



*A CASEWISE™ INITIATIVE*

# *MISSION: ~~IMPOSSIBLE~~*

*MATCHING TREATMENT GOALS  
OF PATIENTS AND PROVIDERS  
IN IBD IN CLINICAL PRACTICE*

*Supported by an educational grant from Johnson & Johnson.*



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To submit a question, please go to the *Ask Question* tab at the bottom of the screen.



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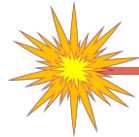
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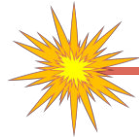
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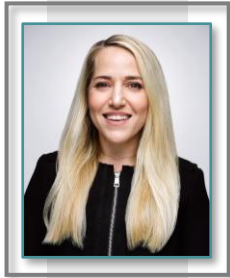


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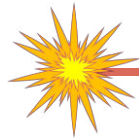
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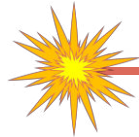
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*All identified conflicts of interest have been mitigated.*

# Disclosures

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*All identified conflicts of interest have been mitigated.*

# LEARNING OBJECTIVES

1

Integrate the latest data and guideline recommendations for IL-23 inhibitors into clinical practice as part of treatment selection for patients with IBD

2

Develop treatment plans utilizing effective communication and SDM strategies that factor in patient needs, preferences, QoL considerations, and treatment goals to optimize adherence and long-term outcomes

# LEARNING OBJECTIVES

**3** Evaluate the latest clinical trial efficacy and safety data for recently approved IL-23 therapies in IBD

**4** Utilize the latest clinical evidence in real-world patient scenarios

# From Treat-to-Target to Precision Care

## What Guides IBD Decisions Today?

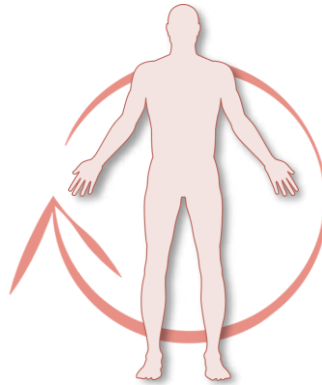
### ULCERATIVE COLITIS (UC)

#### DISEASE CHARACTERISTICS

- IBD severity
- Disease behavior/complications
- Early vs late disease
- Extraintestinal manifestations
- Associated IMID

#### PATIENT CHARACTERISTICS

- Age
- Comorbidities
- Pregnancy/fertility
- Prior malignancy
- Infection risk
- Biologic naïve vs biologic exposure
- Treatment preferences
- Administrative route



### CROHN'S DISEASE (CD)

#### ACCESS

- Insurance coverage
- Cost

#### EFFICACY

- Available evidence
- Onset of action
- Durability of response
- PK/therapeutic drug monitoring
- Combination vs monotherapy
- Positioning and sequencing

#### SAFETY

- Disease severity
- Drug-specific concerns

# Why Target the IL-23/Th17 Axis in IBD

- IL-23 is a key driver of pathogenic Th17 responses in both UC and CD
- IL-23 promotes
  - Chronic intestinal inflammation
  - Resistance to anti-TNF therapy
  - Persistence to pathogenic immune memory
- Selective IL-23p19 inhibition
  - Suppresses pathogenic inflammation
  - Preserves protective IL-17 gut immunity
  - Offers mechanistic rationale for durable remission

# Pivotal and Supportive Regulatory Trials for FDA-approved IL-23p19 Inhibitors

**COMMAND**  
SC maintenance

**INSPIRE**  
IV maintenance

**ADVANCE**  
IV induction

**MOTIVATE**  
IV induction

**SEQUENCE**  
IV induction  
SC maintenance

**FORTIFY**  
SC maintenance



**QUASAR**  
IV induction  
and SC maintenance

**ASTRO**  
SC induction  
and maintenance

**GALAXI 1/2/3**  
IV induction  
and SC maintenance

**GRAVITI**  
SC induction  
and maintenance

**LUCENT-1**  
IV induction

**LUCENT-2**  
SC maintenance

**VIVID-1**  
IV induction  
and SC maintenance

**ULCERATIVE COLITIS  
CHROHN'S DISEASE**



# The Evolving Landscape of IL-12/23 and IL-23p19 Inhibitors in IBD

Therapeutic	FDA Indications	Route/Regimen ( <i>induction</i> → <i>maintenance</i> )	Key Efficacy Snapshot
Guselkumab* (IL-23p19)	UC and CD	<ul style="list-style-type: none"> <li>• <b>UC + CD induction:</b> 200 mg IV or 400 mg SC (two 200 mg injections at week 0, 4, 8)</li> <li>• <b>UC + CD maintenance:</b> 100 mg SC q8w or 200 mg SC q4w</li> </ul>	<ul style="list-style-type: none"> <li>• <b>UC induction (week 12):</b> CR 23% vs 8% placebo (QUASAR)</li> <li>• <b>UC maintenance (week 44):</b> CR 45%–50% vs 19% placebo (QUASAR)</li> <li>• <b>CD induction (week 12):</b> CR 56.1% vs 21.4% placebo (GRAVITI)</li> <li>• <b>CD maintenance (week 48):</b> CR 60%–66.1% vs 17.1% placebo (GRAVITI)</li> </ul>
Mirikizumab (IL-23p19)	UC and CD	<ul style="list-style-type: none"> <li>• <b>UC:</b> 300 mg IV (week 0, 4, 8) → 200 mg SC q4w (starting week 12)</li> <li>• <b>CD:</b> 900 mg IV (week 0, 4, 8) → 300 mg SC q4w (starting week 12)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>UC induction (week 12):</b> CR 24.2% vs 13.3% placebo (LUCENT-1)</li> <li>• <b>UC maintenance (week 40):</b> CR 49.9% vs 25.1% placebo (LUCENT-2)</li> <li>• <b>CD induction (week 12):</b> endoscopic response 32% vs 11% placebo (VIVID-1)</li> <li>• <b>CD maintenance (week 52):</b> CR 53% vs 36% placebo; endoscopic response 46% vs 23% (VIVID-1)</li> </ul>

\*Fully subcutaneous option for induction through maintenance. Agents listed in alphabetical order.

CR, clinical remission; FDA, U.S. Food and Drug Administration; IV, intravenous; q#w, every # weeks; SC, subcutaneous.

Hart A, et al. *Gastroenterology*. 2025;169(2):308–325. Loftus EV Jr, et al. *JAMA*. 2024;332(11):881–897.

Sands BE, et al. *N Engl J Med*. 2019;381(13):1201–1214. Feagan BG, et al. *N Engl J Med*. 2016 Nov 17;375(20):1946–1960.

Guselkumab [package insert]. Revised September 2025. [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2025/761061s026lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761061s026lbl.pdf).

Mirikizumab-mrkz [package insert]. Revised November 2025. [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2025/761279s005lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761279s005lbl.pdf)

Risankizumab-rzaa [package insert]. Revised September 2025. [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2025/761105s039,761262s011lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761105s039,761262s011lbl.pdf)

Ustekinumab [package insert]. Revised November 2025. [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2025/125261s171,761044s019lbl.pdf#page=36](https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/125261s171,761044s019lbl.pdf#page=36).

# The Evolving Landscape of IL-12/23 and IL-23p19 Inhibitors in IBD (cont.)

Therapeutic	FDA Indications	Route/Regimen ( <i>induction</i> → <i>maintenance</i> )	Key Efficacy Snapshot
Risankizumab (IL-23p19)	UC and CD	<ul style="list-style-type: none"> <li>UC: 1,200 mg IV (week 0, 4, 8) → 180 mg or 360 mg SC q8w</li> <li>CD: 600 mg IV (week 0, 4, 8) → 180 mg or 360 mg SC q8w</li> </ul>	<ul style="list-style-type: none"> <li>UC induction (week 12): CR 20.3% vs 6.2% placebo (INSPIRE)</li> <li>UC maintenance (week 52): CR 40.2% / 37.6% vs 25.1% placebo (COMMAND)</li> <li>CD induction (week 12): CR 45% vs 25% placebo (ADVANCE); 42% vs 20% placebo (MOTIVATE)</li> <li>CD maintenance (week 52): CR 57%–61% vs 46% placebo; endoscopic response 48%–50% vs 22% (FORTIFY)</li> </ul>
Ustekinumab (IL-12/23p40)	UC & CD	<ul style="list-style-type: none"> <li>UC &amp; CD: weight-based induction IV → 90 mg SC q8w (starting week 8)</li> </ul>	<ul style="list-style-type: none"> <li>UC induction (week 8): CR 15.5%–15.6% vs 5.3% placebo (UNIFI)</li> <li>UC maintenance (week 44): CR 38%–44% vs 24% placebo (UNIFI)</li> <li>CD induction (week 8): CR 21%–40% vs 7%–20% placebo (UNITI-1/UNITI-2)</li> <li>CD maintenance (week 44): CR 53% vs 36% placebo (IM-UNITI)</li> </ul>

\*Fully subcutaneous option for induction through maintenance. Agents listed in alphabetical order.

Hart A, et al. *Gastroenterology*. 2025;169(2):308–325. Loftus EV Jr, et al. *JAMA*. 2024;332(11):881–897.

Sands BE, et al. *N Engl J Med*. 2019;381(13):1201–1214. Feagan BG, et al. *N Engl J Med*. 2016 Nov 17;375(20):1946–1960.

Guselkumab [package insert]. Revised September 2025. [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2025/761061s026lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761061s026lbl.pdf).

Mirikizumab-mrkz [package insert]. Revised November 2025. [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2025/761279s005lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761279s005lbl.pdf)

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# Safety Overview: UC (Adults)

Outcome	Guselkumab	Mirikizumab	Risankizumab	Ustekinumab
<b>Serious infections</b>	Low; similar to placebo in UC trials	Low; similar to placebo in UC trials	Low; similar to placebo in UC trials	Low; similar to placebo in UC trials
<b>Most common AEs</b>	URTI ~10%, injection-site reactions ~7%–8%, headache ~5%–6%, arthralgia ~5%, fatigue ~3%–4%, diarrhea ~4%	URTI ~14%, injection-site reactions ~9%, headache ~8%, arthralgia ~7%, fatigue ~5%, diarrhea ~5%, rash ~5%	Arthralgia ~5%–10%, injection-site reactions ~3%, headache ~5%, pyrexia ~4%–5%, rash ~4%	Nasopharyngitis ~20%–25%, headache ~10%, abdominal pain ~7%, fatigue ~4%–5%, diarrhea ~4%
<b>Monitoring</b>	TB screening; avoid live vaccines	TB screening; avoid live vaccines	TB screening; avoid live vaccines; baseline liver enzymes and bilirubin required	TB screening; avoid live vaccines; malignancy risk per label
<b>IBD-specific label note</b>	Hepatotoxicity warning/precaution included for UC/CD	No UC-specific label warnings	Hepatotoxicity reported → obtain baseline LFTs	No UC-specific lab requirement

AEs, adverse events; LFTs, liver function tests; TB, tuberculosis; URTI, upper respiratory tract infection.

Guselkumab [package insert]. Revised September 2025. [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2025/761061s026lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761061s026lbl.pdf).

Mirikizumab-mrkz [package insert]. Revised November 2025. [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2025/761279s005lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761279s005lbl.pdf)

Risankizumab-rzaa [package insert]. Revised September 2025. [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2025/761105s039,761262s011lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761105s039,761262s011lbl.pdf).

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# Safety Overview: CD (Adults)

Outcome	Guselkumab	Mirikizumab	Risankizumab	Ustekinumab
<b>Serious infections</b>	Low; similar to placebo in CD trials	Low; similar to placebo in CD trials	Low; generally similar to placebo in CD trials	Low; similar to placebo in CD trials
<b>Most common AEs</b>	URTI ~30%–38%, abdominal pain ~12%–14%, headache ~6%–8%, injection-site reactions ~3%–4%, arthralgia ~4%–5%, diarrhea ~3%–5%	URTI ~28%, injection-site reactions ~10%, diarrhea ~9%, abdominal pain ~7%, fatigue ~6%, headache ~6%	URTI ~10%–11%, headache ~6%–7%, arthralgia ~5%, injection-site reactions ~4%–6%, anemia ~4%–5%	Nasopharyngitis ~11%, injection-site erythema ~5%, bronchitis ~5%, pruritus ~4%, UTI ~4%, sinusitis ~3%
<b>Monitoring</b>	TB screening; avoid live vaccines	TB screening; avoid live vaccines	TB screening; avoid live vaccines; baseline liver enzymes and bilirubin required	TB screening; avoid live vaccines
<b>IBD-specific label note</b>	<b>SC induction is FDA approved for CD</b>	No CD-specific label warnings	Hepatotoxicity reported → obtain baseline LFTs	No CD-specific lab requirement

UTI, urinary tract infection.

Guselkumab [package insert]. Revised September 2025. [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2025/761061s026lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761061s026lbl.pdf).

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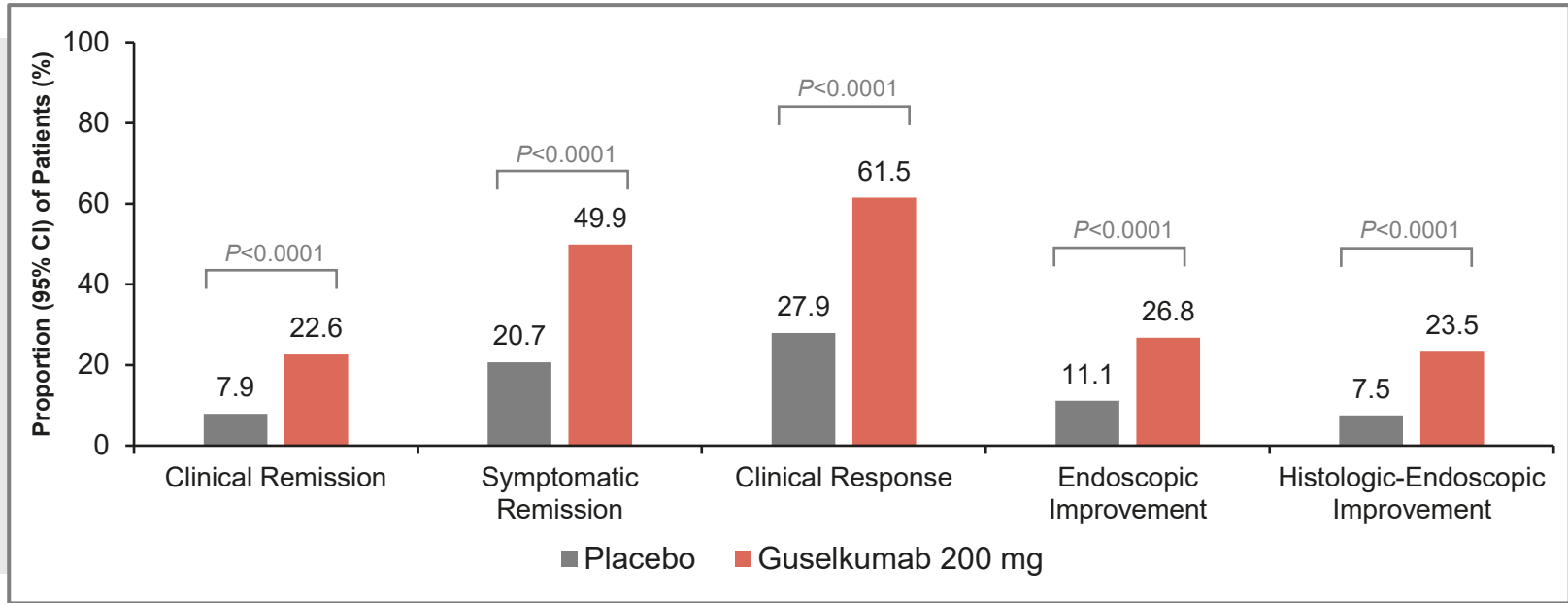
Ustekinumab [package insert]. Revised November 2025. [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2025/125261s171,761044s019lbl.pdf#page=36](https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/125261s171,761044s019lbl.pdf#page=36).

