Table VI. Supporting statements for apremilast in psoriasis

Statement No.	Supporting statement	Reference
1	Patients should initially start at a lower dose (10 mg), which is titrated up over 5 days to reduce the risk of gastrointestinal adverse effects. Thereafter, apremilast is dosed 30 mg by mouth twice daily. Dosage titration schedule: Day 1—10 mg (AM) Day 2—10 mg (AM & PM) Day 3—10 mg (AM); 20 mg (PM) Day 4—20 mg (AM & PM) Day 5—20 mg (AM); 30 mg (PM) Day 6—30 mg (AM & PM)	87
2	The most common adverse effects of apremilast are diarrhea, nausea, upper respiratory tract infections, and headache (those 65 and older are prone to experience dehydration and its complications).	87
3	Apremilast may be associated with the emergence or worsening of depression. Discuss the risk of depression with patients in advance of therapy.	87
4	Apremilast is metabolized in the liver by cytochrome P450. Use with strong inducers of cytochrome P450 (eg, rifampin, phenobarbital, carbamazepine, phenytoin) may result in decreased efficacy and is not recommended.	87
5	Apremilast should be reduced to 30 mg once daily in patients with severe renal impairment (creatine clearance <30 mL/min).	87
6	A small percentage of patients may lose weight on apremilast. Weight should be monitored regularly, and if weight loss occurs (>5% from baseline), discontinuation of apremilast should be considered.	87
7	Routine laboratory screening and monitoring can be considered on an individual basis.*	
8	There is currently no strong evidence to support the combined use of apremilast with other systemic or phototherapy treatments for psoriasis.*	
9	Pregnancy Should only be used in pregnancy if benefit justifies potential risk to fetus.	87

*Supplemental information is expert consensus and not part of evidence-based recommendations.

Apremilast is metabolized in the liver by cytochrome P450 and is thus susceptible to the forms of drug interactions that are typical of medications metabolized by this route. Use of apremilast in conjunction with strong inducers of cytochrome P450 (eg, rifampin, phenobarbital, carbamazepine, and phenytoin) is not recommended, because this combination may result in decreased efficacy. Dangerous drug interactions have not yet been reported, but medication lists should be reviewed before initiating therapy and periodically thereafter.

Overall, apremilast as monotherapy is beneficial to treat psoriasis and psoriatic arthritis. These benefits include oral administration and the lack of a requirement for laboratory monitoring. For patients who would prefer to avoid frequent injections as well as laboratory monitoring and are willing to accept a slower onset of skin clearance and lower likelihood of clearing, apremilast is an appropriate choice. Table VII provides the strength of recommendation and Table VIII[86,93-97] provides the level of evidence for apremilast in psoriasis therapy.

CYCLOSPORINE

Cyclosporine received FDA approval for psoriasis in 1997. It is a potent immunosuppressant that functions by binding cyclophilin, which then inhibits calcineurin and blocks proinflammatory signaling.[98-100] Several inflammatory cytokines, including interferon-γ and IL-2, are consequently reduced, leading to decreased activation of T cells.[99,100] Because of the long list of potential serious adverse effects, cyclosporine is not used as a long-term treatment for psoriasis. Nevertheless, it does have an important role as a rapid-acting medication for severe, recalcitrant disease, acute flares, and erythroderma. It can also be used as a bridge therapy in the transition to a safer long-term treatment.

Dosage

There are 2 main approaches in the use of cyclosporine for the treatment of psoriasis. Some clinicians prefer to start at an intermediate dose of 2.5 to 3.0 mg/kg/day given twice daily for approximately 4 weeks before gradually increasing