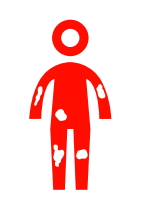



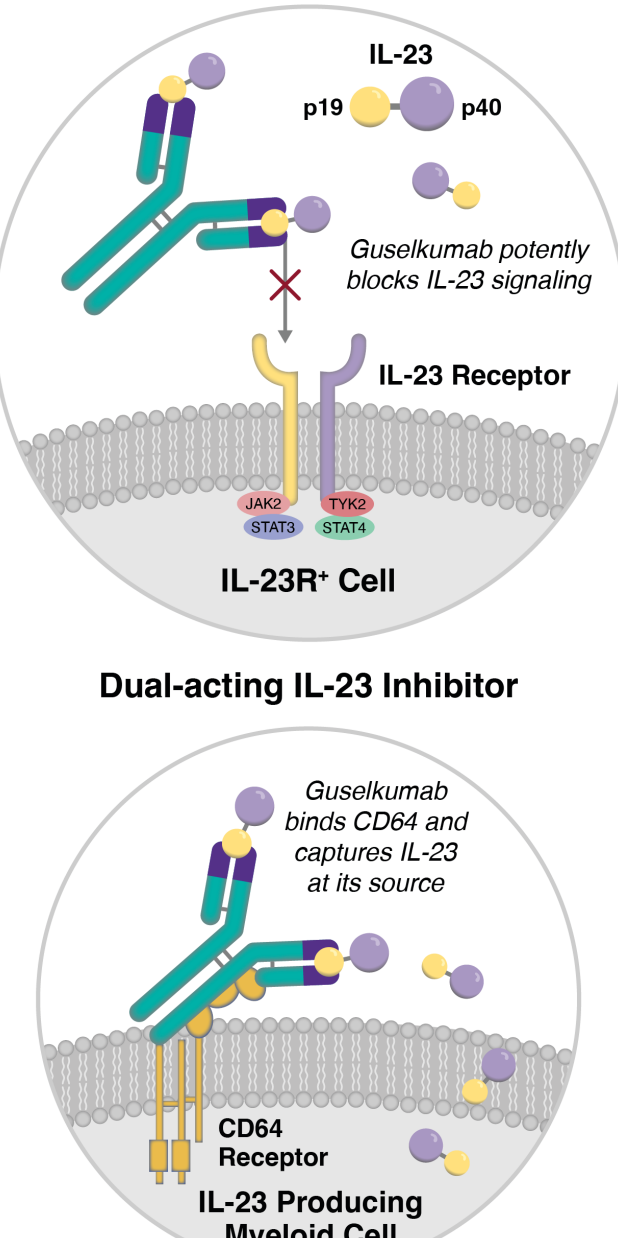
Inhibition of Structural Damage Progression with Guselkumab, a Selective IL-23i, in Participants with Active PsA: Results Through Week 24 of the Phase 3b, Randomized, Double-Blind, Placebo-Controlled APEX Study

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Background

-  Psoriatic arthritis (PsA), a chronic, heterogeneous, inflammatory disease affecting joints and skin, can substantially impact health-related quality of life^{1,2}
- Structural damage resulting from chronic inflammation leads to poorer outcomes³
-  Guselkumab (GUS) is a fully human, dual-acting, monoclonal antibody that selectively inhibits the interleukin (IL)-23p19 subunit⁴
- Indicated to treat moderate-to-severe plaque psoriasis (PsO), active PsA, and moderately-to-severely active Crohn's disease and ulcerative colitis⁵

In DISCOVER-2, biologic-naïve participants (pts) with active PsA receiving GUS every 4 weeks (Q4W) exhibited significantly less radiographic progression vs placebo (PBO); the lower rate of radiographic progression seen with GUS every 8 weeks (Q8W) vs PBO did not reach statistical significance⁶



Objectives

-  Report findings through W24 of the ongoing Phase 3b, randomized, double-blind, placebo-controlled APEX study (NCT04882098), intended to further evaluate GUS effects on clinical and radiographic progression outcomes in pts with active PsA

Results

Characteristics of APEX pts with active and erosive PsA were comparable across groups