*Pivotal UC Efficacy: IL-23p19 Inhibitors*

**Clinical Remission and Endoscopic Improvement**

# Guselkumab Induction in UC

## QUASAR Phase 3 Week 12 Endpoints



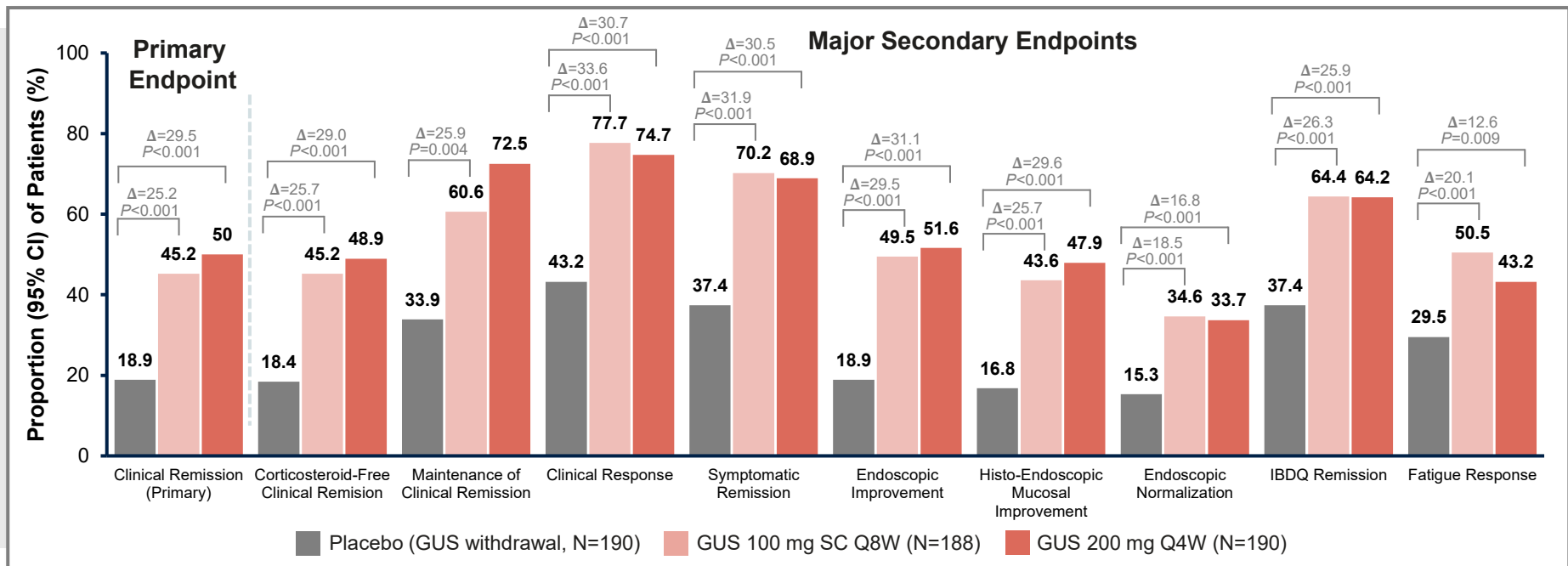
Clinical remission defined as a Mayo SFS of 0 or 1 with no increase from baseline, an RBS of 0, and a MES of 0 or 1 with no friability.

MES, Mayo endoscopic subscore; RBS, rectal bleeding subscore; SFS, stool frequency subscore.

Rubin DT, et al. *Lancet*. 2025;405(10472):33–49.

# Guselkumab Maintenance in UC

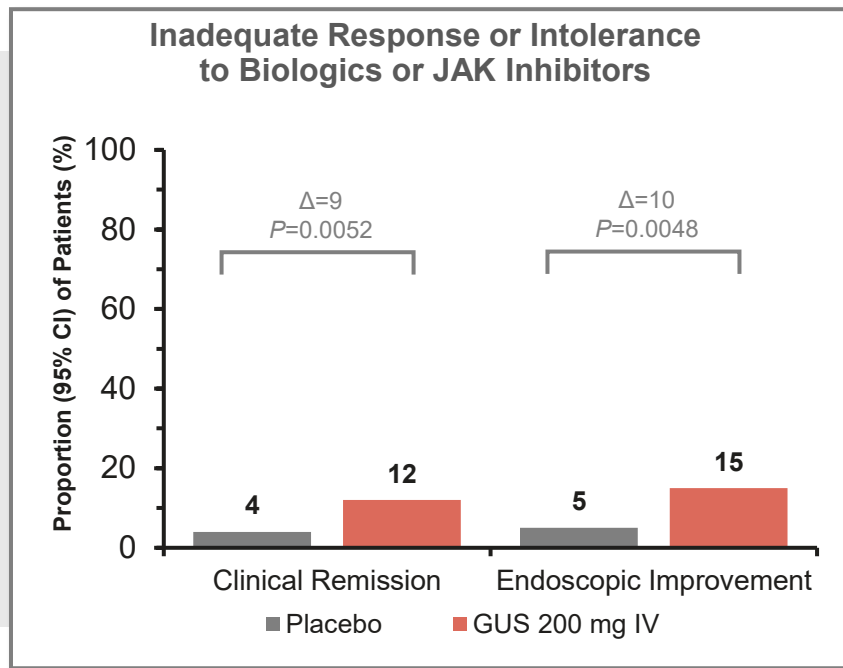
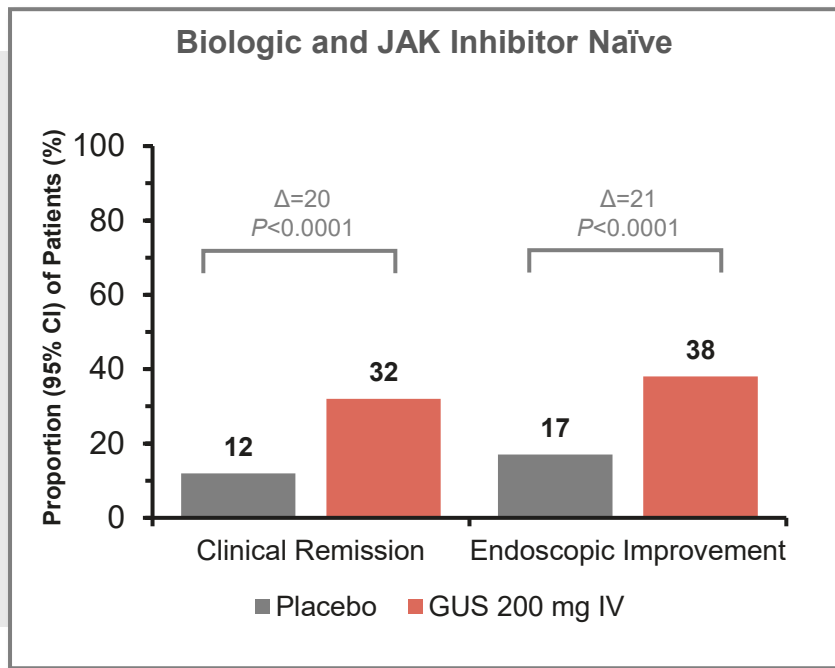
## QUASAR Phase 3 Week 44 Endpoints after Induction



Primary analysis population: randomized patients with an MMS of 5–9 at induction who received at least one maintenance study treatment dose.

GUS, guselkumab; IBDQ, IBD questionnaire.  
Rubin DT, et al. *Lancet*. 2025;405(10472):33–49.

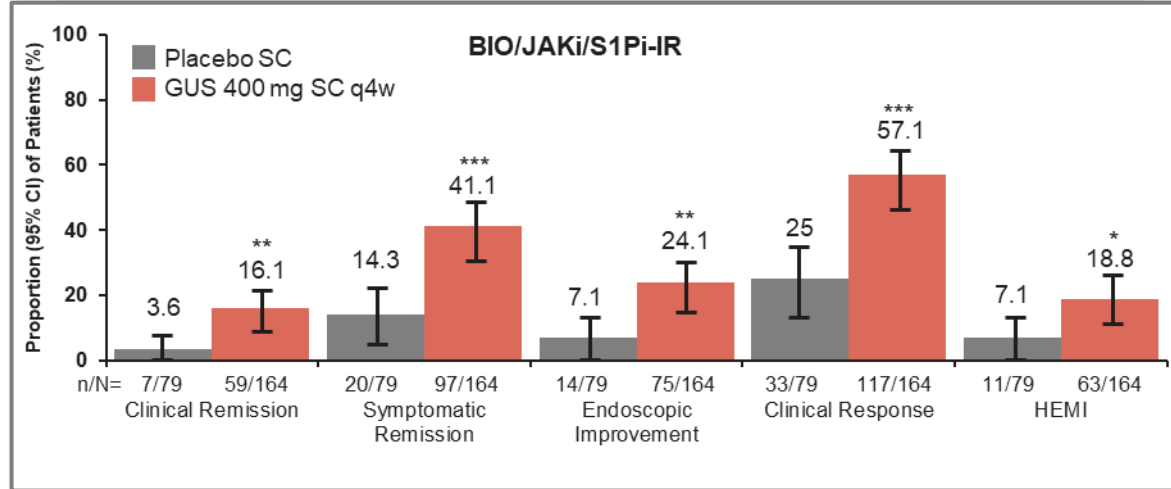
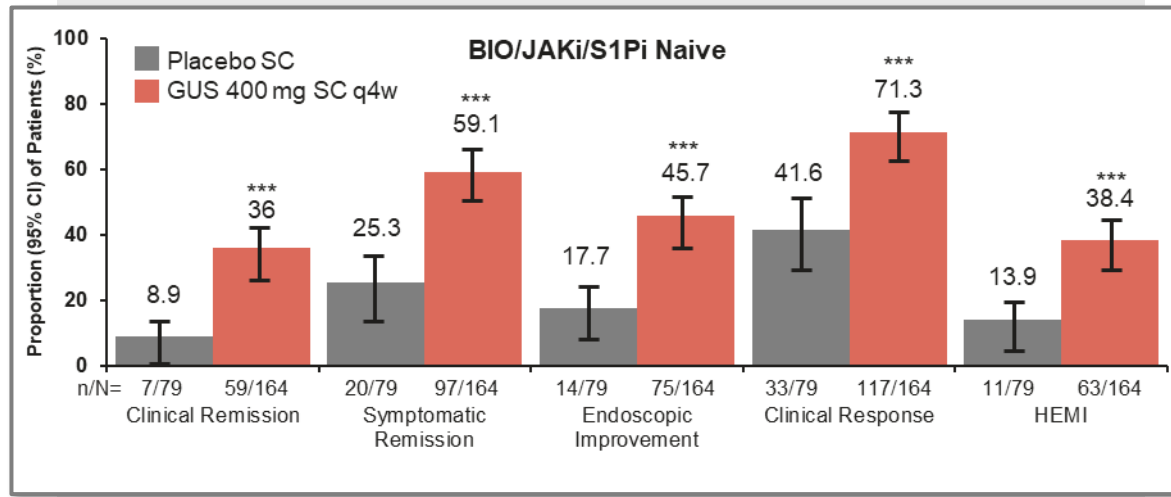
# Guselkumab in Previously Treated Patients with UC at Week 44: QUASAR





# SC Guselkumab Induction in UC

## ASTRO Phase 3 at Week 12



\*Nominal  $P < 0.05$ ; \*\*Nominal  $P < 0.01$ ; \*\*\*Nominal  $P < 0.001$ .

**Clinical remission:** Mayo SFS 0/1 and not increased from BL, a Mayo RBS=0, and MES 0/1 with no friability.

**Symptomatic remission:** SFS 0/1 and not increased from BL and RBS=0.

**Endoscopic improvement:** MES 0/1 with no friability.

**Clinical response:**  $\geq 30\%$  and  $\geq 2$ -point decrease from BL in Modified Mayo Score with  $\geq 1$ -point decrease from BL in RBS or RBS 0/1.

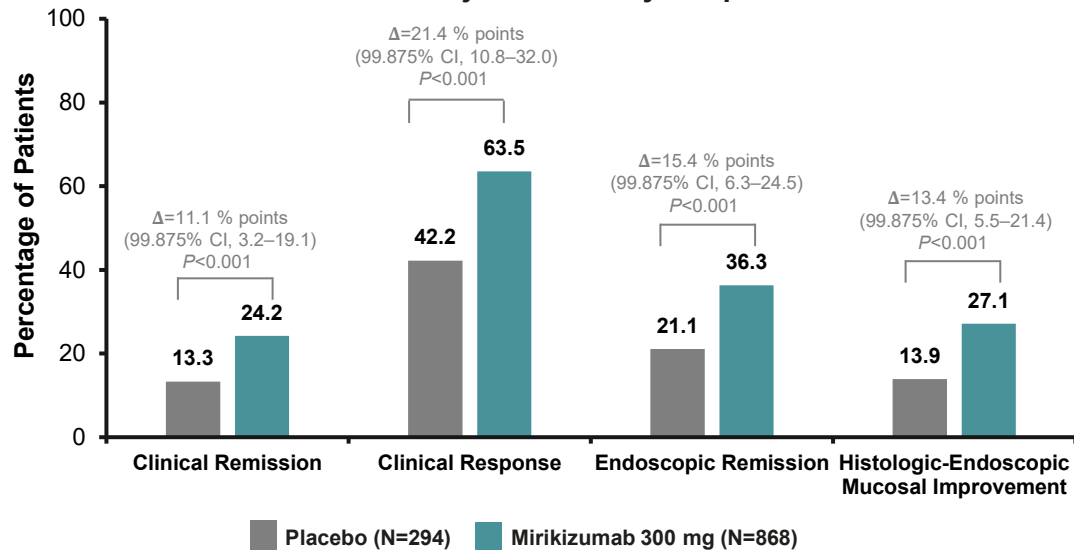
**HEMI:** histologic improvement (neutrophil infiltration in  $< 5\%$  of crypts, no crypt destruction, and no erosions, ulcerations, or granulation tissue per Geboes grading system) and endoscopic improvement.

