Real-World Effectiveness of Upadacitinib in Atopic Dermatitis Based on Prior Exposure to Biologic Therapy: 6-month Interim Analysis of the Multicountry AD-VISE Study

Rodney Sinclair[1,2], Hermenio Lima[3,4], Caterina Foti[5], Ignasi Figueras Nart[6], Filip Rob[7], Gabriel Gattolin[8], Ieva Saulite[9], Fatima Saleh Albreiki[10], José-Juan Pereyra Rodriguez[11,12], Michael Lane[13], Richard Ta[13], Yolanda Armendariz[13], David Prefontaine[13], Melinda J. Gooderham[14]

[1]Department of Medicine, University of Melbourne, Melbourne, Australia; [2]Sinclair Dermatology, Melbourne, Australia; [3]LEADER Research Inc., Hamilton, Canada; [4]Division of Dermatology, Department of Medicine, Faculty of Health Sciences, McMaster University, Hamilton, Canada; [5]Section of Dermatology, Department of Precision and Regenerative Medicine and Ionian Area, University Aldo Moro of Bari, Bari, Italy; [6]Department of Dermatology, Bellvitge University Hospital, L'Hospitalet de Llobregat, Spain; [7]Department of Dermatovenerology, Second Faculty of Medicine, Charles University, Bulovka University Hospital, Prague, Czech Republic; [8]Centro Respiratorio Infantil, Rosario, Argentina; [9]Clinic of Dermatology and Allergology, Cantonal Hospital St Gallen, St. Gallen, Switzerland; [10]Department of Dermatology, Tawam Hospital and Shaikh Tahnoon Bin Mohammed Medical City (STMC), Al Ain, United Arab Emirates; [11]Department of Medicine, School of Medicine, University of Seville, Seville, Spain; [12]Department of Dermatology, Virgen del Rocio University Hospital, Seville, Spain; [13]AbbVie Inc., North Chicago, United States of America; [14]SKiN Centre for Dermatology, Queen's University, Probity Medical Research, Peterborough, Canada

Learning Objective: Assess upadacitinib effectiveness in atopic dermatitis in clinical practice based on prior biologic therapy exposure.

Scan QR code to download an electronic version of this presentation and other AbbVie ISAD 2025 scientific presentations:
QR Code expiration: Sept 26, 2026

To submit a medical question, please visit
www.abbviemedinfo.com

15th Georg Rajka Symposium on Atopic Dermatitis (ISAD) 2025, Melbourne, Australia (DV#017204)

Background and Methods

Introduction/Background

- Upadacitinib (UPA) is an oral, selective Janus Kinase inhibitor approved across multiple countries, with variations in indications/posology across countries
- In clinical trials, UPA has demonstrated high levels of skin clearance and itch relief for the treatment of moderate-to-severe atopic dermatitis (AD); previously published safety data have shown a favorable benefit–risk profile[1-3]
- AD-VISE (NCT05081557) is an ongoing observational, prospective, multicountry study that explores real-world usage patterns and effectiveness of UPA 15 mg and 30 mg in adults and adolescents with AD for up to 2 years[4]
- Here, we present effectiveness results for UPA in clinical practice, based on prior biologic therapy exposure assessed at baseline

Methods

- This 6-month interim data analysis (data cutoff: January 16, 2025) included adolescents and adults who enrolled at least 6 months prior to the cut off date or had discontinued the study
- Patients were stratified as bionaïve (BN) or bioexperienced (BE), based on prior biologic therapy exposure
- Key outcomes evaluated included the validated Investigator Global Assessment for AD (vIGA-AD) 0/1 (primary), Eczema Area and Severity Index (EASI), Worst Pruritus Numerical Rating Scale (WP-NRS), achievement of minimal disease activity (EASI ≤ 3 and WP-NRS 0/1), Dermatology Life Quality Index (DLQI), Patient Oriented Eczema Measurement (POEM), and AD Control Tool (ADCT), all assessed using clinically relevant response thresholds

1. Guttman-Yassky E, et al. *Lancet*. 2021;397(10290):2151–6. 2. Simpson EL, et al. *JAMA Dermatol*. 2022;1458(4):404-413. 3. Irvine AD, et al. *Am J Clin Dermatol*. 2025. [published online ahead of print Sept 3, 2025]. 4. Lima H, et al. *Br Jr Dermatol*. 2024;190(Suppl 2):ii7-ii8.