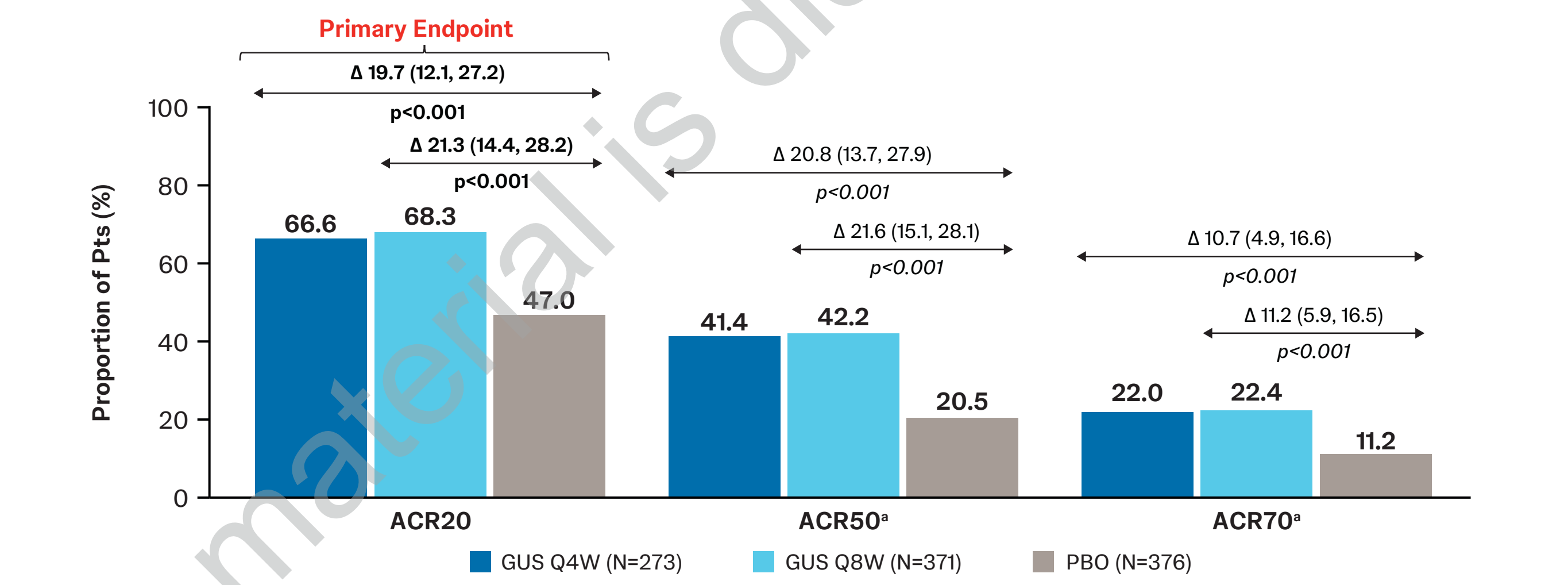
- Background PsA medication use and treatment completion through W24 (96–97%) were consistent across treatment groups

	GUS Q4W (N=273)	GUS Q8W (N=371)	PBO (N=376)	Total (N=1020)
Baseline Demographics				
Age, years	52.2 (13.2)	53.2 (12.9)	53.5 (13.0)	53.0 (13.0)
Male	55%	54%	57%	55%
Weight, kg	85.6 (20.1)	83.2 (17.4)	83.1 (18.2)	83.8 (18.5)
BMI, kg/m ²	29.4 (6.0)	29.0 (5.6)	28.9 (5.7)	29.1 (5.7)
PsA Characteristics				
PsA disease duration, years	7.5 (7.1)	7.2 (7.6)	7.2 (6.9)	7.3 (7.2)
SJC [0–66] ^a	9.0 (6.0; 14.0)	10.0 (6.0; 14.0)	9.0 (6.0; 15.0)	9.0 (6.0; 14.0)
TJC [0–68] ^a	16.0 (10.0; 27.0)	17.0 (11.0; 26.0)	16.6 (10.0; 25.5)	16.1 (10.0; 26.0)
HAQ-DI [0–3]	1.2 (0.7)	1.2 (0.6)	1.2 (0.7)	1.2 (0.7)
CRP, mg/dL ^a	0.7 (0.4; 1.5)	0.8 (0.4; 1.6)	0.8 (0.4; 1.8)	0.8 (0.4; 1.6)
Enthesitis / Dactylitis	58% / 44%	59% / 39%	59% / 45%	58% / 43%
Mean LEI [1–6] / DSS [1–60]	3.2 / 10.8	3.0 / 11.0	3.0 / 10.2	3.1 / 10.6
PsO Characteristics				
% BSA	15.0 (19.2)	16.5 (21.9)	16.3 (21.5)	16.0 (21.0)
PASI [0–72]	7.6 (8.3)	8.3 (10.1)	8.2 (9.5)	8.1 (9.4)
Radiographic Characteristics				
PsA-modified vdH-S score [0–528]	27.7 (47.6)	26.7 (43.4)	26.8 (42.2)	27.0 (44.1)
Erosion score [0–320]	13.7 (24.3)	13.4 (21.9)	13.4 (20.7)	13.5 (22.1)
JSN score [0–208]	14.0 (24.2)	13.3 (22.8)	13.4 (22.4)	13.5 (23.0)