CI, confidence interval; HEMI, histo-endoscopic mucosal improvement; S1Pi, sphingosine 1-phosphate inhibitor; S1Pi-IR, sphingosine 1-phosphate inhibitor–inadequate response.

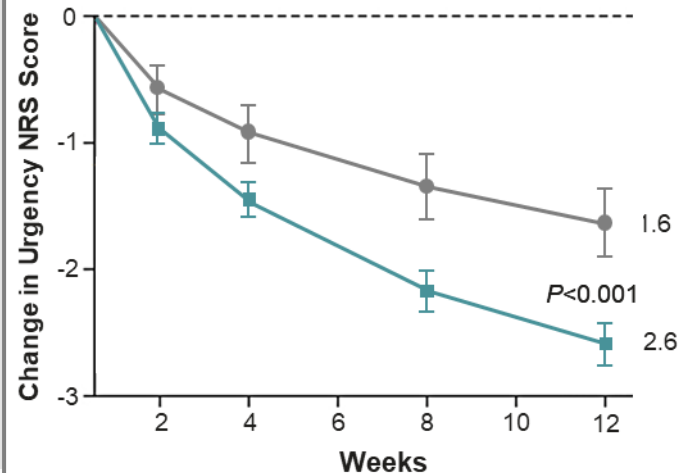
# Mirikizumab Induction in UC

## LUCENT-1

**Primary Endpoint of Clinical Remission and Three Major Secondary Endpoints**



**Change in Bowel Urgency from Baseline**

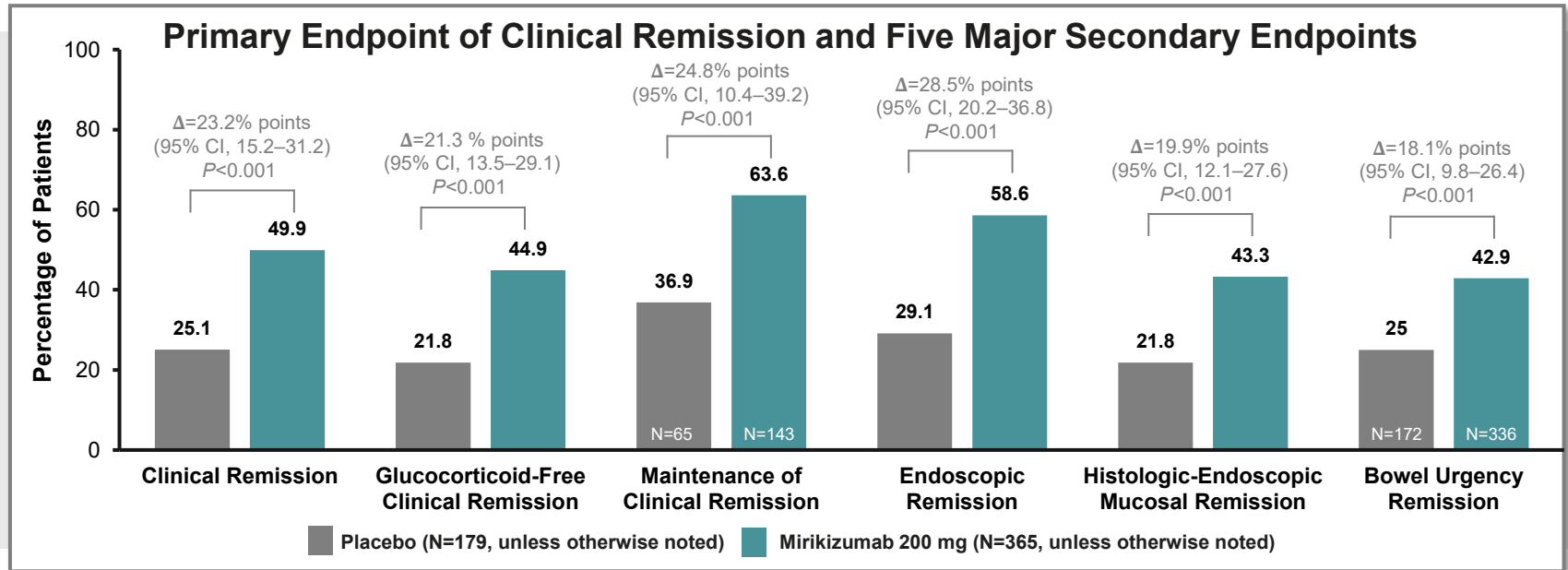


NRS, numeric rating scale.

D'Haens G, et al. *N Engl J Med.* 2023;388(26):2444–2455.

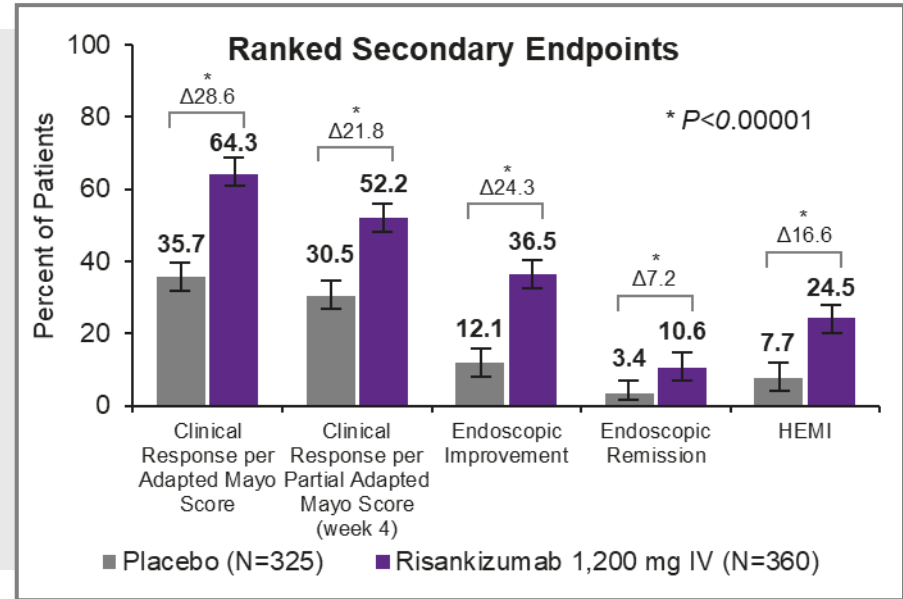
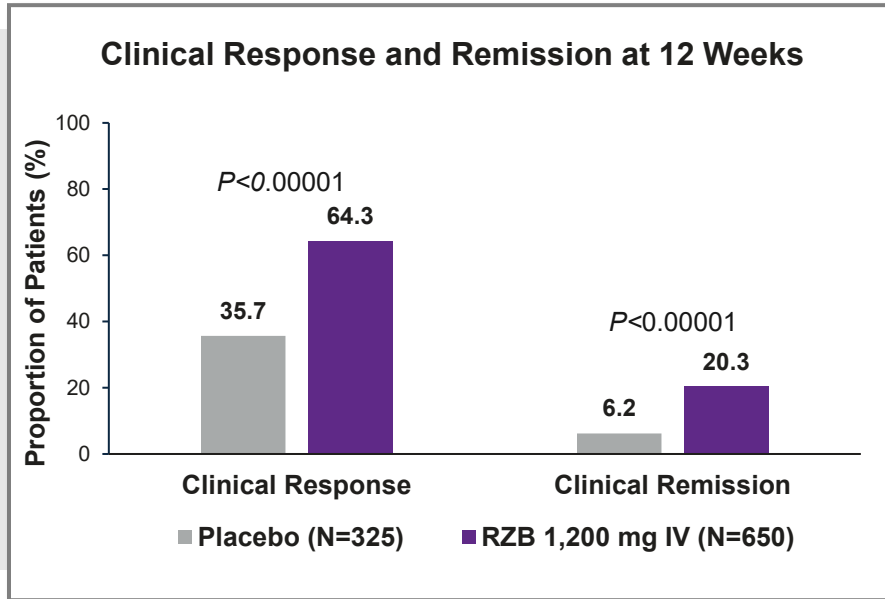
# Mirikizumab Maintenance in UC

## LUCENT-2 Week 40 Endpoints after Induction



# Risankizumab Induction in UC

INSPIRE



\*P<0.00001 vs placebo.

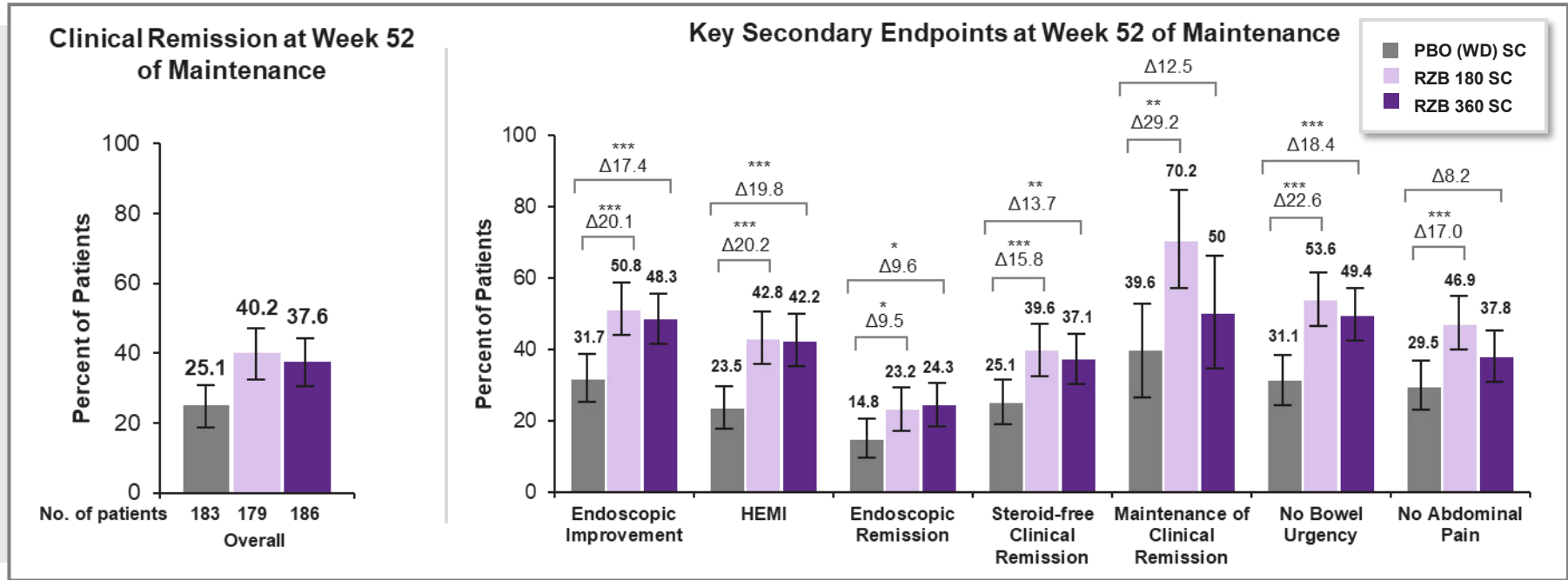
Clinical remission per Adapted Mayo Score is defined as stool frequency subscore (SFS) ≤1 and not greater than baseline, rectal bleeding subscore (RBS) of 0 and ES ≤1 without friability. Clinical response is defined as a decrease from baseline in the Adapted Mayo Score ≥2 points and ≥30% from baseline, plus a decrease in RBS ≥1 or an absolute RBS ≤1.

RZB, risankizumab.

Louis E, et al. *Am J Gastroenterol.* 2023;118(10S):S624–S625.

# Risankizumab Maintenance in UC

## COMMAND Week 52 Endpoints



\* $P \leq 0.05$ ; \*\* $P \leq 0.01$ ; \*\*\* $P \leq 0.001$  vs PBO (WD) SC.

HEMI, histo-endoscopic mucosal improvement; IR, inadequate response; PBO, placebo; WD, withdrawal.

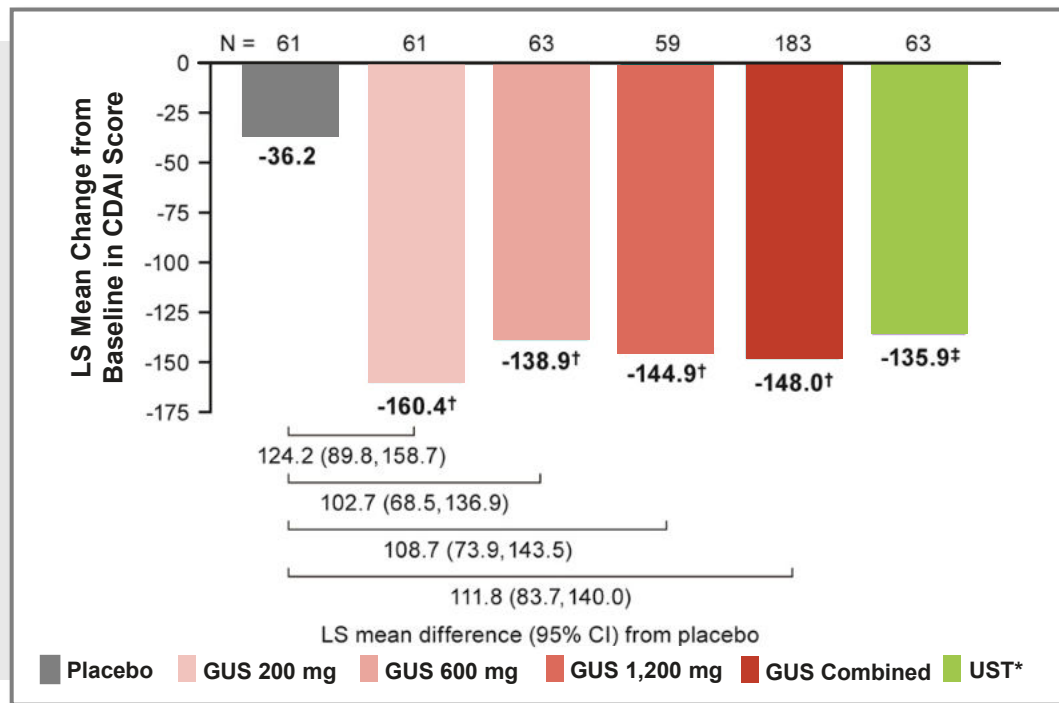
Louis E, et al. *J Crohns Colitis*. 2024;18(Suppl 1):i10–i12.