Demographic and Baseline Disease Characteristics by Starting Dose

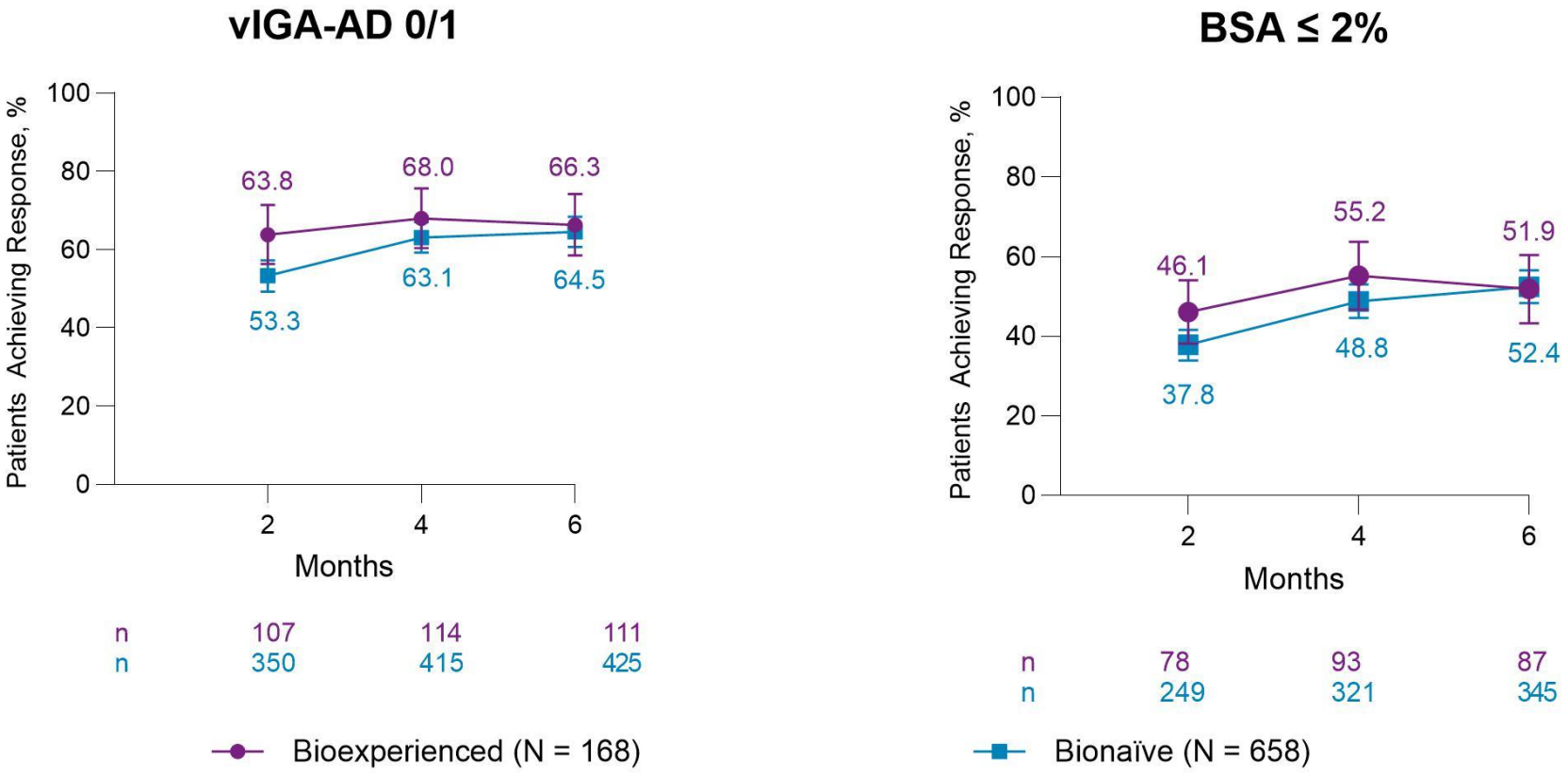
	Bioexperienced (BE)		Bionaïve (BN)	
	Started on UPA 15 mg (N = 84)	Started on UPA 30 mg (N = 92)	Started on UPA 15 mg (N = 381)	Started on UPA 30 mg (N = 299)
Age, years, mean (SD)	36.2 (17.2)	36.0 (13.5)	37.1 (19.1)	36.3 (13.4)
Male, n (%)	52 (61.9)	52 (56.5)	196 (51.4)	180 (60.2)
Duration of AD symptoms, years, mean (SD)	26.4 (15.2)	30.6 (15.1)	22.3 (15.2)	25.1 (14.8)
Comorbidities, n (%)				
Asthma	27 (32.1)	43 (46.7)	89 (23.4)	95 (31.8)
Allergic rhinitis	39 (46.4)	45 (48.9)	111 (29.1)	88 (29.4)
vIGA-AD - n (%)				
Moderate (3)	47 (56.6)	46 (51.1)	181 (48.3)	132 (44.4)
Severe (4)	28 (33.7)	37 (41.1)	164 (43.7)	152 (51.2)
EASI total score, mean (SD)	19.3 (11.2)	20.5 (10.4)	22.4 (12.0)	23.5 (11.9)
EASI body region scores, median (range)				
Head and Neck	1.8 (0.0, 6.6)	2.2 (0.0, 6.0)	2.0 (0.0, 7.2)	1.8 (0.0, 7.2)
Trunk	4.8 (0.0, 18.0)	6.2 (0.0, 19.8)	6.3 (0.0, 21.6)	6.3 (0.0, 21.6)
Upper limbs	4.0 (0.0, 13.2)	4.2 (0.0, 12.0)	4.8 (0.0, 14.4)	4.8 (0.0, 14.4)
Lower limbs	7.2 (0.0, 24.0)	7.2 (0.0, 22.0)	8.4 (0.0, 28.8)	9.2 (0.0, 26.4)
Body surface area, %, mean (SD)	29.3 (20.8)	36.8 (22.9)	36.8 (23.8)	39.4 (23.7)
PROs, mean (SD)				
WP-NRS	6.1 (2.6)	6.4 (2.3)	7.3 (2.2)	7.3 (2.2)
POEM	15.5 (6.5)	17.2 (6.5)	18.4 (6.6)	19.6 (6.3)
DLQI	12.5 (7.7)	13.2 (7.1)	14.6 (7.0)	15.4 (7.1)
ADCT	13.2 (5.9)	13.2 (6.2)	15.7 (5.7)	15.8 (5.5)