Values are reported as mean (SD) for pts with nonmissing data unless otherwise noted. ^aValues are median (IQR). **BMI**=body mass index; **BSA**=body surface area; **CRP**=C-reactive protein; **DSS**=Dactylitis Severity Score; **GUS**=guselkumab; **HAQ-DI**=Health Assessment Questionnaire-Disability Index; **IQR**=interquartile range; **JSN**=joint space narrowing; **LEI**=Leeds Enthesitis Index; **PASI**=Psoriasis Area and Severity Index; **PBO**=placebo; **PsA**=psoriatic arthritis; **PsO**=psoriasis; **Q4W**=every 4 weeks; **Q8W**=every 8 weeks; **SD**=standard deviation; **SJC**=swollen joint count; **TJC**=tender joint count; **vdH-S**=van der Heijde-Sharp; **W**=week.

GUS demonstrated significantly higher ACR20 response rates vs PBO at W24

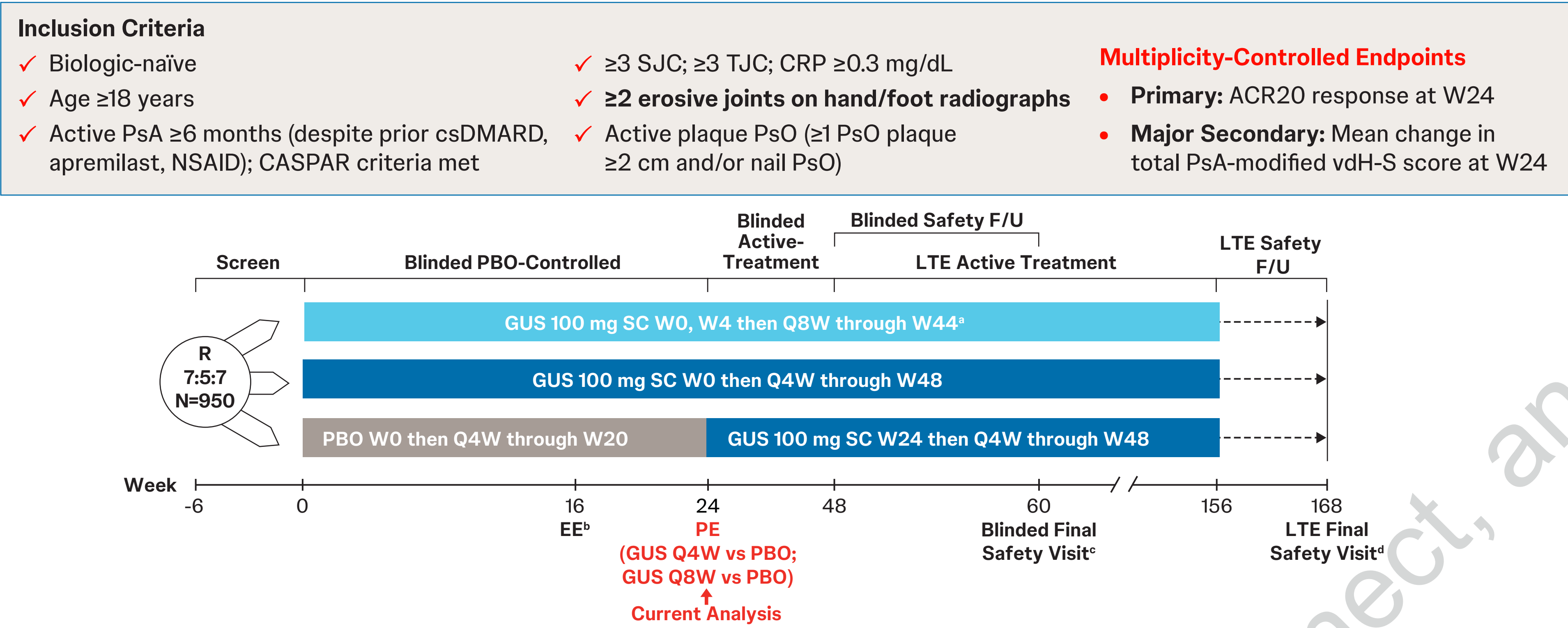
- GUS demonstrated higher rates of ACR50 and ACR70 vs PBO at W24



Primary endpoint analyses are multiplicity controlled using a fixed sequence testing procedure and can be used to determine statistical significance. Statistics are based on Cochran-Mantel-Haenszel across multiply imputed datasets. ^aItalicized p-values are nominal. **Δ**=treatment difference (95% CI). **ACR**=American College of Rheumatology; **CI**=confidence interval; **GUS**=guselkumab; **PBO**=placebo; **Pts**=participants; **Q4W**=every 4 weeks; **Q8W**=every 8 weeks.