*Pivotal CD Efficacy: IL-23p19 Inhibitors*

*Clinical Remission and Endoscopic Improvement*

# GALAXI-1

## Guselkumab Induction in CD



### Primary Endpoint

- Change from baseline in CDAI score at week 12
- GALAXI-1 is a DBPC trial
- Randomized patients 1:1:1:1:1 to
  - 3 different doses of IV GUS given at weeks 0, 4, and 8
  - IV UST at week 8
  - Placebo
- UST was a reference arm
- N=309

\*UST 6 mg/kg IV → 90 mg SC; † <0.05 for GUS vs placebo; ‡Nominal <0.05 from post hoc analysis of UST vs placebo.

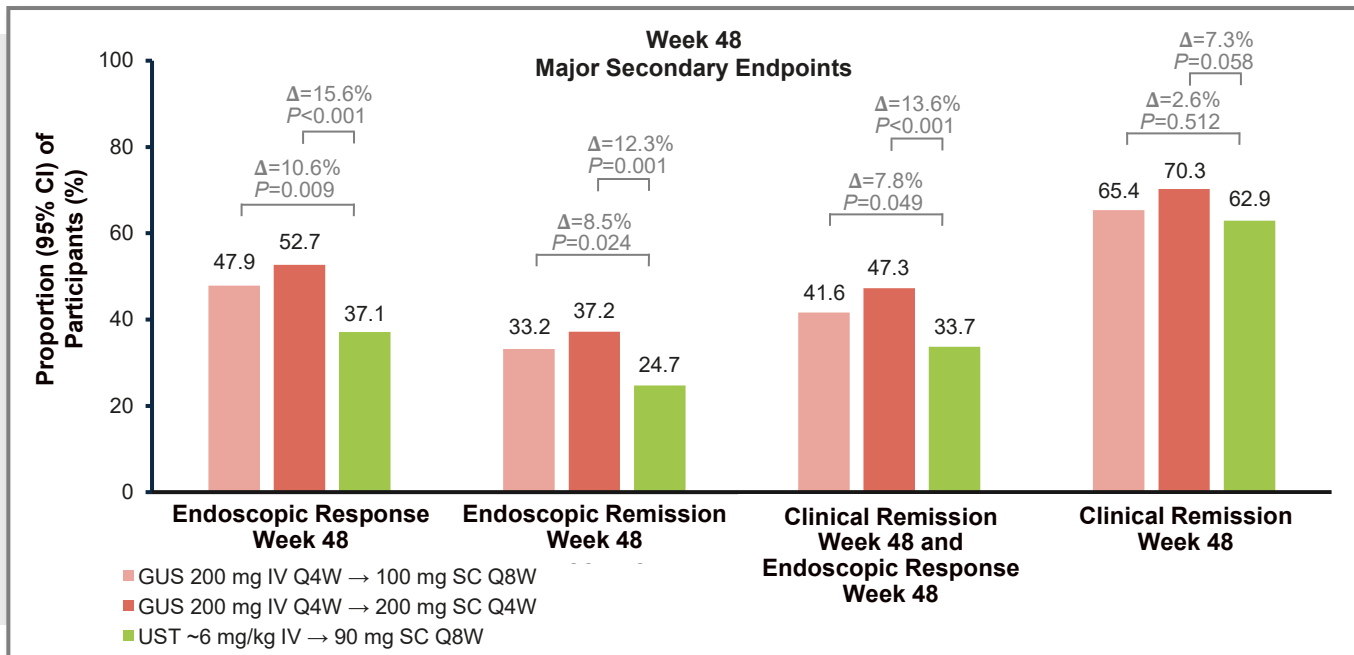
CDAI, Crohn's disease activity index; DBPC, double-blind placebo controlled; LS, least squares; UST, ustekinumab.

Sandborn W, et al. *Gastroenterology*. 2022;162(6):1650–1664.

# GALAXI 2 and 3

## Guselkumab Maintenance in CD

GALAXI 2 and 3 are identical 48-week, randomized, double-blind, double-dummy, placebo, and active-comparator (UST) treat-through trials assessing the efficacy and safety of GUS in patients with moderately to severely active CD



**Clinical response:** ≥100-point reduction from baseline in CDAI or CDAI <150

**Endoscopic response:** ≥50% improvement from baseline in SES-CD or SES-CD ≤2

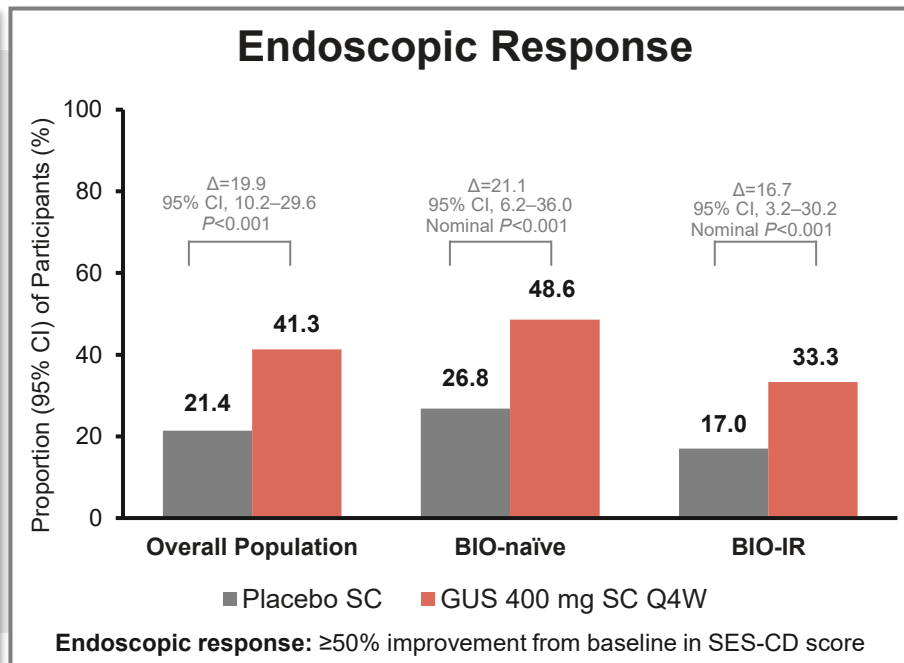
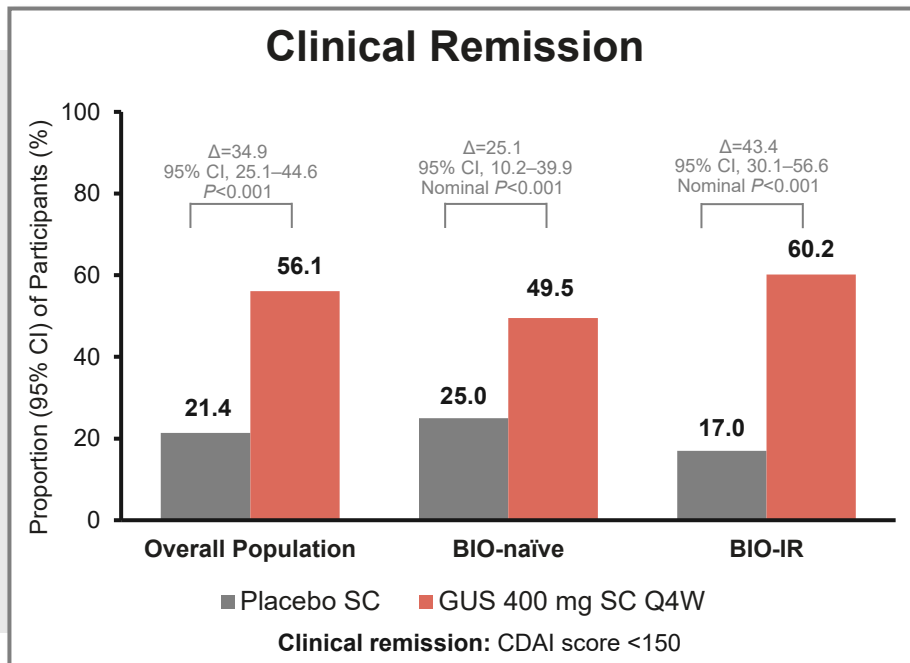
**Clinical remission:** CDAI <150

**Endoscopic remission:** SES-CD ≤4 and a ≥2-point reduction from baseline and no subscore greater than 1 in any individual component



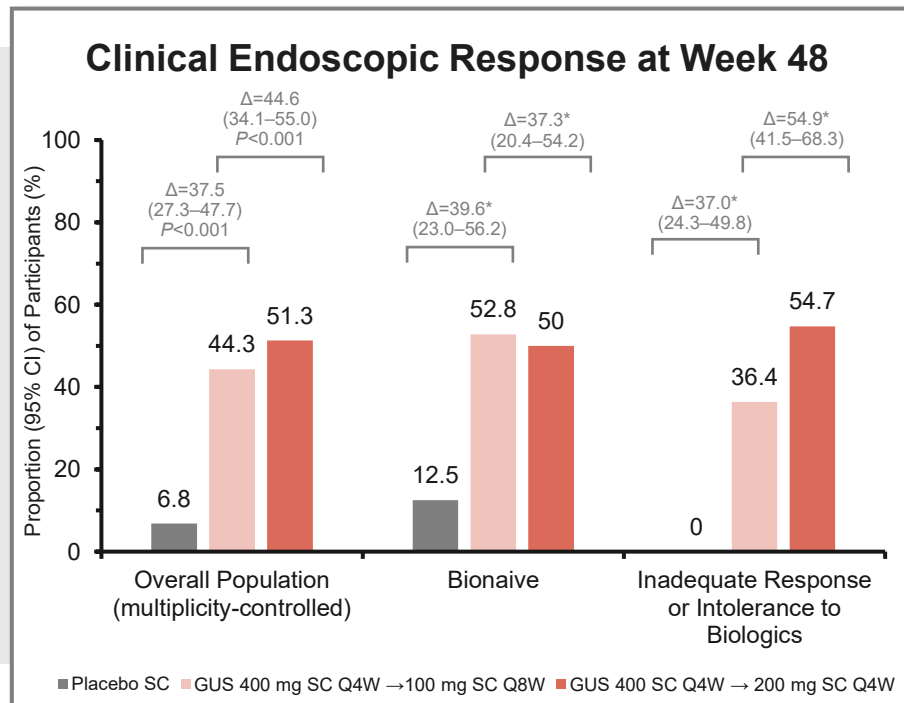
# GRAVITI

## Subcutaneous Guselkumab in CD at Week 12



# GRAVITI

## Subcutaneous Guselkumab in CD at Week 48

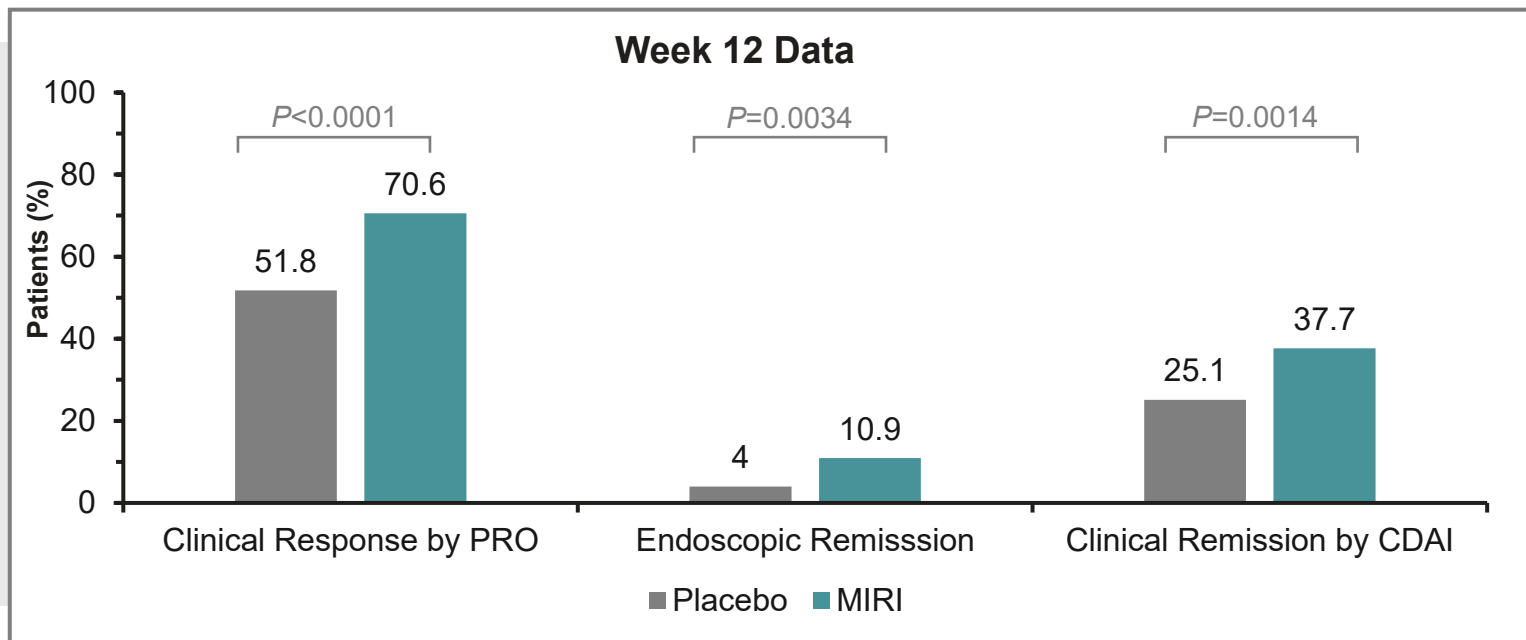


\*Nominal p-value<0.05

Hart A, et al. *Gastroenterology*. 2025;169(2):308–325.