- The analysis included 176 BE and 680 BN patients, with 6.3% and 9.4% of adolescents in each group, respectively
- Baseline characteristics were generally similar for both treatment groups
  - BE patients generally experienced less severe disease (eg, BSA, EASI score, vIGA-AD) and were more likely to have asthma and allergic rhinitis vs BN patients
- In both groups, patients started on UPA 15 mg in an attempt to use the lowest possible dose
- Patients started on UPA 30 mg:
  - **BN group:** mainly for skin severity (42.2%), itch (21.1%), and lack of effectiveness of prior therapies (17.5%)
  - **BE group:** reasons included skin severity (29.1%), itch (19.0%), lack of effectiveness of prior therapies (17.7%), lesion location (12.7%), and other disease burden factors (10.1%)
- **Prior biologic therapy usage among patients (≥5%)** in the BE group consisted mainly of dupilumab (n = 155; 88.1%) and tralokinumab (n = 25; 14.2%)

AD, atopic dermatitis; ADCT, Atopic Dermatitis Control Tool; DLQI, Dermatology Life Quality Index; EASI, Eczema Area and Severity Index; POEM, Patient Oriented Eczema Measure; PRO, patient-reported outcome; vIGA-AD, validated Investigator Global Assessment for Atopic Dermatitis; WP-NRS, Eczema Area and Severity Index.

