Clinical, Cosmetic and Investigational Dermatology

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EXPERT OPINION

Optimizing Abrocitinib Use for Atopic Dermatitis in India: Expert Recommendations for Patient Selection, Dosing, and Long-Term Remission

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Abstract: Atopic dermatitis (AD) is a chronic, relapsing inflammatory skin disorder which significantly impairs quality of life due to persistent pruritus, sleep disturbance, and recurrent flares. Conventional systemic therapies, such as cyclosporine and methotrexate, often provide inadequate itch and disease control, with limited safety and poor long-term tolerability. The introduction of targeted small-molecule therapies, particularly Janus kinase (JAK) inhibitors, has substantially transformed AD management by enabling rapid itch relief and sustained clinical improvements. Abrocitinib, an oral selective JAK1 inhibitor, has demonstrated rapid and clinically meaningful reduction in pruritus, improvement in skin lesions, and a favorable benefit–risk profile in pivotal clinical trials. However, guidance regarding its optimal real-world use in Indian patients remains limited. This expert recommendation aims to provide practical, experience-based recommendations for the initiation, dosing, monitoring, and long-term management of abrocitinib in patients with moderate-to-severe AD in India. A multistep approach was employed, including a targeted literature review conducted between September and November 2025, a nationwide survey of 36 experienced dermatologists, and two virtual expert panel meetings involving 10 senior clinicians. Experts have identified abrocitinib as a valuable systemic option, particularly for patients with pruritus-dominant disease, head and neck involvement, hand eczema, elderly patients with comorbidities, and those inadequately controlled with biologics or other systemic agents. Baseline assessment of hematologic, hepatic, renal, lipid, infectious, cardiovascular, and thrombotic risks was emphasized, with follow-up monitoring recommended at four weeks and following dose modifications. An induction dose of 200 mg once daily was preferred for most patients, with 100 mg reserved for the selected populations. Strategies for maintenance, dose tapering, and treatment transitions were also discussed. Overall, these expert recommendations provide practical real-world guidance supporting the individualized, safe, and effective use of abrocitinib in the Indian clinical setting, while emphasizing the importance of structured monitoring and long-term treatment planning.

Keywords: atopic dermatitis, abrocitinib, Janus kinase inhibitors, itching management, strategy, real-world, India

Introduction

Atopic dermatitis (AD) is a common chronic inflammatory skin disorder that significantly affects patients' quality of life (QOL) due to frequent flare-ups.[1] The clinical presentation of AD is diverse, often marked by recurrent eczema and severe itching, which disrupts daily activities and sleep.[2] Currently, topical and systemic treatments (like

https://doi.org/10.2147/CCID.S611587
Received: 21 April 2026
Accepted: 13 June 2026
Published: 24 June 2026

cyclosporine and methotrexate) are effectively helping many patients with AD, but these mainstay therapies pose limitations for long-term use, quick and effective itch relief in AD patient.[3] This led to introduction of newer treatment options like biologics and small molecules for a tailored approach in the management of AD.[4] Recent advances in the management of JAK inhibitors have also emphasized the importance of individualized treatment strategies, safety monitoring, and long-term therapeutic optimization in inflammatory skin diseases.[5]

Dupilumab was the first newer systemic therapy to receive approval for the management of moderate-to-severe AD. However, despite their introduction, unmet needs remain. In Phase 3 trials, more than 60% of patients did not achieve predefined efficacy endpoints, and real-world studies have highlighted that approximately 30% of patients failed to achieve adequate disease control after one year of treatment. These limitations underscore the need to expand the treatment arsenal with effective alternatives.[6]

To address this gap, Janus kinase (JAK) inhibitors, which target the JAK-signal transducer and activator of the transcription (STAT) pathway, have demonstrated efficacy in treating AD. JAK inhibitors approved by the U.S. Food and Drug Administration (FDA) for AD include oral agents, such as upadacitinib, baricitinib, and abrocitinib, and a topical formulation, such as ruxolitinib. These therapies differ in their JAK-binding site selectivity, as abrocitinib and upadacitinib selectively inhibit JAK1, whereas baricitinib inhibits both JAK1 and JAK2.[7] Abrocitinib, the most selective JAK inhibitor for AD, has demonstrated significant efficacy in alleviating pruritus and skin inflammation compared with other therapeutic option.[8]