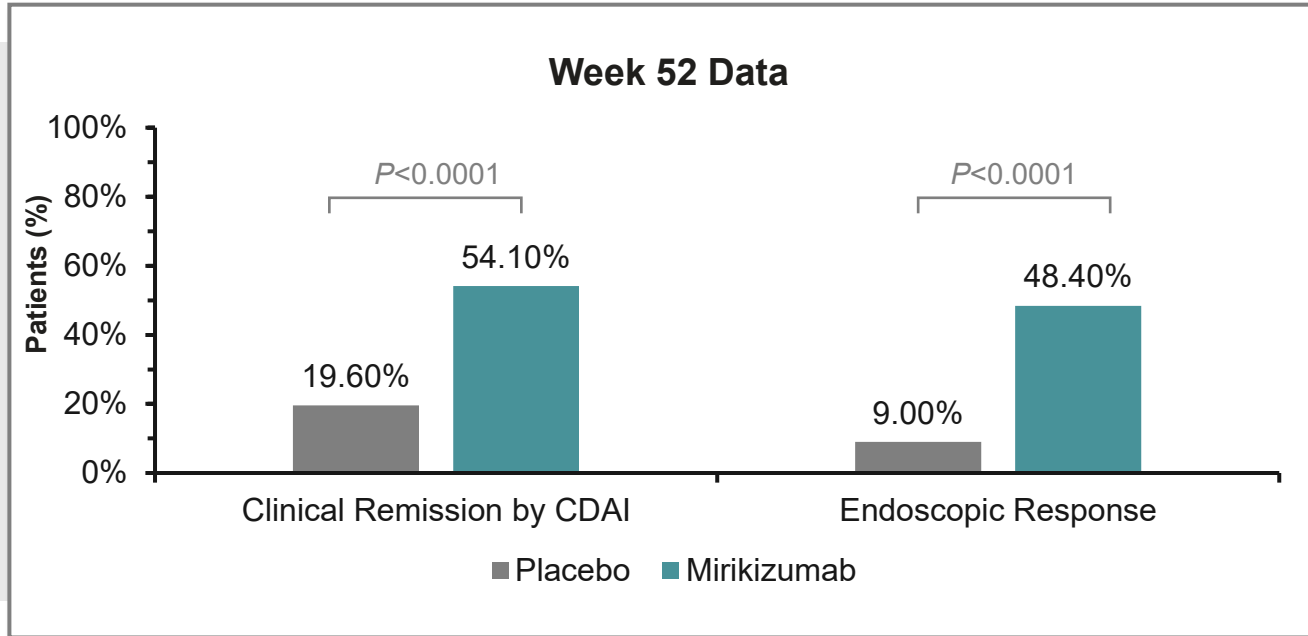
# VIVID-1

## Mirikizumab Induction in CD



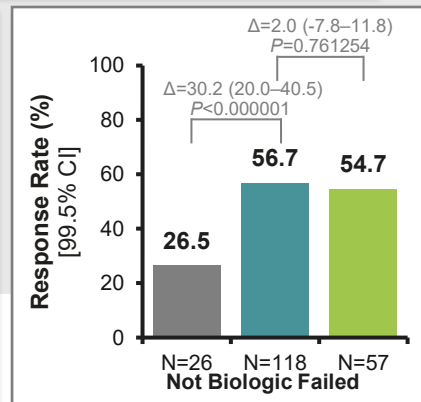
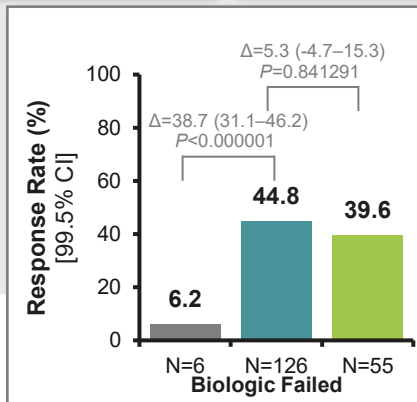
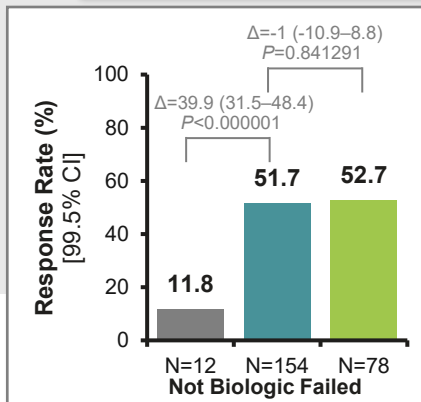
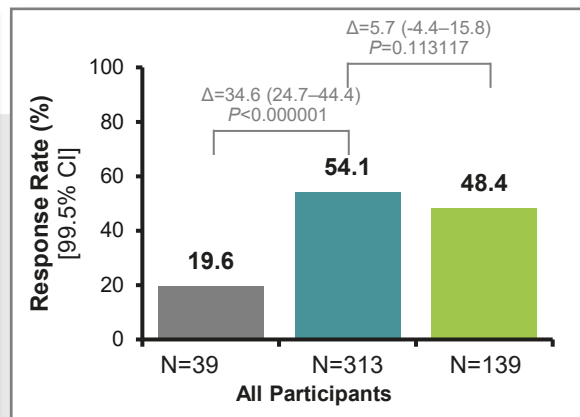
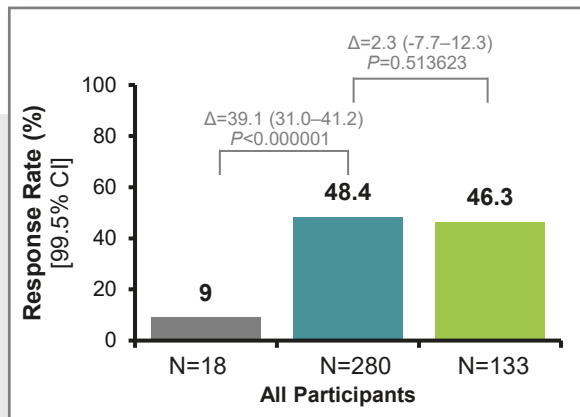
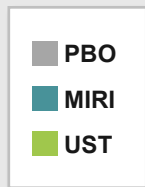
# VIVID-1

## Mirikizumab Maintenance in CD



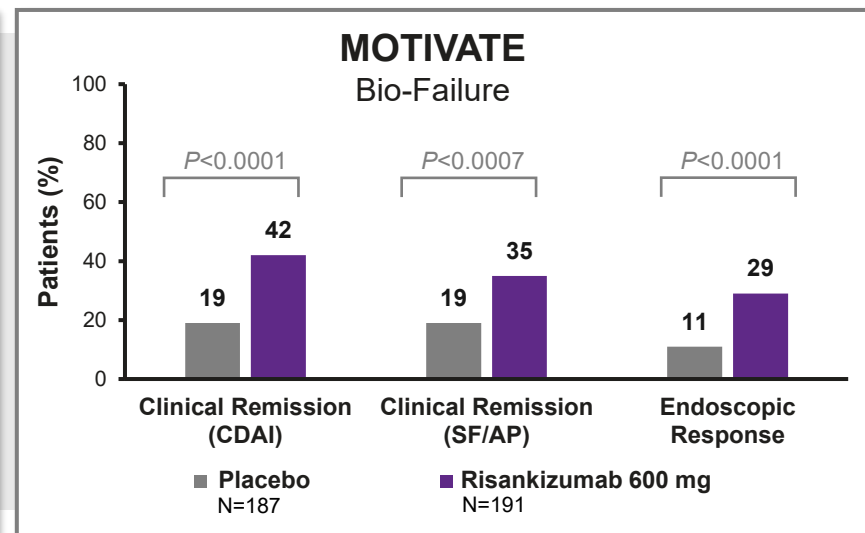
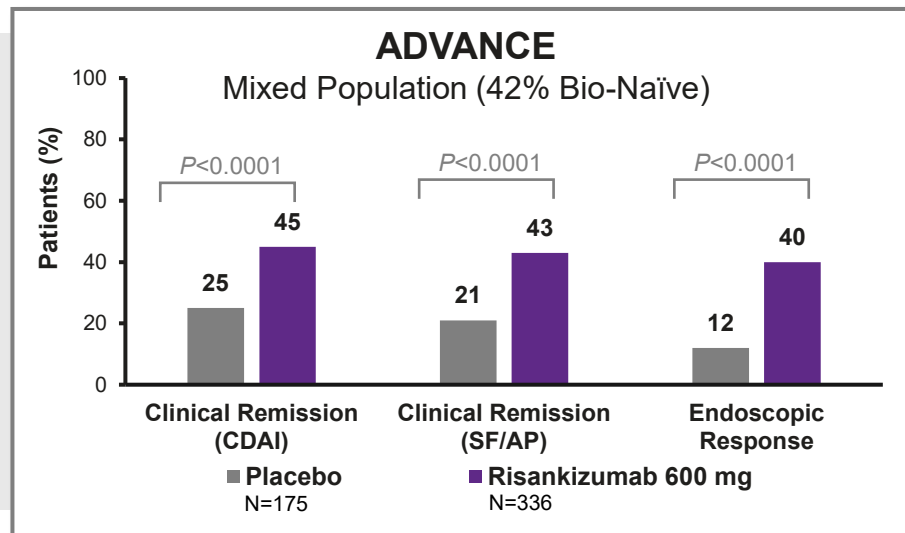
# VIVID-1 Secondary Endpoints

Mirikizumab vs Ustekinumab in Moderate-to-Severe CD



# ADVANCE and MOTIVATE

## Risankizumab Induction in CD



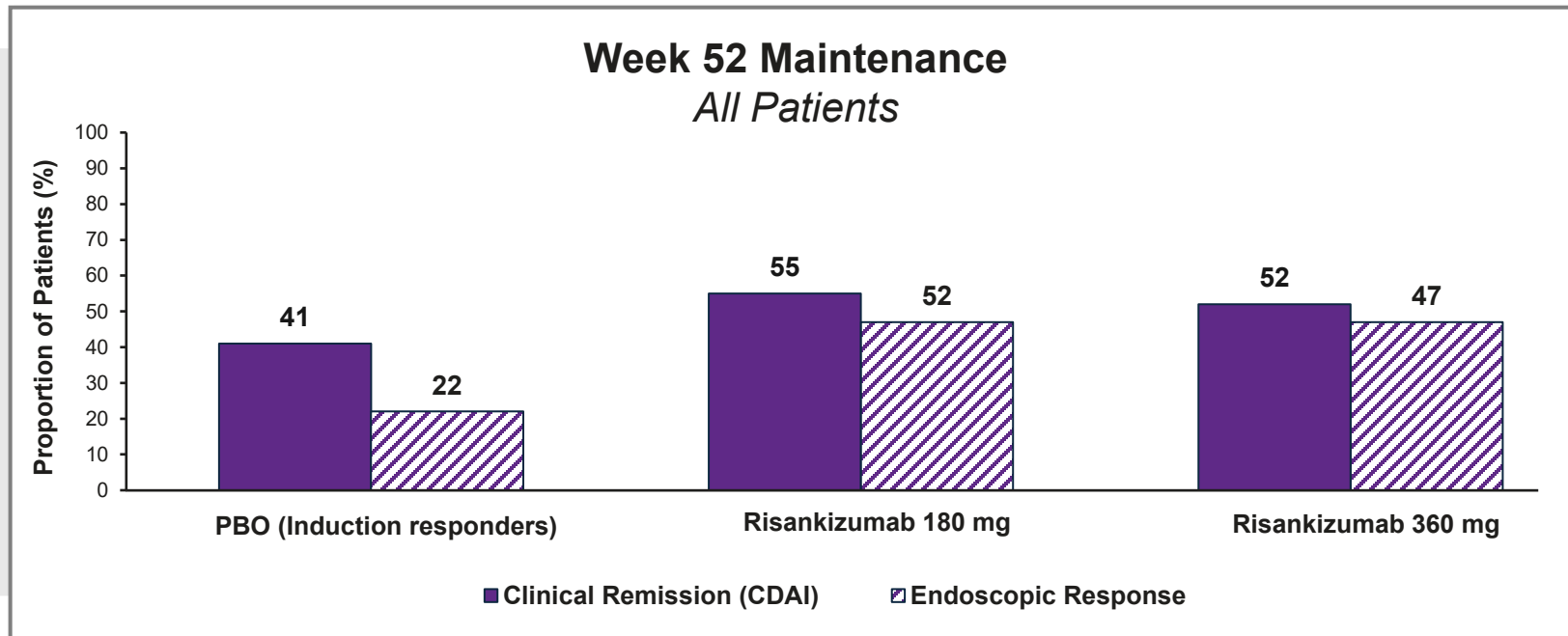
Clinical responders defined as  $\geq 30\%$  decrease in average daily stool frequency or abdominal pain score (APS) and not worse than baseline; endoscopic response defined as  $> 50\%$  decline in simple endoscopic score (SES-CD) vs baseline by central reviewer (or in patients with SES-CD of 4 at baseline,  $\geq 2$ -point decrease vs baseline); CDAI clinical remission, a CDAI of  $< 150$ .

CDAI, Crohn's disease activity index; SF/AP, stool frequency/abdominal pain.

D'Haens G, et al. *Lancet*. 2022;399(10340):2015–2030. Ferrante M, et al. *Lancet*. 2022;399(10340):2031–2046.

# FORTIFY

## Risankizumab Maintenance in CD

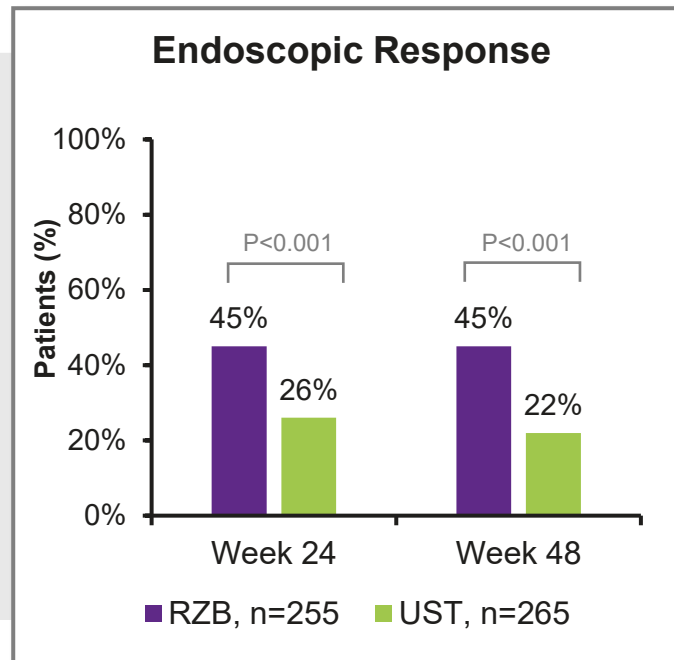
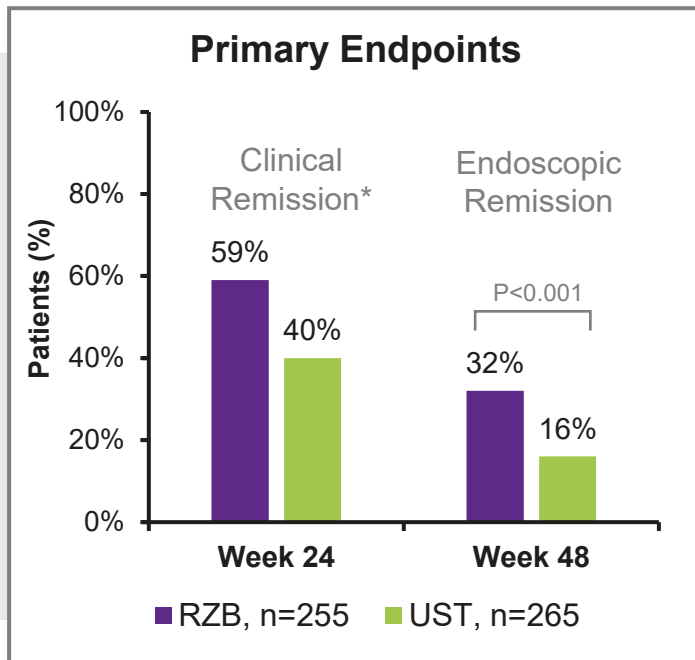


Endoscopic response defined as >50% decline in SES-CD vs baseline by central reviewer (or in patients with SES-CD of 4 at baseline,  $\geq 2$ -point decrease vs baseline); CDAI clinical remission, a CDAI of <150.