Achievement of vIGA-AD 0/1 and BSA at Months 2, 4, and 6

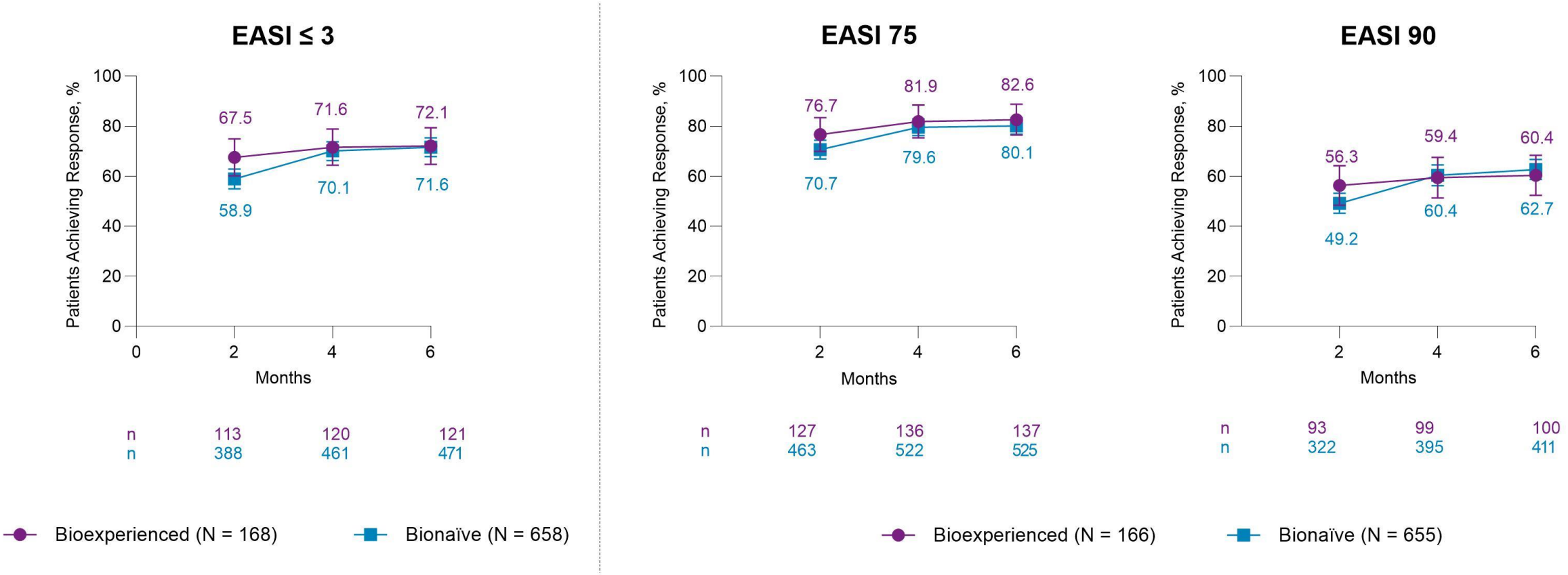
- At baseline, only 2.3 and 1.2% of BE/BN patients, respectively, had a vIGA-AD 0/1
- Most BE and BN patients achieved vIGA–AD 0/1, and over 37% had BSA ≤ 2% at month 2
  - Achievement rates increased by month 4 and were generally maintained by month 6



Error bars correspond to the 95% confidence interval for response rate.
Results are based on non-responder imputation with multiple imputation (NRI-MI).
BE, bioexperienced; BN, bionaïve; BSA, body surface area; vIGA-AD, validated Investigator Global Assessment for Atopic Dermatitis.