PRESENTED AT: Las Vegas Dermatology (LV Derm) Seminar 2025, Las Vegas, NV, USA; September 11–13, 2025. **REFERENCES:** 1. Gladman DD, et al. *C J Med*. 1997;62:127–41. 2. Ritchlin CT. *J Rheumatol*. 2008;35:1434–7. 3. van der Heijde D, et al. *Arthritis Rhe*. 2009;51:126–38. **ACKNOWLEDGMENTS:** Medical writing support was provided by Mona Patel, PharmD, under the direction of the authors in accordance with Good Publication Practice guidelines and editorial review by the authors. **DISCLOSURES:** P.J.M. received grants from AbbVie, Amgen, Bristol Myers Squibb, Eli Lilly, Johnson & Johnson, Novartis, Pfizer, and UCB; consulting fees from AbbVie, Amgen, Bristol Myers Squibb, Eli Lilly, Johnson & Johnson, Novartis, Pfizer, and UCB; and has been paid as a speaker for AbbVie, Amgen, Bristol Myers Squibb, Eli Lilly, Johnson & Johnson, Novartis, Pfizer, and UCB. C.T.R. received grants/research support from AbbVie, Amgen, Bristol Myers Squibb, Eli Lilly, Johnson & Johnson, Novartis, Pfizer, and UCB; consulting fees from AbbVie, Amgen, Bristol Myers Squibb, Eli Lilly, Johnson & Johnson, Novartis, Pfizer, and UCB; and has been paid as a speaker for AbbVie, Amgen, Bristol Myers Squibb, Eli Lilly, Johnson & Johnson, Novartis, Pfizer, and UCB. A.P.K. is an employee of Johnson & Johnson; may own stock/stock options in Johnson & Johnson. S.D.C. is an employee of Johnson & Johnson; may own stock/stock options in Johnson & Johnson. R.R. received consulting fees from AbbVie, Amgen, Bristol Myers Squibb, Eli Lilly, Johnson & Johnson, Novartis, Pfizer, and UCB; meeting attendance/travel support from Johnson & Johnson; and research grants from Johnson & Johnson, and Novartis. D.v.d.H. received consulting fees from AbbVie, Amgen, Bristol Myers Squibb, Eli Lilly, Johnson & Johnson, Novartis, Pfizer, Takeda, and UCB; serves as the Associate Editor of *Annals of Rheumatic Diseases*; on the editorial board of *Journal of Rheumatology*; and as the director of Imaging Rheumatology BV. Previously presented at European Alliance of Associations for Rheumatology (EULAR) 2025, Barcelona, Spain, June 11–14, 2025.