Ferrante M, et al. *Lancet*. 2022;399(10340):2031–2046.

# SEQUENCE

## Risankizumab vs Ustekinumab in CD



\*Noninferiority met.

Peyrin-Biroulet L, et al. *N Engl J Med.* 2024;391:213–223.



# *Patient Cases: What Would You Do?*

*Audience, Community/Rural Clinician, KOL, AI,  
and Faculty Responses to Three Patients with IBD*



# PATIENT VOICE

*Natalie Hayden, Patient Advocate*

- 42-year-old female with long-standing Crohn's ileitis, diagnosed at age 21
- Worsening symptoms over 6–8 weeks
  - Increased abdominal pain/cramping and bloating
  - Loose stools/diarrhea and fatigue
  - Decreased appetite; weight stable
- Previously in long-term remission on adalimumab
  - Payer-mandated non-medical switch to an adalimumab biosimilar 3 months ago (no dose/schedule change)
  - Expresses frustration with payer-driven switch but understands coverage constraints
- Required a recent short course of budesonide with partial symptom relief
- Denies fevers or vomiting
- Reports embarrassment discussing bowel symptoms and concern about losing disease control
- Prefers to avoid IV therapies
  - Cites work as a news reporter, concerns about time away from work, visibility, and stigma
  - Asks about options for durable control without long-term steroids or infusions
- Notes mild psoriasiform rash (umbilicus, ears, now scalp), increasingly bothersome





# PATIENT VOICE

*Natalie Hayden, Patient Advocate*

**Endoscopy:** Colonoscopy with SES-CD score: 11 (moderate to marked disease activity within the ileum)

	Result	Reference Range
<b>C-reactive protein (CRP)</b>	9.8 mg/L	<10 mg/L: normal/low, common in healthy adults
<b>Fecal calprotectin</b>	620 µg/g	<50 µg/g: normal (low inflammation)
<b>Adalimumab trough level</b>	19 µg/mL	4.5 µg/mL to 12 µg/mL: optimal trough levels
<b>Anti-adalimumab abs</b>	None detected	—
<b>Hemoglobin</b>	11.2 g/dL	13.5 g/dL to 17.5 g/dL: normal range for women
<b>Platelets</b>	420,000/µL	150,000/µL to 450,000/µL: normal
<b>Albumin</b>	3.5 g/dL	3.5 g/dL to 5 g/dL: normal





# AUDIENCE POLLING

## What would you do next?

- A. Increase dosing frequency of her current adalimumab therapy
- B. Switch to another anti-TNF agent
- C. Switch to an IL-23 inhibitor
- D. Switch to vedolizumab
- E. Switch to upadacitinib
- F. Manage symptoms with budesonide and re-evaluate in 3 months





# EXPERT FACULTY

*Live Discussion*



**Decision Point**  
*Patient Case: Natalie Hayden*





# COMMUNITY GASTROENTEROLOGIST

*Audio Recording: Case 1*



## **C** Switch to an IL-23 inhibitor

- **Moderate disease activity** with flare requiring steroids, anemia symptoms, and elevated biomarkers
- **Escalation beyond anti-TNF warranted** → switch to a different advanced therapy class
- **IL-23 inhibitor favored:** strong efficacy, favorable safety vs JAK inhibitors, potential benefit for psoriasis
- **Vedolizumab:** acceptable alternative if gut-selective therapy preferred, but likely less efficacious
- **Subcutaneous administration preferred** to align with patient's social and work circumstances



# RURAL GASTROENTEROLOGIST: 12 YEARS

*Audio Recording: Case 1*



A

**Increase dosing frequency of her current adalimumab therapy**

- **Long-term remission on adalimumab** prior to recent biosimilar switch
- **Short symptom duration (6–8 weeks)** → may reflect pharmacokinetic loss of response
- **Dose escalation is practical and payer-friendly** before changing mechanism
- **Assess before switching:** check trough/antibodies; rule out *C. difficile*; recheck CRP and fecal calprotectin

## Rule outs

- **Another anti-TNF:** reserve for antibodies or clear secondary loss
- **IL-23 inhibitor:** prefer more long-term real-world experience first
- **Vedolizumab:** IV only, slower onset
- **Upadacitinib:** higher monitoring and safety burden; not first move
- **Budesonide alone:** risks masking disease activity and promoting steroid dependence



# COMMUNITY MD: 9 YEARS

*Audio Recording: Case 1*



## **C** Switch to an IL-23 inhibitor

- **Loss of disease control** after anti-TNF biosimilar switch with steroid rescue
- **New psoriasiform rash** → consistent with paradoxical anti-TNF effect; favors mechanism change
- **Switch to IL-23 inhibitor** for durable, steroid-free control
- **Guselkumab preferred:** fully subcutaneous; avoids IVs/work disruption and aligns with patient priorities

## Rule outs

- **Increase adalimumab dose:** possible if low exposure, but rash suggests class-related issue
- **Another anti-TNF:** paradoxical psoriasis often persists across class
- **Vedolizumab:** IV-based, slower onset, no skin benefit
- **Upadacitinib:** effective but reserved for later/need for speed due to safety monitoring
- **Budesonide alone:** risks masking disease and steroid dependence







# Additional Community Gastroenterologist Responses for Case 1



RESPONDENT 1

**C** Switch to an IL-23 inhibitor

RESPONDENT 2

**C** Switch to an IL-23 inhibitor

RESPONDENT 3

**C** Switch to an IL-23 inhibitor

RESPONDENT 4

**E** Switch to upadacitinib



# KOL: MILLIE D. LONG, MD, MPH

*Video Recording: Case 1*

**C** Switch to an IL-23 inhibitor



# Paradoxical Psoriasiform Rash with Anti-TNF Therapy in IBD

- **What it is:** new-onset psoriasis/psoriasiform eruption (or flare/phenotypic shift of prior psoriasis) occurring during anti-TNF treatment, despite anti-TNFs being used to treat psoriasis
- **How often it happens in IBD:** systematic review/meta-analysis estimates an overall incidence of ~6% in anti-TNF-treated IBD
- **Common patterns:** frequently involves scalp, palms/soles (palmoplantar pustulosis), and plaque-type lesions; may be distressing and adherence-limiting
- **Who's at higher risk:** higher risk reported with smoking, female sex, younger age at anti-TNF start, and ileocolonic Crohn's; risk may vary by specific anti-TNF agent
- **Variation in the IL-23 receptor gene** may identify those at risk of anti-TNF $\alpha$ -induced paradoxical psoriasis (PP), beyond clinical variables



# KOL: JESSICA R. ALLEGRETTI, MD, MPH, FACG, AGAF

*Video Recording: Case 1*

**C** Switch to an IL-23 inhibitor





# KOL: EDWARD V. LOFTUS, JR., MD

*Video Recording: Case 1*

**C** Switch to an IL-23 inhibitor





# AI: ChatGPT 5.2

## *User-Fed Response: Case 1*



**New chat** → Here's the case subjective, objective, and plan/multiple choice question. Based on the information provided, which answer choice would you choose and what is your brief rationale for your chosen answer and unchosen options?



### **C** Switch to an IL-23 inhibitor



**Rationale:** active Crohn's despite therapeutic adalimumab levels and no antibodies → mechanistic failure, not underdosing. An IL-23 offers durable efficacy, subcutaneous dosing, and potential improvement in psoriasiform rash



### Rule outs

- Another anti-TNF:** dose escalation or class cycling unlikely to help
- Budesonide:** delays disease-modifying therapy
- Vedolizumab:** IV induction and slower onset conflict with patient preferences
- Upadacitinib:** broader systemic safety considerations; no skin benefit



# NATALIE HAYDEN

*Video Clip: Introduction*







# NATALIE HAYDEN

*Video Clip: Quality of Life*







# Case Perspective Summary

## Case 1



	Community/Rural	KOLs	AI
Increase dosing frequency of her current adalimumab therapy	1	—	—
Switch to another anti-TNF agent	—	—	—
Switch to an IL-23 inhibitor	5	3	1
Switch to vedolizumab	—	—	—
Switch to upadacitinib	1	—	—
Manage symptoms with budesonide and re-evaluate in 3 months	—	—	—

# Pearls Learned from Natalie's Case

➡➡ CD, anti-TNF experience, payer switch, EIMs, patient preferences



## EIMs can guide mechanism selection

New or worsening psoriasiform rash during anti-TNF therapy supports moving away from the class and considering IL-23–targeted therapy



## Durable control requires aligning efficacy with patient priorities

High-efficacy therapies with subcutaneous dosing can improve adherence and long-term success when treatment choice reflects work, stigma, and lifestyle concerns

**ACG explicitly highlights patient-specific factors:** prior intolerance, safety profile, RoA, and life stage considerations



## Loss of control after a non-medical switch warrants reassessment—not reassurance

Symptom relapse and steroid rescue following a biosimilar switch should prompt evaluation for mechanistic failure and appropriate therapy escalation



## AUDIENCE POLLING REVISITED

### NOW, what would you do next?

- A. Increase dosing frequency of her current adalimumab therapy
- B. Switch to another anti-TNF agent
- C. Switch to an IL-23 inhibitor
- D. Switch to vedolizumab
- E. Switch to upadacitinib
- F. Manage symptoms with budesonide and re-evaluate in 3 months





# PATIENT VOICE

*Kaylaa' White, Patient Advocate*

- 34-year-old female with ulcerative colitis
- Ongoing symptoms for 3–4 months
  - 5–6 loose stools per day with intermittent blood
  - Urgency and occasional incontinence
  - Lower abdominal cramping and fatigue
  - Symptoms significantly limit ability to work full time
- Steroid-dependent disease
  - ≥3 prednisone tapers in the past year
  - Concerned about long-term effects of repeated steroid use
- Inadequate response to optimized oral and rectal 5-aminosalicylic acid (ASA) therapy
- Prior infliximab intolerance
  - Severe fatigue, headaches, and infusion reactions
- Feels discouraged by prior treatment failures
  - Seeks a treatment plan she can maintain long term
- Family planning considerations
  - Considering pregnancy within the next year





# PATIENT VOICE

*Kaylaa' White, Patient Advocate*

## Endoscopy

- Flexible sigmoidoscopy shows continuous moderate inflammation involving the rectum and sigmoid colon, with no deep ulcerations

## Disease Activity

- Partial Mayo Score = 3 (moderate disease activity)
- Mayo endoscopy subscore = 2 (moderate disease activity)

	Result	Reference Range
CRP	12 mg/L	<10 mg/L: normal/low, common in healthy adults
Fecal calprotectin	850 µg/g	<50 µg/g: normal (low inflammation)
Hemoglobin	11.2 g/dL	13.5 g/dL to 17.5 g/dL: normal range for women
Albumin	3.5 g/dL	3.5 g/dL to 5 g/dL normal





## AUDIENCE POLLING

### What would you do next?

- A. Continue current therapy and attempt another prednisone taper
- B. Switch to another anti-TNF agent
- C. Switch to an IL-23 inhibitor
- D. Switch to upadacitinib
- E. Switch to vedolizumab
- F. Begin thiopurine monotherapy and reassess in 3–6 months



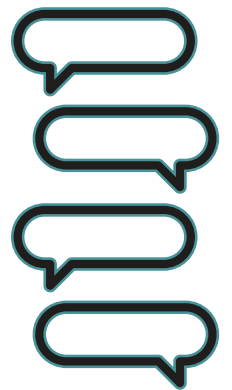


# EXPERT FACULTY

*Live Discussion*



**Decision Point**  
*Patient Case: Kaylaa' White*





# COMMUNITY GASTROENTEROLOGIST

*Audio Recording: Case 2*



## E Switch to vedolizumab

- **Moderate UC** with recurrent flares requiring repeated steroid rescue
- **TNF intolerance** → avoid further anti-TNF therapy
- **Continued steroids:** ineffective and unsafe long term
- **Advance therapy warranted:** IL-23 and upadacitinib are options
- **Vedolizumab preferred** given pregnancy planning and gut-selective profile







# COMMUNITY MD: 9 YEARS

*Audio Recording: Case 2*



## E Switch to vedolizumab

- **Escalation needed:** failure of optimized oral and rectal 5-ASA
- **Prior infliximab intolerance** → avoid anti-TNF agents
- **Pregnancy planning** within the next year influences therapy choice
- **Vedolizumab selected** for gut-selective mechanism and pregnancy comfort
- Clinician has **limited familiarity with IL-23 data in pregnancy**

## Rule outs

- **Do not continue 5-ASA alone:** inadequate response; delays control and increases steroid risk
- **Do not restart infliximab:** prior infusion reactions and systemic intolerance
- **Another anti-TNF:** considered given pregnancy data, but prior intolerance raises adherence concerns
- **IL-23 inhibitor:** appealing efficacy, but limited pregnancy data influence caution
- **Avoid upadacitinib:** pregnancy planning makes risk profile unfavorable



# RURAL GASTROENTEROLOGIST: 18 YEARS

*Audio Recording: Case 2*



## E Switch to vedolizumab

- **Moderate–severe UC** with persistent symptoms impacting work and quality of life
- **Steroid dependence** ( $\geq 3$  prednisone tapers in past year) → urgent need to stop steroid cycle
- **Goal:** durable, safe maintenance therapy with rapid steroid withdrawal
- **Vedolizumab selected:** effective in UC with strong long-term safety profile
- **Practical choice:** manageable monitoring and feasible in a rural practice