However, real-world experience regarding the use of abrocitinib remains limited, especially in terms of practical considerations prior to its initiation and strategies employed during the maintenance phase. Furthermore, the utilization of systemic therapies for atopic dermatitis in India is low, with limited access to JAK inhibitors. This narrative review provides a practical approach to abrocitinib use in Indian patients with AD based on expert opinions on patient selection, optimal dosing patterns, monitoring, and strategies for the maintenance phase.[6]

To bridge this gap, a panel of 10 dermatologists with more than 15 years of experience in AD management (expert panel) convened to share their practice-driven strategies with abrocitinib. This process consisted of three stages: literature review, a survey conducted among clinical dermatologists, and panel discussion to develop practical treatment strategies for abrocitinib.

Methodology

This manuscript presents expert recommendations derived from a structured literature review, a survey of practicing dermatologists, and expert panel discussions, rather than a formal Delphi-based consensus process.

The goal of the literature search was to review real-world experiences with abrocitinib in moderate-to-severe atopic dermatitis. Relevant studies were identified through databases including PubMed, Scopus, and Google Scholar between September 2025 and November 2025. The literature was reviewed to identify key clinical domains, including ideal patient profiles, dosing preferences, treatment duration, step-down strategies, maintenance of remission, safety considerations, laboratory monitoring, and use in special populations. Based on the literature review, a structured survey questionnaire was developed and validated by the expert panel to capture real-world clinical practices and prescribing patterns. A pan-India survey was subsequently conducted among 36 dermatologists who had ≥12 months of prescribing experience with abrocitinib and over 15 years of clinical and academic experience in managing atopic dermatitis. The survey aimed to gather insights into clinical decision-making, treatment approaches, and practical challenges. The findings from the survey were qualitatively analyzed and used to inform expert recommendations. These insights were further discussed and refined during expert panel meetings, where practical recommendations were formulated and validated based on collective clinical experience. As this was not a formal consensus exercise, predefined agreement thresholds, anonymous voting, or multiple iterative rounds of voting were not employed (Figure 1).