Achievement of EASI 75, EASI 90, and EASI ≤ 3 at Months 2, 4, and 6

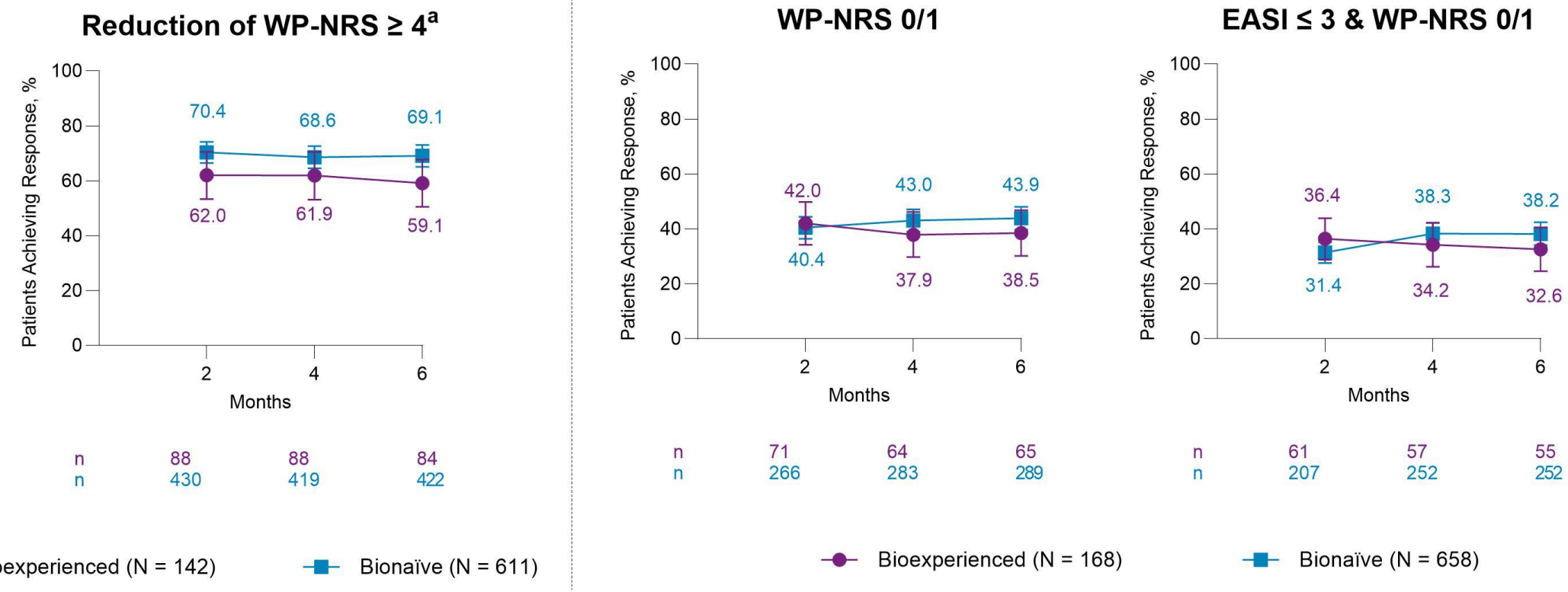
- Both BE and BN patients achieved similar and high response rates across all EASI endpoints (EASI 75, EASI 90, EASI ≤ 3), with improvement over time



Error bars correspond to the 95% confidence interval for response rate.
Results are based on non-responder imputation with multiple imputation (NRI-MI).
BE, bioexperienced; BN, bionaïve; EASI 75/90, 75%/90% reduction in baseline Eczema Area and Severity Index score.

Achievement of Stringent Itch and Combined Stringent Itch and Skin Clearance (Minimal Disease Activity) Outcome Measures at Months 2, 4, and 6

- Numerically more BN than BE patients reported clinically relevant itch improvements, while response rates for little–to-no itch (WP-NRS 0/1) and the simultaneous achievement of little-to-no itch and almost clear skin (EASI ≤ 3 + WP-NRS 0/1), a definition of Minimal Disease Activity,[1] were consistent over the study period and similar between the 2 groups



Error bars correspond to the 95% confidence interval for response rate. Results are based on non-responder imputation with multiple imputation (NRI-MI).
[a]Among patients with baseline WP-NRS ≥ 4.
1. Silverberg JI, et al. *J Eur Acad Dermatol Venereol*. 2024;38(11):2139-2148.
BE, bioexperienced; BN, bionaïve; EASI, Eczema Area and Severity Index score; WP-NRS, Worst Pruritus – Numerical Rating Scale.

