The Biologic Reckoning

The global consensus health plans can't ignore. 62 dermatologists. Every continent. One conclusion: patients with controlled psoriasis are staying on high-cost biologics longer than they need to.

01 The Problem

Dermatology spend is growing- with no clinical off-ramp.

>45%

Dermatology drug spend growth YoY[1]

5 of 10

Drugs with fastest spend growth treat psoriasis & eczema

>$24B

Annual spend growth among top 5 derm drugs[2]

Biologics have transformed psoriasis, atopic dermatitis, & eczema care.

But with the current system, members stay on high-cost drugs indefinitely, because there has been **no clinical mechanism to reassess**.

1. Navitus. (2025). 2024 drug trend report snapshot. https://navitus.com/drug-trend-reports/2024-snapshot/
2. IQVIA. (2026, April). Healthcare & pharmaceutical marketplace trends [Conference presentation]. AMCP Annual Meeting, Nashville, TN, United States.

The Science is In. The Off-Ramp is Here.

International scientific consensus: biologic dose reduction for psoriasis is appropriate, safe, and **overdue**

Funded by the European Academy of Dermatology and Venereology

DR Delphi Study – JEADV, 2026*

Dose reduction is appropriate

when disease is controlled for ≥6 months on the same biologic

A clear two-step algorithm was established

for adalimumab, etanercept, and ustekinumab – and deemed applicable to IL-17 and IL-23 inhibitors

Safety is maintained if disease returns

patients return to effective dose – no permanent step-down required

"Biologics are expensive drugs often prescribed in a fixed, registered dose and patients with a good response might be overtreated."

Dose reduction of biologics might reduce avoidable overtreatment, reduce costs and possibly avoid adverse events.

van Riel et al., Journal of the European Academy of Dermatology and Venereology, 2026

The autoantibody objection is resolved.

Anti-drug antibody (ADA) development was not clinically relevant for adalimumab, etanercept, or ustekinumab at reduced doses – removing a key network resistance argument.

*van Riel, C. A. M., Boehncke, W.-H., Lambert, J. L. W., Spuls, P. I., van der Schoot, L. S., van Ee, I., de Jong, E. M. G. J., & van den Reek, J. M. P. A. (2026). International consensus on dose reduction of biologics for patients with psoriasis: The DR. Delphi study. Journal of the European Academy of Dermatology and Venereology, 00, 1–11. https://doi.org/10.1111/jdv.70447

The protocol is here. Operationalizing it at scale isn't.

Anyone can read the DR. Delphi algorithm today. Running it—with the clinical oversight, member engagement, and monitoring cadence the consensus requires—is a different matter entirely. The protocol assumes continuous disease tracking, regular PASI and DLQI assessments, and the ability to act on those signals before costs compound. Fee-for-service dermatology sees patients once or twice a year. That's not a gap that a workflow tweak closes.

Frequent clinical touchpoints

The consensus algorithm requires 3–6 month monitoring cadence and immediate response when disease returns. That's not compatible with a quarterly office visit.

Clinical accountability at scale

Someone has to act on the data in a continuous cycle beyond disparate appointments: adjust dosing, manage transitions, document the rationale. That requires dedicated clinical capacity, not a referral.

Sustained member engagement

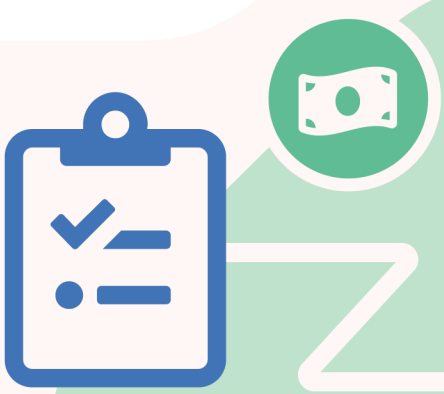
PASI and DLQI must be collected at every touchpoint, consistently, over time. Sporadic data cannot identify, or sustain, remission.

Whole-patient clinical picture

Dose reduction decisions account for lifestyle factors and comorbidities, not PASI scores alone. Addressing what's driving disease activity gives patients the best chance at sustained remission, not just a lower dose.

Transforming protocol to value.

Knowing the protocol and being able to execute it at scale and in a clinically sound way are not the same thing.



One Model Already Does It. At Scale. For Health Plans.

Zest is the only value-based dermatology program purpose-built to execute the DR. Delphi protocol. Zest practices dose reduction not as a pilot, not as a future roadmap, but in active health plan partnerships today. The model was designed from the ground up for exactly what the consensus algorithm demands: continuous monitoring, high member enrollment, frequent clinical touchpoints, and the clinical capacity to act when remission signals appear.

Targeted member outreach

Proactive outreach and no-cost access drives the member participation rates that make program economics meaningful

Clinical engagement

Regular PASI and DLQI completion creates the longitudinal data needed to continuously monitor remission to initiate dose reduction (DR)

Clinical follow-through

High-frequency virtual touchpoints and 24/7 access mean monitoring signals become clinical decisions – not data points

Real-World Outcomes

>50%
of enrollees deprescribed

$17K+
PEPY savings net of rebates

94%
improved or stable disease

>3:1
return on investment
Health Plan Case Study

Ready to deploy in 6 weeks. Minimal lift for the health plan. Proven playbooks from day one. Visit our website.