APEX Study Design

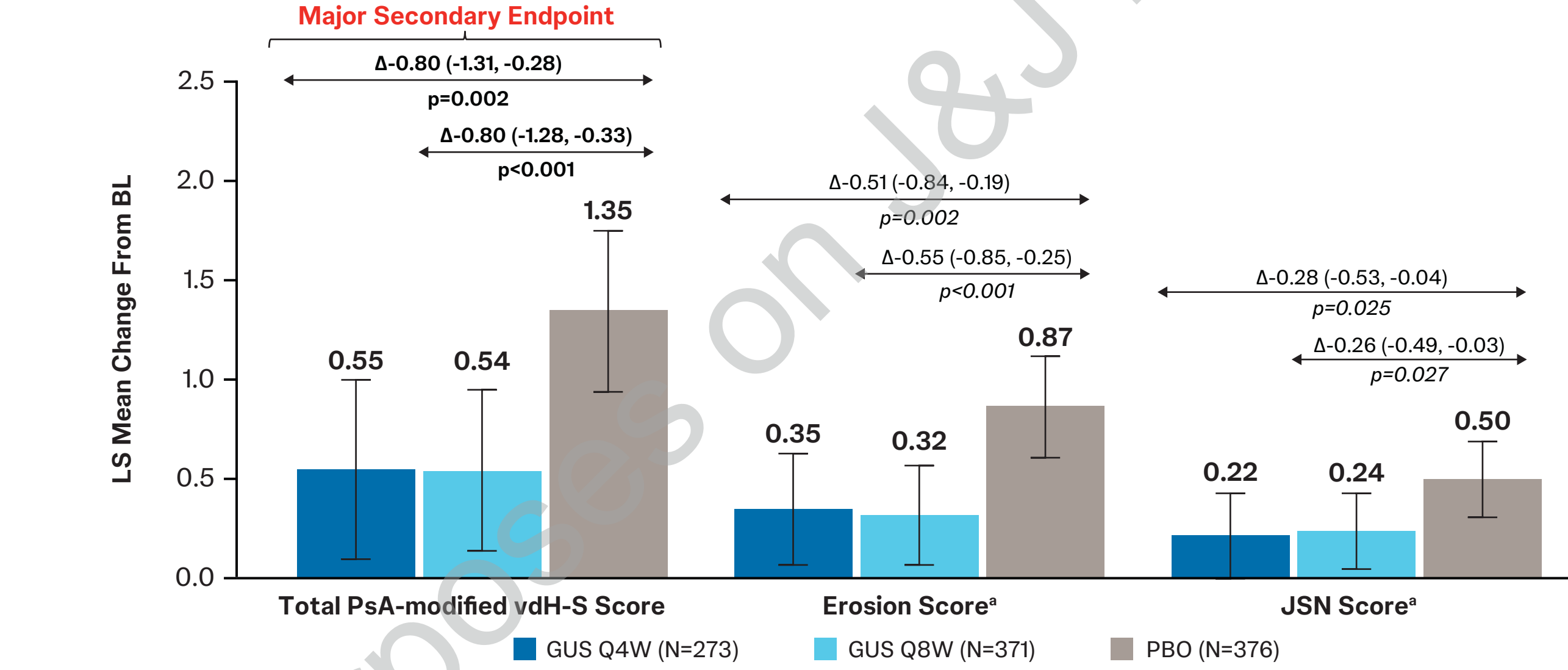


- Modified full analysis set (mFAS):** All randomized pts excluding those from Ukraine sites rendered unable to support key study operations due to major disruptions; employed as the main efficacy analysis set (N=1020)
- Safety analysis set:** All pts who received ≥1 administration of any study intervention (N=1054)

^aPBO SC W0 then Q8W through W48 administered to maintain blinding. ^bEE if <20% improvement from BL in both TJC and SJC at W16. EE pts may initiate/increase dose permitted medication up to the maximum dose, at the investigator's discretion. ^cFinal safety visit for those who do not enter LTE. ^dFinal safety visit for those who entered LTE. **ACR**=American College of Rheumatology; **BL**=baseline; **CASPAR**=CASPAS (Clinical Assessment of Psoriatic Arthritis); **CRP**=C-reactive protein; **csDMARD**=conventional synthetic disease-modifying antirheumatic drug; **EE**=early escape; **F/U**=follow-up; **GUS**=guselkumab; **LTE**=long-term extension; **NSAID**=nonsteroidal anti-inflammatory drug; **PBO**=placebo; **PE**=primary endpoint; **PsA**=psoriatic arthritis; **PsO**=psoriasis; **Q4W**=every 4 weeks; **Q8W**=every 8 weeks; **R**=randomization; **SC**=subcutaneous; **SJC**=swollen joint count; **TJC**=tender joint count; **vdH-S**=van der Heijde-Sharp; **W**=week.