Achievement of Stringent Quality of Life, Symptom Relief, and Disease Control Outcome Measures at Months 2, 4, and 6

- In both BE and BN populations, more than 74% achieved meaningful improvements in QoL (ΔDLQI ≥ 4), symptom relief (ΔPOEM ≥ 4), and disease control (ΔADCT ≥ 5) at months 2, 4, and 6
- Over 71% of patients in the BN and BE populations achieved ADCT scores < 7 through month 6, indicating well-controlled AD symptoms
- More stringent outcomes of DLQI 0/1 (no impact on QoL) and POEM ≤ 2 (clear/almost clear eczema) were achieved by 35% of patients or more in both groups at months 2, 4, and 6

DLQI, POEM, and ADCT Outcomes

Outcome Measures	Bioexperienced Any UPA, n/N (%)			Bionaïve Any UPA, n/N (%)		
	Month 2	Month 4	Month 6	Month 2	Month 4	Month 6
DLQI 0/1[a]	64/163 (39.4)	61/163 (37.4)	63/163 (38.5)	230/627 (36.7)	266/627 (42.5)	263/627 (42.0)
DLQI ≥ 4-point reduction from BL[b]	109/147 (74.4)	117/147 (79.5)	121/147 (82.6)	504/591 (85.2)	513/591 (86.7)	513/591 (86.8)
POEM ≤ 2	61/168 (36.3)	56/168 (33.6)	59/168 (35.1)	235/658 (35.8)	243/658 (37.0)	258/658 (39.2)
POEM ≥4-point reduction from BL[c]	135/163 (82.7)	131/163 (80.8)	131/163 (80.4)	559/645 (86.7)	548/645 (84.9)	550/645 (85.3)
ADCT < 7	122/168 (72.8)	120/168 (71.4)	121/168 (71.8)	483/658 (73.4)	483/658 (73.5)	482/658 (73.3)
ADCT ≥5-point reduction from BL[d]	119/154 (77.8)	118/154 (76.6)	124/154 (80.4)	525/632 (83.1)	517/632 (81.9)	515/632 (81.5)

[a]Among patients ≥16 years old; [b]Among patients ≥16 years old with baseline DLQI ≥ 4; [c]Among patients with baseline POEM ≥ 4; [d]Among patients with baseline ADCT ≥ 5.
AD, atopic dermatitis; ADCT, Atopic Dermatitis Control Tool; BE, bioexperienced; BL, baseline; BN, bionaïve; DLQI, Dermatology Life Quality Index; POEM, Patient Oriented Eczema Measurement; QoL, quality of life; UPA, upadacitinib. Results are based on non-responder imputation with multiple imputation (NRI-MI).

CONCLUSIONS

Compared to bionaïve patients, bioexperienced patients generally presented with less severe disease, and started on UPA 30 mg for more varied reasons, including the anatomical location of lesions

Regardless of prior biologic therapy exposure, real-world patients with atopic dermatitis treated with upadacitinib achieved high rates of skin clearance and itch relief, with about one third simultaneously achieving little-to-no itch and almost clear skin, up to month 6

Bionaïve and bioexperienced patients experienced meaningful improvements in quality of life, symptom relief, and disease control, with consistent outcomes observed in both groups

Scan QR code to download an electronic version of this presentation and other AbbVie ISAD 2025 scientific presentations:
QR Code expiration: Sept 26, 2026

To submit a medical question, please visit *www.abbviemedinfo.com*

AbbVie and the authors thank the participants, study sites, and investigators who participated in this clinical trial. AbbVie funded this trial and participated in the trial design, research, analysis, data collection, interpretation of data, and the review and approval of the publication. All authors had access to relevant data and participated in the drafting, review, and approval of this publication. No honoraria or payments were made for authorship. Medical writing support was provided by Ana Vicente-Sanchez, PhD of AbbVie.