## Rule outs

- **Do not continue prednisone tapers:** confirms steroid dependence and increases long-term toxicity
- **Another anti-TNF:** possible, but favors mechanism change given ongoing steroid reliance
- **IL-23 inhibitor:** effective option, but preference for more real-world durability and payer predictability before first-line use
- **Upadacitinib:** rapid efficacy but greater systemic safety and monitoring burden; reserved for later lines
- **Thiopurine monotherapy:** too slow and insufficient for current disease severity



# Additional Community Gastroenterologist Responses for Case 2



RESPONDENT 1

**C** Switch to an IL-23 inhibitor



RESPONDENT 2

**E** Switch to vedolizumab



RESPONDENT 3

**E** Switch to vedolizumab



RESPONDENT 4

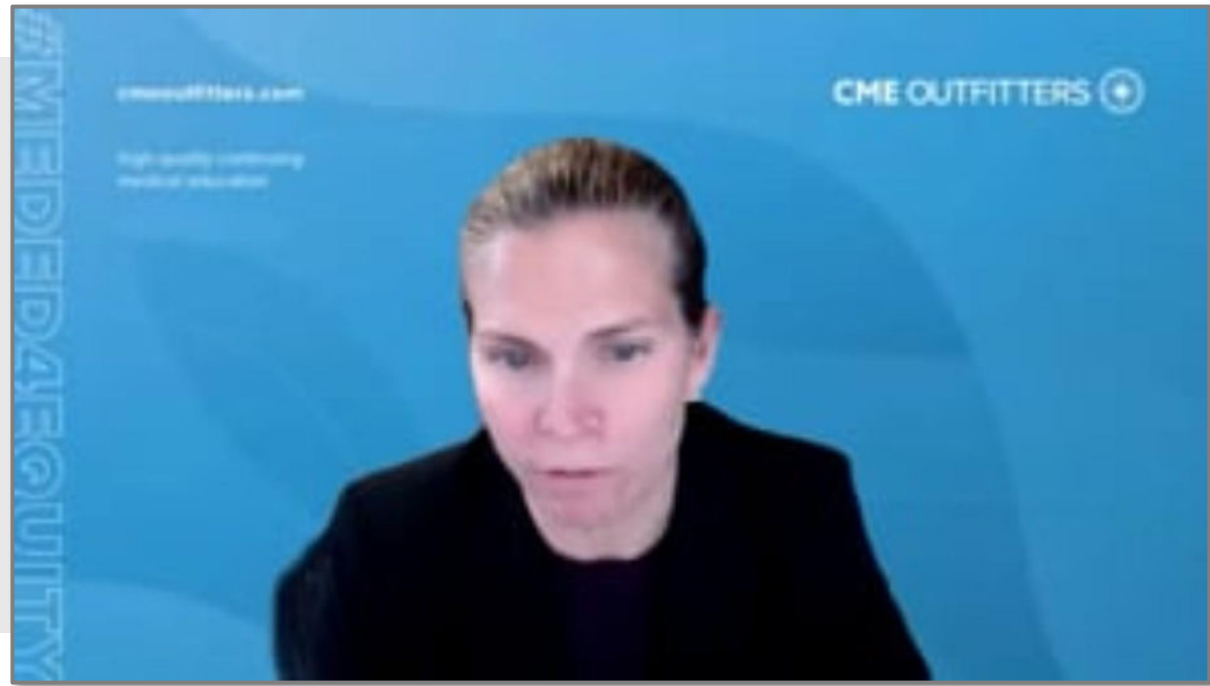
**C** Switch to an IL-23 inhibitor



# KOL: MILLIE D. LONG, MD, MPH

*Video Recording: Case 2*

**C** Switch to an IL-23 inhibitor

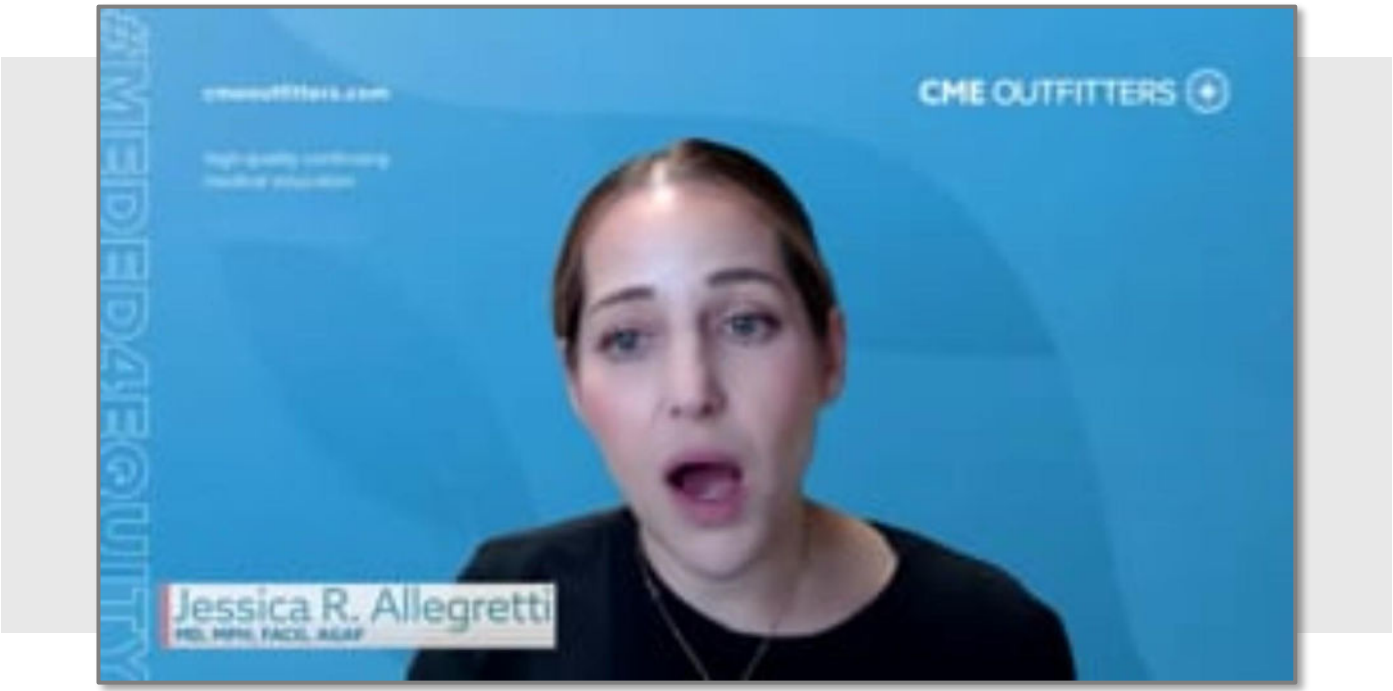




# KOL: JESSICA R. ALLEGRETTI, MD, MPH, FACG, AGAF

*Video Recording: Case 2*

**C** Switch to an IL-23 inhibitor



# Pearls from the PIANO Study



## Active disease poses greater pregnancy risk

Poor control—not biologic therapy—drives adverse maternal and neonatal outcomes



## Biologics did not increase adverse outcomes

No higher risk of congenital anomalies, infections, or developmental harm



## Steroid exposure carries measurable risk

Associated with preterm birth, low birth weight, and NICU admission



## Continuation of effective therapy is recommended

Maintaining remission through pregnancy improves outcomes



## Pregnancy should guide proactive treatment planning

Pregnancy should guide therapy choice—not delay escalation

# IBD Medications from Preconception through Pregnancy and Lactation

Medication	Preconception	First Trimester	Second Trimester	Third Trimester	Lactation
<b>Aminosalicylates</b> <ul style="list-style-type: none"> <li>Folic acid supplementation with sulfasalazine</li> </ul>	☑	☑	☑	☑	☑
<b>Thiopurine</b> <ul style="list-style-type: none"> <li>Monitor metabolites, liver enzymes</li> </ul>	☑	☑	☑	☑	☑
<b>Methotrexate</b> <ul style="list-style-type: none"> <li>Teratogen</li> <li>Cessation 1–3 months prior to conception</li> </ul>	☒	☒	☒	☒	☒
<b>Corticosteroids</b> <ul style="list-style-type: none"> <li>Minimize use</li> <li>Employ steroid-sparing therapy</li> </ul>	☑	☑	☑	☑	☑
<b>Anti-TNF</b>	☑	☑	☑	☑	☑
<b>Anti-integrin</b>	☑	☑	☑	☑	☑
<b>Anti-IL-12/23 or anti-IL-23</b>	☑	☑	☑	☑	☑
<b>JAKi</b> <ul style="list-style-type: none"> <li>Avoid</li> <li>Use only if no other viable option for maternal health</li> </ul>	!	!	!	!	!
<b>S1P receptor modulator</b> <ul style="list-style-type: none"> <li>Avoid</li> <li>Use only if no other viable option for maternal health</li> </ul>	!	!	!	!	!

☑, appropriate to use during pregnancy; ☒, avoid during pregnancy; !, avoid unless no viable option for maternal health.



# KOL: EDWARD V. LOFTUS, JR., MD

*Video Recording: Case 2*

**C** Switch to an IL-23 inhibitor







# AI: CHATGPT 5.2

## *User-Fed Response: Case 2*



**New chat** → Here's the case subjective, objective, and plan/multiple choice question. Based on the information provided, which answer choice would you choose and what is your brief rationale for your chosen answer and unchosen options?



### **E** Switch to vedolizumab



**Rationale:** This patient has moderate, steroid-dependent ulcerative colitis with objective inflammation, despite optimized 5-ASA therapy. Continued steroid tapers are no longer appropriate. **Vedolizumab** offers effective disease control with a favorable long-term safety profile and is well suited for a patient planning pregnancy, making it the best overall choice.



### Rule outs

- Another prednisone taper:** perpetuates steroid dependence
- Another anti-TNF:** less favorable due to prior infliximab intolerance
- Thiopurine monotherapy:** slow onset and limited efficacy
- Upadacitinib:** effective but contraindicated with pregnancy planning
- IL-23 inhibitor:** reasonable option, but less pregnancy safety data than vedolizumab



# KAYLAA' WHITE

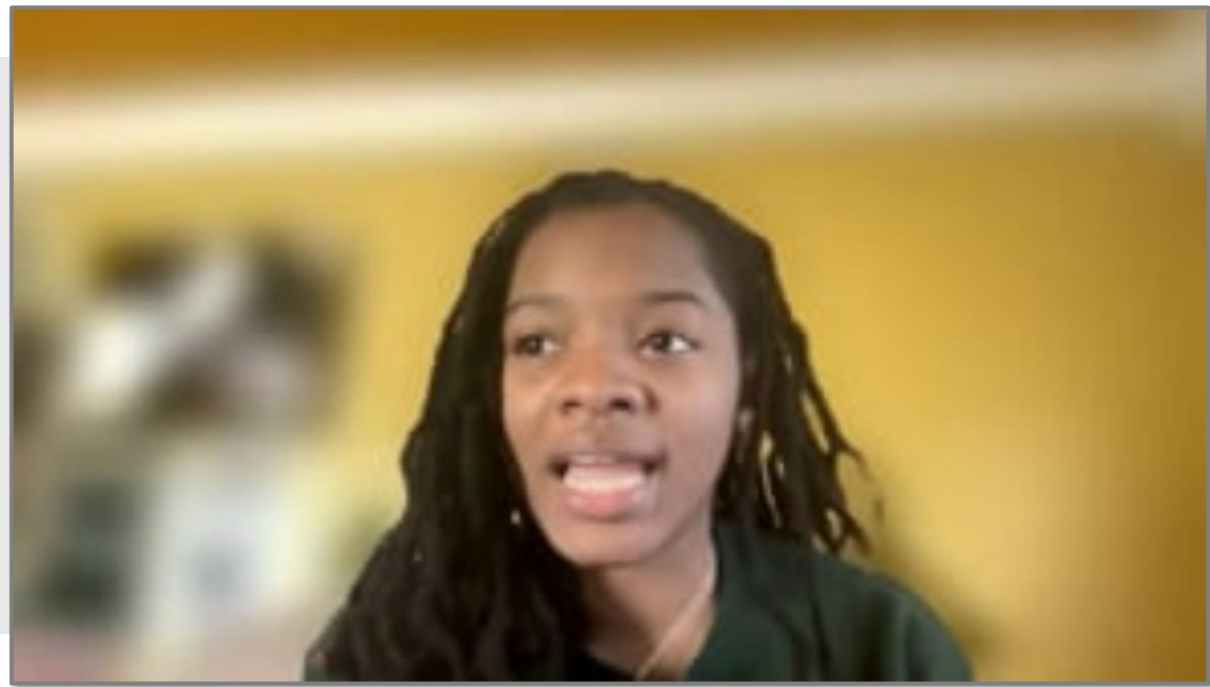
*Video Clip: Introduction and Symptom Onset*





# KAYLAA' WHITE

*Video Clip: Acute Symptom Flare*





# Case Perspective Summary

## Case 2



	Community/Rural	KOLs	AI
Continue current therapy and attempt another prednisone taper	—	—	—
Switch to another anti-TNF agent	—	—	—
Switch to an IL-23 inhibitor	2	3	—
Switch to upadacitinib	—	—	—
Switch to vedolizumab	5	—	1
Begin thiopurine monotherapy and reassess in 3–6 months	—	—	—

# Pearls Learned from Kaylaa's Case

➤ UC, steroid dependence, TNF intolerance, pregnancy planning, safety-first strategy



## Steroid dependence defines disease severity and mandates durable maintenance therapy

Repeated prednisone tapers indicate uncontrolled UC and should trigger transition to effective, steroid-sparing advanced therapy

**ACG** reinforces that **recurrent or steroid-dependent UC should not be managed with repeated tapers**



## Treatment intolerance is as meaningful as treatment failure

Prior infusion reactions and systemic intolerance appropriately steer clinicians away from class cycling—even when efficacy data exist



## Therapy selection must balance efficacy with long-term safety confidence

In patients planning pregnancy, choosing a therapy with established safety and real-world familiarity supports timely disease control and sustained adherence



## AUDIENCE POLLING REVISITED

### NOW what would you do next?

- A. Continue current therapy and attempt another prednisone taper
- B. Switch to another anti-TNF agent
- C. Switch to an IL-23 inhibitor
- D. Switch to upadacitinib
- E. Switch to vedolizumab
- F. Begin thiopurine monotherapy and reassess in 3–6 months