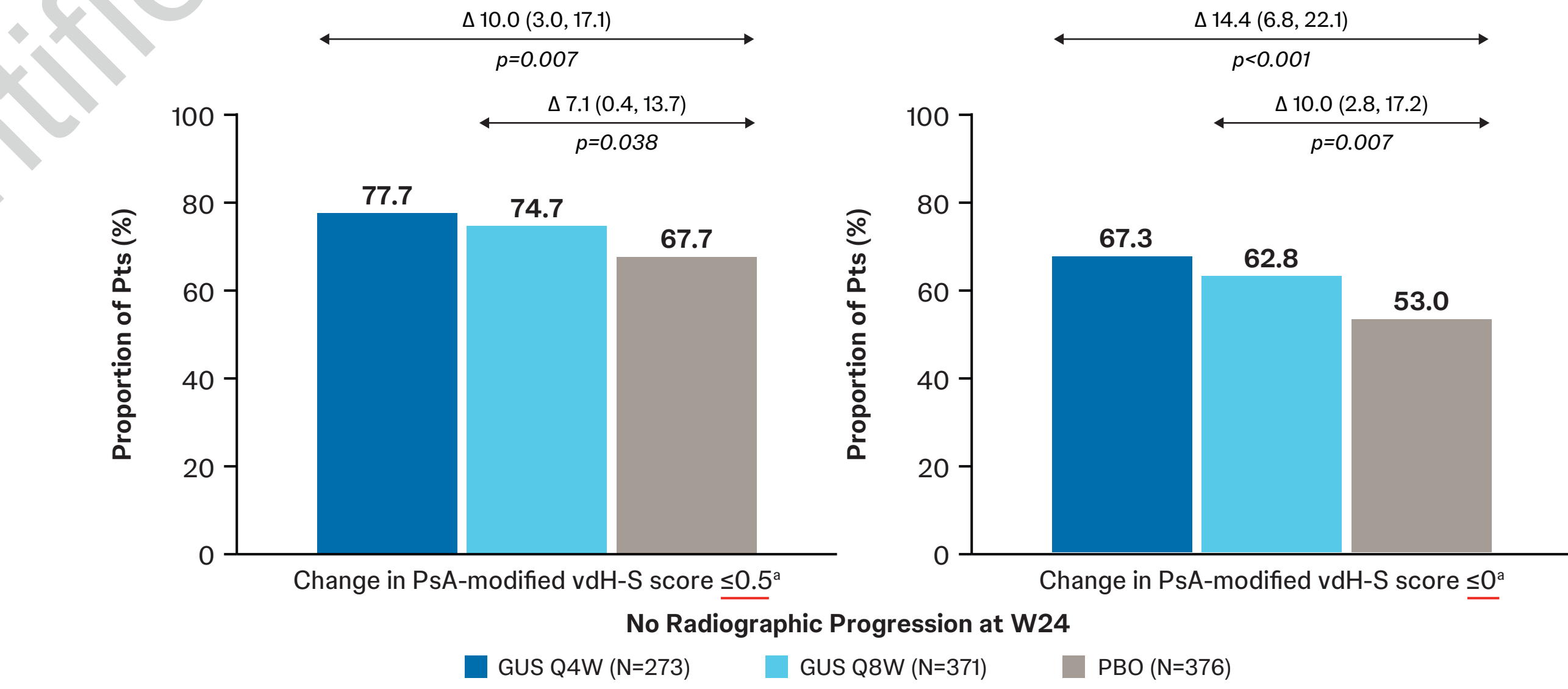
GUS exhibited significantly lower rates of radiographic progression vs PBO at W24

- GUS exhibited consistent treatment effects for both erosion and joint space narrowing (JSN) scores



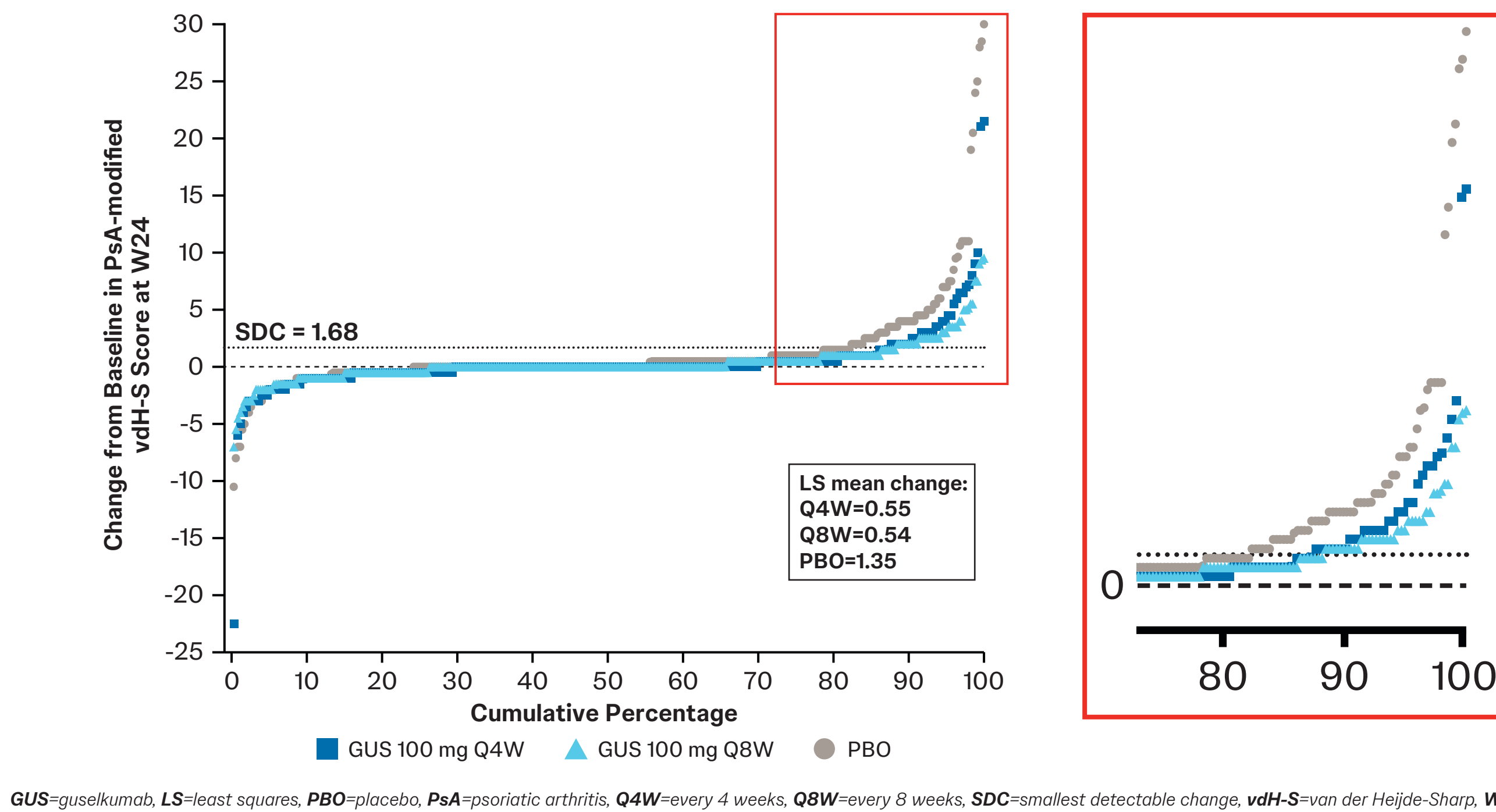
Major secondary endpoint (PsA-modified vdH-S score) p-values are multiplicity controlled using a fixed sequence testing procedure and can be used to determine statistical significance. Statistics are based on analysis of covariance across multiply imputed datasets. ^aItalicized p-values are nominal. **Δ**=treatment difference (95% CI). **BL**=baseline; **CI**=confidence interval; **GUS**=guselkumab; **JSN**=joint space narrowing; **LS**=least squares; **PsA**=psoriatic arthritis; **PBO**=placebo; **Q4W**=every 4 weeks; **Q8W**=every 8 weeks; **vdH-S**=van der Heijde-Sharp; **W**=week.

