mild disease and an inadequate response to at least one csDMARD, in whom neither a bDMARD nor a JAK inhibitor is appropriate and the value of apremilast may be found in treating patients with relatively mild disease (oligoarticular)³.

Objectives: The objective of this prospective, multicentre, non-interventional study is to describe patient reported outcomes, effectiveness and real-life use of

apremilast in patients with PsA. Patients will be followed up for a maximum of 12 months. This interim analysis compared the baseline characteristics and experience on apremilast for two subgroups of patients, those remaining on apremilast versus the ones that discontinued.

Methods: In this interim analysis we included patients with data available at cut-off date of 03 November 2020. Patient enrollment and follow up of current subjects is ongoing. Descriptive statistics (n's and percents for categorical data, means for continuous data) were used to summarize the baseline data by subgroup. Kaplan Meier plots are presented to show patients' experience on apremilast by subgroup.

Results: 85 patients were included in the analysis. 30 patients have completed the study, 39 patients have discontinued and 16 are ongoing. At baseline 22 (26%) patients were biologic experienced and 62 (74%) were biologic naïve. Both groups had a comparable disease activity measured with clinical disease activity in psoriatic arthritis (cDAPSA) scores. Biologic experienced patients had a longer disease duration compared to biologic naïve patients (mean 9.7 vs 6.2 years). Inefficacy of previous medication was the main reason for starting apremilast in both subgroups. Overall, 86% (n=69) of patients were still receiving apremilast at month 3, 60% (n=46) at month 6, and 41% (n=26) at month 12 (Figure 1). Drug survival (length of time until discontinuation of apremilast) for biologic naïve patients was 93% at month 3, 73% at month 6 and 58% at month 12. Drug survival of biologic experienced patients was 67%, 20%, and 0% at months 3, 6, and 12, respectively. At baseline mean values of body mass index (BMI), swollen joint count (SJC), tender joint count (TJC), psoriatic arthritis impact of disease (PsAID) were comparable between both groups (Table 1). Reasons for discontinuation were mainly lack of efficacy (49%) and adverse events (44%). In this analysis the nature and frequency of adverse events is in line with the known profile of apremilast.

Conclusion: In this interim analysis, patients who were biologic naïve had a better probability to remain on treatment than those who were biologic experienced. Baseline characteristics were similar between the two groups, apart from disease duration that was longer in the biologic experienced group. Best drug survival is achieved when apremilast is prescribed earlier in the PsA treatment course, before biologics and after csDMARDs, as per apremilast EU label.

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POS1054

UPADACITINIB PHARMACOKINETICS AND EXPOSURE-RESPONSE RELATIONSHIPS FOR EFFICACY AND SAFETY IN PSORIATIC ARTHRITIS – ANALYSES OF THE PHASE 3 SELECT-PsA STUDIES

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Background: Upadacitinib (UPA) is an oral, reversible, JAK inhibitor approved for the treatment of rheumatoid arthritis (RA). The efficacy and safety profile of UPA in psoriatic arthritis (PsA) has been established in the SELECT-PsA program which includes two global Phase 3 studies.

Objectives: These analyses characterize UPA pharmacokinetics and exposure-response relationships for efficacy and safety endpoints using data from the SELECT-PsA studies.

Methods: The SELECT-PsA program enrolled patients with prior inadequate response (IR) or intolerance to ≥1 non-bDMARD1 (N=1705) and prior IR or intolerance to ≥1 bDMARD2 (N=642). Data from both trials was integrated for patients receiving placebo (PBO), UPA 15mg once daily (QD) and UPA 30mg QD; adalimumab data was excluded from this analysis. UPA pharmacokinetics were characterized in PsA patients using Bayesian population pharmacokinetics analyses and utilizing prior information from analyses in healthy subjects and RA patients. Exposure-response analyses were conducted using logistic regression to characterize the relationships between upadacitinib average plasma concentration during a dosing interval (C_{avg}) and the percentage of patients achieving