Financial arrangements of the authors with companies whose products may be related to the present report are listed as declared by the authors: **RS** has participated in pharmaceutical advisory boards and/or speaker bureaus for AbbVie, LEO Pharma, Lilly, Novartis and Pfizer, and has acted as a principal investigator in clinical trials for AbbVie, Aerotech, Akesobio, Amgen, Arcutis, Arena, Ascend, AstraZeneca, Bayer, Boehringer Ingelheim, Bristol Myers Squibb, Celgene, Coherus BioSciences, Connect, Demira, Galderma, GlaxoSmithKline, F Hoffman–La Roche, Janssen, Lilly, MedImmune, Merck, Merck Sharpe & Dohme, Novartis, Oncobiologics, Pfizer, Principia, Regeneron, Roche, Reistone Biopharma, Samson Clinical, Sanofi-Genzyme, Sun Pharma, UCB, Valeant, and Zai Labs. **HL** has received consulting fees, attended advisory boards, and participated in clinical trials for the following: Aslam Pharm, AbbVie (Abbott), Amgen, AstraZeneca, Bausch health, Bristol-Myers-Squibb, Celgene, Dermira, Eli Lilly, GSK, Incyte, Janssen, La Roche-Posay, Leo Pharmaceutics, Merck Sharp & Dohme, Moonlake, Novartis, Pediapharma, Pfizer, RAPT, Regeneron, Sanofi, Takeda, and UBS. **CF** has participated in pharmaceutical advisory boards and/or speaker for AbbVie, Sanofi, Amgen, UCB Pharma, LEO Pharma, Lilly, Novartis, Pfizer, and Almirall. **IFN** has served as an advisory board member, consultant, and/or investigator for AbbVie, Amgen, Celgene, Galderma, Gebro Pharma, LEO Pharma, Lilly, L'Oréal, Novartis, Pfizer, and Sanofi, and has served as a speaker for AbbVie, Galderma, Gebro Pharma, La Roche-Posay, LEO Pharma, Lilly, Novartis, Pfizer, Pierre Fabre, Sanofi, and Sobi. **FR** has served as an advisory board member, consultant, speaker and/or investigator for AbbVie, Almirall, Amgen, ArgenX, Bristol Myers Squibb, Celldex, Eli Lilly, Jonhson and Johnson, LEO Pharma, Novartis, Pfizer, Sanofi, and UCB. **GG** has served as a speaker, advisory board member, consultant, and/or researcher for AbbVie, Amgen, Novartis, Pfizer, Astra Zeneca, GSK, Takeda, Teva, Chiesi, ROCHE, Genentech, and Sanofi. **IS** has served as an advisory board member, speaker, and/or investigator for AbbVie, Almirall, BMS, Boehringer Ingelheim, Celgene, GSK, Lilly, Galderma, Incyte Dermatology, Janssen, LEO-Pharma, MSD, Novartis, Pfizer, Roche, Sandoz, Sanofi-Genzyme, UCB. **FSA** has no conflicts of interest to declare. **JJPR** has served as an advisory board member, consultant, speaker and/or investigator for AbbVie, Almirall, Eli Lilly, Johnson and Johnson, LEO Pharma, Novartis, Pfizer, Sanofi, Incyte, and UCB. **RT** is a contracted employee of AbbVie and may own stock/options. **MCL, DP,** and **YA** are full time employees of AbbVie and may own AbbVie stock or stock options. **MJG** served as an advisory board member of AbbVie, Amgen, Arcutis, Boehringer Ingelheim, BMS, Eli Lilly, Galderma, Incyte, Janssen, Leo Pharma, Novartis, Pfizer, Regeneron, Sanofi Genzyme, and UCB; served as a member of a speakers bureau for AbbVie, Amgen, Arcutis, Boehringer Ingelheim, BMS, Eli Lilly, Galderma, Incyte, Janssen, Leo Pharma, Novartis, Pfizer, Sanofi Genzyme, and UCB; received grant from AbbVie, Amgen, Akros, Arcutis, Aristea, Bausch Health, BMS, Boehringer Ingelheim, Celgene, Dermira, Dermavant, Eli Lilly, Galderma, GSK, Incyte, Janssen, Kyowa Kirin, LEO Pharma, MedImmune, Merck, Moonlake, Nimbus, Novartis, Pfizer, Regeneron, Reistone, Roche, Sanofi Genzyme, Sun Pharma, and UCB; and participated in a clinical trial within the past two years for AbbVie, Amgen, Akros, Arcutis, Aristea, Bausch Health, BMS, Boehringer Ingelheim, Celgene, Dermira, Dermavant, Eli Lilly, Galderma, GSK, Incyte, Janssen, Kyowa Kirin, LEO Pharma, MedImmune, Merck, Moonlake, Nimbus, Novartis, Pfizer, Regeneron, Reistone, Roche, Sanofi Genzyme, Sun Pharma, Takeda, Tarsus, and UCB.