Higher proportions of GUS- vs PBO-treated pts showed no radiographic progression



^aItalicized p-values are nominal. **Δ**=treatment difference (95% CI). **CI**=confidence interval; **GUS**=guselkumab; **PsA**=psoriatic arthritis; **Pts**=participants; **Q4W**=every 4 weeks; **Q8W**=every 8 weeks; **vdH-S**=van der Heijde-Sharp; **W**=week.

Pt-level data also showed clear separation between GUS and PBO

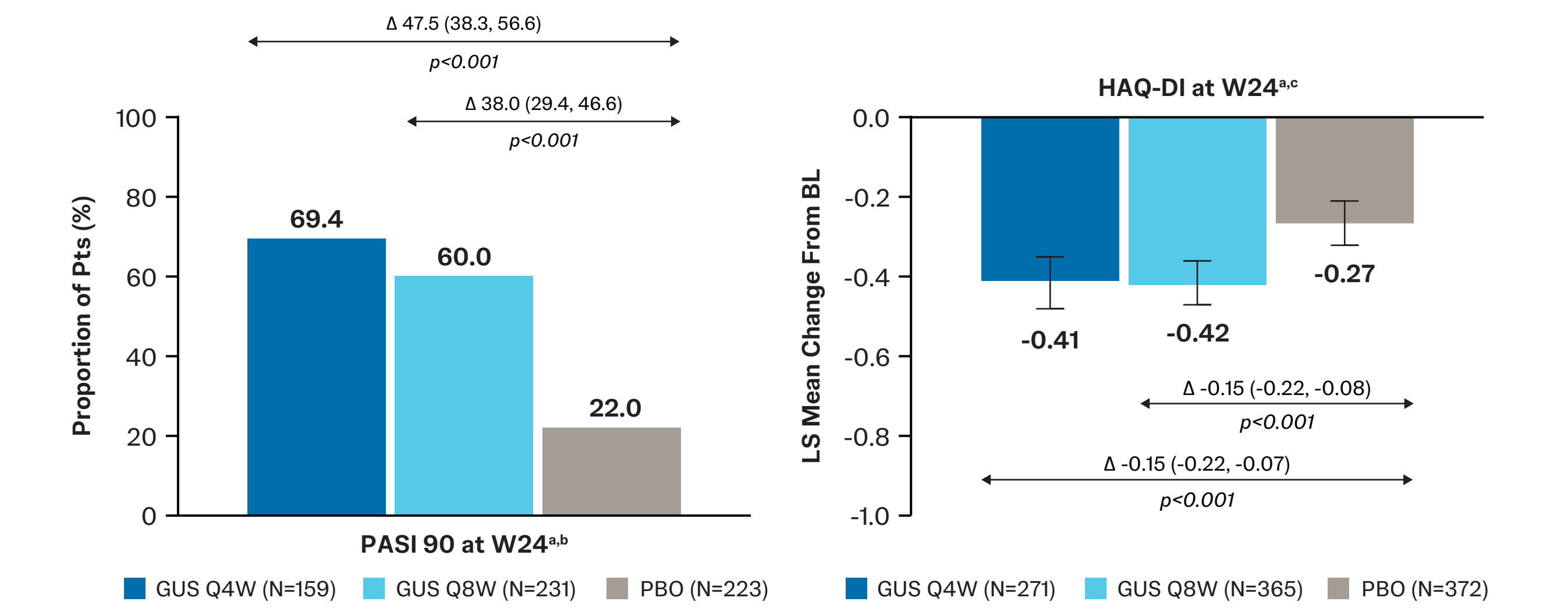


GUS=guselkumab; **LS**=least squares; **PBO**=placebo; **PsA**=psoriatic arthritis; **Q4W**=every 4 weeks; **Q8W**=every 8 weeks; **SDC**=smallest detectable change; **vdH-S**=van der Heijde-Sharp; **W**=week.

Key Takeaways

- At W24 of the ongoing Phase 3b APEX study of GUS, a dual-acting selective IL-23i for PsA, the Q4W & Q8W regimens demonstrated:
 - Significantly higher ACR20 response rates vs PBO
 - Significantly lower rates of radiographic progression (Δ GUS vs PBO = -0.80)
 - Consistent effects on erosion & JSN scores
 - Higher proportion of pts with no progression of structural damage vs PBO
 - Higher rates of ACR50, ACR70, PASI 90 & greater improvement in physical function vs PBO; Similar AE profile for GUS and PBO; No new GUS safety signal
- GUS is the only selective IL-23i to demonstrate significant inhibition of structural damage progression

Higher skin clearance rates and greater improvement in physical function with GUS vs PBO



^aItalicized p-values are nominal. ^bAmong pts who had ≥3% BSA psoriatic involvement and an IGA score of ≥2 (mild) at BL. **PASI** 90 response: ≥90% improvement from baseline in PASI score. ^cHAQ-DI score is the average of the computed categories scores (dressing, arising, eating, walking, hygiene, gripping and daily living). Lower scores indicate better functioning. **Δ**=treatment difference (95% CI). **BL**=baseline; **BSA**=body surface area; **CI**=confidence interval; **GUS**=guselkumab; **HAQ-DI**=Health Assessment Questionnaire-Disability Index; **IGA**=Investigator's Global Assessment; **LS**=least squares; **PASI**=Psoriasis Area and Severity Index; **PBO**=placebo; **Pts**=participants; **Q4W**=every 4 weeks; **Q8W**=every 8 weeks; **W**=week.

GUS AE profile through W24 was similar to PBO

Safety Through W24	GUS Q4W (N=280)	GUS Q8W (N=388)	PBO (N=386)
Mean weeks of follow-up	24.0	23.9	23.8
Pts with ≥1:			
AE	107 (38.2%)	165 (42.5%)	144 (37.3%)
SAE	5 (1.8%)	12 (3.1%)	10 (2.6%)
AE leading to study agent d/c	2 (0.7%)	6 (1.5%)	1 (0.3%)
Infection	52 (18.6%)	91 (23.5%)	81 (21.0%)
Serious infection	2 (0.7%)	5 (1.3%)	1 (0.3%)
Active tuberculosis	0	0	0
Opportunistic infection	0	0	0
Venous thromboembolism event	1 (0.4%)	1 (0.3%)	1 (0.3%)
Anaphylactic or serum sickness reaction	0	0	0
Clinically important hepatic disorder ^a	0	0	0

Safety analysis set. AEs are coded using MedDRA Version 27.0. Data are n (%) unless otherwise noted. ^aClinically important hepatic disorders were prespecified as AE terms within the MedDRA category of Drug-Related Hepatic Disorders that met the criteria for an SAE or led to study agent d/c. **AE**=adverse event; **d/c**=discontinuation; **GUS**=guselkumab; **MedDRA**=Medical Dictionary for Regulatory Activities; **PBO**=placebo; **Pts**=participants; **Q4W**=every 4 weeks; **Q8W**=every 8 weeks; **SAE**=serious adverse event; **W**=week.

- Study remains blinded through W48
- 2 pts with malignancy (prostate, renal); 1 major adverse cardiac event (myocardial infarction); 1 COVID-19 death in unvaccinated elderly pt
- No new-onset inflammatory bowel disease