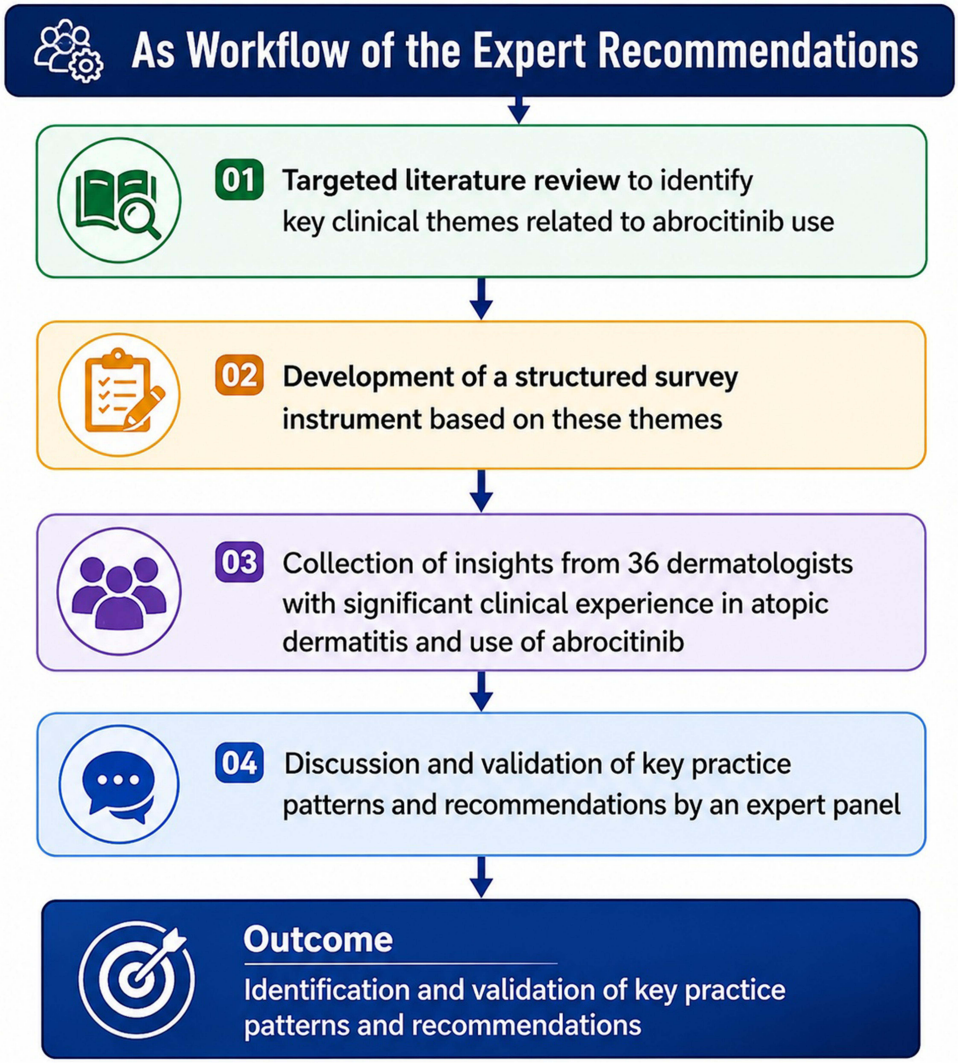

Figure 1 Workflow of the expert recommendation.

Results

This section is based on survey-derived clinical insights and expert panel recommendations, while detailed interpretation and mechanistic discussion are provided in the discussion section. Following the two rounds of virtual meetings, an expert panel of dermatologists reached an agreement regarding the management of atopic dermatitis (AD) and developed a practical treatment strategy for abrocitinib in moderate-to-severe AD. This process culminated in the formation of seven expert recommendation statements organized into five sections: i. optimal positioning of JAK inhibitors, ii. Patient profile of abrocitinib diagnostic evaluation, iv. Preferred Dosing as monotherapy and concomitant medication versus maintenance of remission (Table 1).

Table 1 Expert Recommendations

Sr. No	Section	Recommendation
1	Optimal positioning of JAK inhibitors	1. The use of JAK inhibitors is recommended in the management of moderate-to-severe AD for fast and early relief in symptoms such as itch and rash.
2	Patient profile for Abrocitinib	1. Abrocitinib is recommended in adolescents and adult patients who are refractory to conventional therapies as well as therapy naive patients in whom systemic therapy is contraindicated. 2. Additionally, it may be prescribed in special population like elderly patients and patients with comorbidities.

(*Continued*)

Table 1 (Continued).

Sr. No	Section	Recommendation
3	Preferred Dosing as monotherapy and concomitant medications	1. It is preferred to initiate abrocitinib with 200 mg OD. However, in case moderate disease less than 1-year duration 100 mg OD may be preferred. 2. In case of extensive lesions, concomitant medications like TCS, TCI and moisturizers are also preferred along with abrocitinib.
4	Laboratory Investigation	1. It is recommended to monitor lab investigations like CBC, RFT and LFT before starting and during treatment with abrocitinib.
5	Maintenance of remission	1. It is preferred to adapt one of the 6 maintenance strategies as mentioned below. a. Continue same dosage of abrocitinib: To achieve EASI-75 and EASI-90 and to reduce the risk of flares. b. Down titrate dosage of abrocitinib: Symptoms are rapidly control and maintain efficacy at a low dose. c. Shift to other targeted therapy: Disease is adequately controlled. d. Shift to conventional therapies (cyclosporin or methotrexate): Other JAK inhibitors are contraindicated or not tolerated. e. Shift to topical therapies: Topical tacrolimus preferably after achieving EASI 90 and as a safe option among topicals. f. Shift to emollients only: In patient with EASI-100 and to maintain remission.

Abbreviations: OD, once daily; TCS, topical corticosteroids; TCI, topical calcineurin inhibitors; CBC, complete blood count; RFT, renal function tests; LFT, liver function tests; EASI, Eczema Area and Severity Index.