# PATIENT VOICE

*Brandon*

- 28-year-old male with recently diagnosed ileocecal Crohn's disease
- Persistent symptoms x 3 months
  - 4–5 loose stools per day with urgency
  - Lower abdominal discomfort and fatigue
  - Symptoms interfere with gym routine and social activities
- Unintentional 7-lb weight loss over several weeks
- Completed a 2-month course of budesonide with ongoing active symptoms
- Concerned about prolonged steroid exposure
  - Seeking durable disease control rather than repeated steroid courses
- Biologic- and small molecule-naïve





# PATIENT VOICE

*Brandon*

## Endoscopy

- Ileocolonoscopy shows inflammation involving the distal 15 cm of the ileum and the cecum
- SES-CD score: 12
- No strictures, stenosis, or perianal involvement

	Result	Reference Range
CRP	14 mg/L	<10 mg/L: normal/low, common in healthy adults
Fecal calprotectin	<ul style="list-style-type: none"><li>• 1,050 <math>\mu\text{g/g}</math> prior to budesonide</li><li>• 1,100 <math>\mu\text{g/g}</math> after 2 months of budesonide</li></ul>	<50 $\mu\text{g/g}$ : normal (low inflammation)
Hemoglobin	11.2 g/dL	13.5 g/dL to 17.5 g/dL: normal range for women
Albumin	3.5 g/dL	3.5 g/dL to 5 g/dL: normal







## AUDIENCE POLLING

### What would you do next?

- A. Initiate vedolizumab
- B. Initiate an IL-23 inhibitor
- C. Initiate upadacitinib
- D. Initiate an anti-TNF agent
- E. Initiate 5-ASA therapy
- F. Initiate thiopurine monotherapy and reassess in 3–6 months





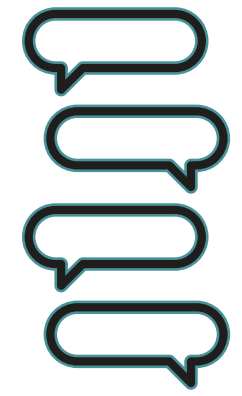
# EXPERT FACULTY

*Live Discussion*



## Decision Point

*Patient Case: Brandon*





# COMMUNITY GASTROENTEROLOGIST

*Audio Recording: Case 3*



## **B** Initiate an IL-23 inhibitor

- **Advanced therapy warranted:** failure of conventional therapy with at least moderately severe Crohn's disease
- **IL-23 inhibitor preferred:** high likelihood of clinical and deep remission; avoids further steroid use
- **Vedolizumab or mesalamine:** less effective for this disease severity
- **Upadacitinib:** reasonable option, but **reserved for second line** per guideline positioning



# COMMUNITY GASTROENTEROLOGIST, 9 YEARS

*Audio Recording: Case 3*



## D Initiate an anti-TNF agent

- **Moderate Crohn's disease** (SES-CD 12) with ileocecal involvement, weight loss, and budesonide failure
- **Biologic-naïve patient** → start with therapy with longest track record
- **Anti-TNF selected:** proven efficacy in moderate–severe and ileal Crohn's; rapid symptom control
- **Practical first biologic:** predictable insurance access, extensive real-world data, clear optimization pathways
- **Strategy:** start strong, avoid repeated steroid rescue and early cycling; pivot mechanisms if needed later

## Rule outs

- **Vedolizumab:** favorable safety, but slower and less reliable in ileal Crohn's with weight loss
- **IL-23 inhibitors:** strong data, but limited personal real-world experience; prefer to reserve early
- **Upadacitinib:** effective, but not first-line in biologic-naïve Crohn's due to safety and monitoring burden
- **5-ASA:** ineffective for moderate ileocecal Crohn's
- **Thiopurine monotherapy:** too slow and unreliable for active disease severity

# COMMUNITY GASTROENTEROLOGIST, 9 YEARS

*Audio Recording: Case 3*



## **B** Initiate an IL-23 inhibitor

- **Moderate CD** with ileocecal involvement, weight loss, and budesonide failure → escalation required
- **Biologic- and small molecule-naïve patient** → opportunity for early, effective disease control
- **IL-23 inhibitor selected:** high efficacy with strong mucosal healing potential
- **Durable, treat-to-target strategy:** early control to prevent progression
- **Subcutaneous maintenance dosing** supports adherence and active lifestyle
- **Avoids anti-TNF limitations** (immunogenicity, secondary loss of response)

## Rule outs

- **Anti-TNF:** reasonable option, but IL-23 favored for long-term durability and convenience
- **Vedolizumab:** strong safety, but less predictable efficacy in ileal Crohn's with weight loss
- **Upadacitinib:** effective, but typically reserved for later lines due to safety/monitoring considerations
- **5-ASA:** not appropriate for moderate ileocecal Crohn's
- **Thiopurine monotherapy:** too slow and unreliable; risks delaying disease control



# Additional Community Gastroenterologist Responses for Case 3



RESPONDENT 1

**B** Initiate an IL-23 inhibitor



RESPONDENT 2

**D** Initiate an anti-TNF agent



RESPONDENT 3

**D** Initiate an anti-TNF agent



RESPONDENT 4

**B** Initiate an IL-23 inhibitor



# KOL: MILLIE D. LONG, MD, MPH

*Video Recording: Case 3*

**D** Initiate an anti-TNF agent







# KOL: JESSICA R. ALLEGRETTI, MD, MPH, FACG, AGAF

*Video Recording: Case 3*

**B** Initiate an IL-23 inhibitor







# KOL: EDWARD V. LOFTUS, JR., MD

*Video Recording: Case 3*

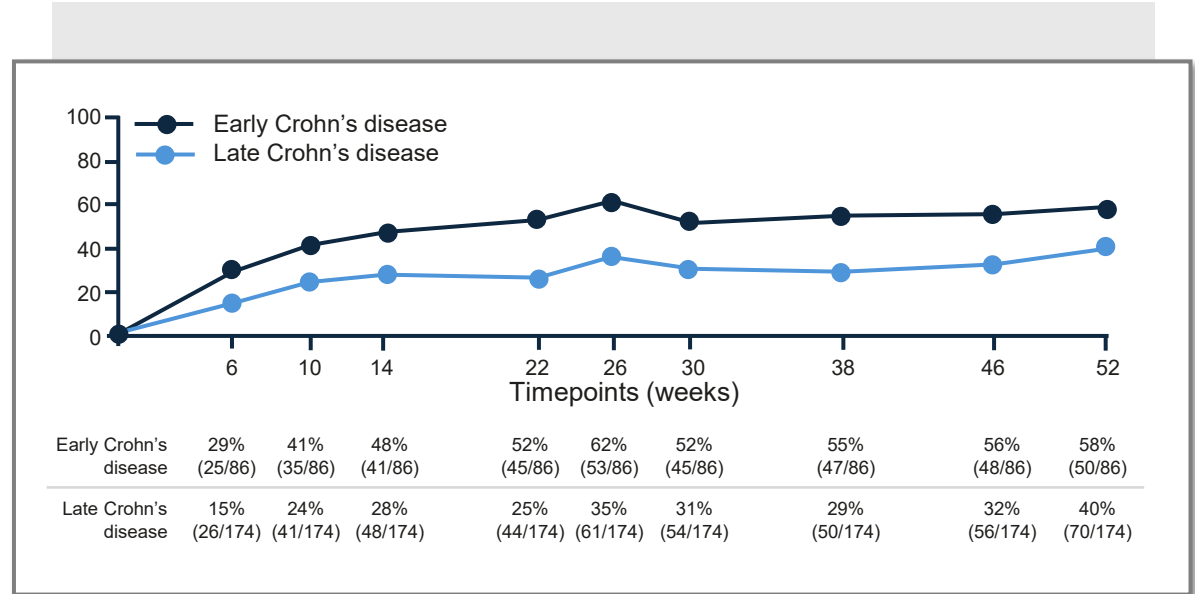
**B** Initiate an IL-23 inhibitor



# Vedolizumab in Early and Late CD

## LOVE-CD

- Vedolizumab shows greater safety and effectiveness in early-stage CD compared to late-stage disease
- It may be a favorable treatment option for patients who are biologic-naïve
- The benefits are most pronounced in individuals with a short disease duration





# AI: CHATGPT 5.2

## *User-Fed Responses: Case 3*



**New chat** → Here's the case subjective, objective, and plan/multiple choice question. Based on the information provided, which answer choice would you choose and what is your brief rationale for your chosen answer and unchosen options?



### **D** Initiate an anti-TNF agent



**Rationale:** This patient has newly diagnosed, moderate-to-severe ileocecal CD with persistent symptoms, weight loss, and a high inflammatory burden despite budesonide, indicating the need for advanced therapy. **Early initiation of an anti-TNF agent** offers the best chance for rapid symptom control, mucosal healing, and durable remission.



### Rule outs

- 5-ASA:** ineffective for Crohn's disease
- Thiopurine monotherapy:** slow onset; delays adequate control
- Vedolizumab:** effective but slower onset; less ideal with significant inflammation and weight loss
- IL-23 inhibitor:** reasonable option, but anti-TNF has strongest first-line evidence in biologic-naïve Crohn's
- Upadacitinib:** typically reserved for patients with prior biologic exposure



# Case Perspective Summary

## Case 3



	Community/Rural	KOLs	AI
Initiate vedolizumab	—	—	—
Initiate an IL-23 inhibitor	<b>4</b>	<b>2</b>	—
Initiate upadacitinib	—	—	—
Initiate an anti-TNF agent	<b>3</b>	<b>1</b>	<b>1</b>
Initiate 5-ASA therapy	—	—	—
Initiate thiopurine monotherapy and reassess in 3–6 months	—	—	—

# Pearls Learned from Brandon's Case

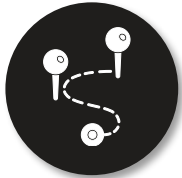
## ➤ Biologic-naïve CD, ileocecal involvement, early weight loss, treatment sequencing



### Early objective disease activity warrants early advanced therapy

Persistent symptoms, weight loss, and endoscopic inflammation in newly diagnosed Crohn's disease argue against "step-up" delay and favor timely initiation of an effective biologic

**ACG emphasizes moving beyond step-up inertia**, particularly in patients with moderate disease, QoL impairment, and objective inflammation



### First-line biologic choice shapes long-term disease trajectory

Selecting a therapy with strong efficacy and mucosal healing potential early may reduce future flares, steroid exposure, and treatment cycling



### Durability and feasibility matter in young, active patients

Therapies that offer subcutaneous dosing and low treatment friction can support adherence and sustained disease control in patients balancing work, fitness, and social life



## AUDIENCE POLLING Revisited NOW what would you do next?

- A. Initiate vedolizumab
- B. Initiate an IL-23 inhibitor
- C. Initiate upadacitinib
- D. Initiate an anti-TNF agent
- E. Initiate 5-ASA therapy
- F. Initiate thiopurine monotherapy and reassess in 3–6 months



# Mission Possible

## *Turning Complexity Into Clarity in IBD Care*

**IBD care is about choosing the *right therapy for the right patient at the right time.***



### **Uncontrolled disease demands action, not delay**

Steroid dependence, weight loss, and objective inflammation require timely escalation to effective maintenance therapy



### **Mechanism matters—and so does context**

Loss of response, intolerance, extraintestinal manifestations, and life stage (e.g., pregnancy) should guide mechanism selection, not habit



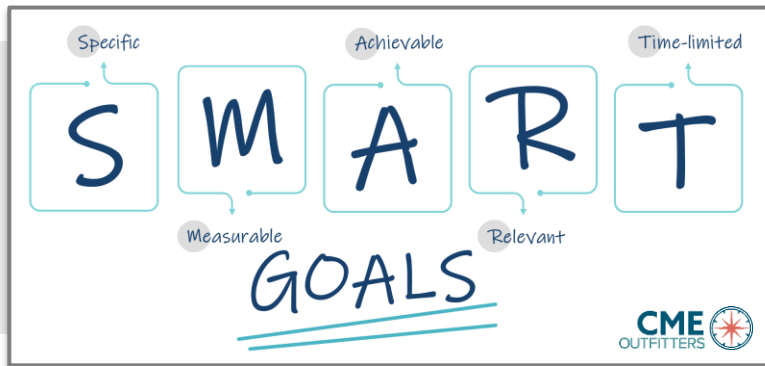
### **Efficacy alone is not enough**

Durability, safety confidence, route of administration, and real-world feasibility determine long-term success



### **The “right” therapy is patient-specific**

Optimal outcomes come from aligning evidence, guidelines, and what matters most to the patient



## Put information into action!

Takeaways from this program can be implemented into your practice to improve patient care.

- **Improve clinician confidence by  $\geq 20\%$**  in applying clinical trial evidence, FDA labeling, and guideline recommendations to individualized IBD treatment decisions
- **Increase documented shared decision-making by  $\geq 25\%$**  among patients with IBD, incorporating treatment goals, route of administration, quality-of-life considerations, and patient preferences at the time of therapy selection
- **Increase appropriate consideration of IL-23 inhibitor therapy by  $\geq 20\%$**  for patients with moderate-to-severe IBD who require escalation beyond corticosteroids or anti-TNF therapy
- **Increase steroid-free clinical remission by  $\geq 15\%$ – $20\%$**  by reducing reliance on repeated corticosteroid courses and transitioning eligible patients to evidence-based advanced therapies



# QUESTIONS & ANSWERS

Thank you for joining us.  
Don't forget to collect your credit.

# Additional Resources

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Visit [www.cmeoutfitters.com](http://www.cmeoutfitters.com)  
for clinical information and  
certified educational activities



# Visit the Gastroenterology Hub

Free resources and education to educate  
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## In-Person



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## Livestream



# Claim ABIM MOC Credit

## 3 Steps to Complete

1. Actively participate in the discussion today by **responding to questions** and/or **asking the faculty questions** (*MOC credit can be claimed even if a question goes unanswered or an incorrect response is entered*)
2. Complete the post-test and evaluation at the conclusion of the webcast
3. Enter your **ABIM ID number** and **DOB** (MM/DD) on the evaluation, so credit can be submitted to ABIM



# CME for MIPS Improvement Activity

## How to Claim This Activity as a CME for MIPS Improvement Activity

- Actively participate today by responding to ARS questions and/or asking the faculty questions
- Complete the post-test and activity evaluation at the link provided
- Over the next 3 months, actively work to incorporate improvements from this presentation into your clinical practice
- In approximately 3 months, complete the follow-up survey from CME Outfitters



CMEO will send you confirmation of your participation to submit to CMS attesting to your completion of a CME for MIPS Improvement Activity.



*A CASEWISE™ INITIATIVE*

# *MISSION: ~~IMPOSSIBLE~~*

*MATCHING TREATMENT GOALS  
OF PATIENTS AND PROVIDERS  
IN IBD IN CLINICAL PRACTICE*

*Supported by an educational grant from Johnson & Johnson.*