Discussion

The dermatology expert panel reached an agreement on seven key statements as follows:

Optimal Positioning of JAK Inhibitors

JAK1 inhibitors play a pivotal role in the management of moderate-to-severe AD, as they offer the advantage of modulating/inhibition of the JAK-STAT Pathway. This inhibition curtails the intracellular signaling of several pro-inflammatory cytokines, particularly: Interleukin-4 (IL-4), Interleukin-13 (IL-13), Interleukin-31 (IL-31), and interferon-γ (IFN-γ) which are responsible for inflammation, pruritus (itching), and skin barrier dysfunction.[9] Henceforth, treatment with JAK inhibitors is associated with achieving high-threshold efficacy endpoints such as rapid relief in itch and improvement in disease severity from the start of the treatment. This was further reinforced by findings from the JAK1 Atopic Dermatitis Efficacy and Safety (JADE) clinical trials and a head-to-head comparison with dupilumab, underscoring the advantages of abrocitinib in terms of the speed of onset and depth of response.[10]

The expert panel broadly concurred that use of JAK inhibitors (JAKi) is recommended as a part of continuum strategy for the management of moderate-to-severe AD for fast and early relief in symptoms such as itch and rash. Moreover, comparing all the available oral JAKi, abrocitinib shows highest selectivity for JAK1 with substantially higher IC50 values for JAK2 and JAK3 compared to upadacitinib, baricitinib, and tofacitinib. Specifically, abrocitinib demonstrated IC50 values of 29 nmol/L for JAK1, 803 nmol/L for JAK2, >10,000 nmol/L for JAK3, and 1250 nmol/L for TYK2, indicating a strong preference for abrocitinib to minimize off-target effects on other JAK isoforms.[8] The recently published AD consensus by Sarkar et al also highlights the use of JAK inhibitors in AD management. The article recommended cautious use of tofacitinib owing to the lack of clinical data. However, Sarkar et al recommended the judicious use of abrocitinib in lieu of cost considerations. Hence, experts have recommended the positioning of abrocitinib in the management of AD over other JAK inhibitors such as tofacitinib, especially in India.[11]

Patient Profile for Abrocitinib

Abrocitinib may be used in most adults and adolescents with moderate-to-severe AD after personalized benefit–risk assessments. Abrocitinib is not indicated for pregnancy or lactating.[6] Patients who present with inadequately managed or active infections such as hepatitis B or C and tuberculosis should not take abrocitinib until these conditions are treated appropriately.[6] Patients with a previous history of human immunodeficiency virus (HIV) infection, recurrent hepatitis B or C, or those who present with a high risk of undiagnosed disease should be assessed before initiating treatment.[6]

As there is a potential risk associated with JAK inhibitors, such as MACE, VTE, and malignancies, it is essential to assess baseline risk before abrocitinib initiation. This is also supported by randomized clinical trials and an ongoing long-

term JADE extension study, highlighting the importance of evaluating the baseline risk and special considerations for patients aged ≥65 years, in patients with current or past long-term history of smoking, and those at increased risk of MACE (eg. previous history of ASCVD, including myocardial infarction or stroke) or VTE (eg. personal or family history of pulmonary embolism [PE] or deep vein thrombosis [DVT]), or with malignancy risk factors (eg. current malignancy or history of malignancy).[6] If a patient presents with clinical comorbidities or other VTE risk factors, such as obesity, prothrombotic disorder, recent trauma or major surgery, or prolonged immobilization, abrocitinib needs to be prescribed with caution. Available clinical data have highlighted that estrogen-containing oral contraceptive pills and hormone replacement therapy also pose a risk of VTE. However, no VTE cases were reported in abrocitinib-treated female patients who received hormonal contraceptives. A single case of VTE (nonfatal bilateral PE) was reported in a patient who received hormone replacement therapy. In cases of past or current history of malignancy, the benefits and risks of JAK inhibitor use in patients should be evaluated according to the severity of the malignancy.[6]

Abrocitinib in Different Patient Profiles

Emerging real-world evidence, case series, and randomized trials highlight abrocitinib as a safe and efficacious therapy across diverse groups of patients, including pruritus-dominant AD,[12] head-and-neck dermatitis (HND),[13] hand eczema in patients with atopic dermatitis,[14] elderly patients with multiple comorbidities, and patients who do not respond to conventional, selective, or non-selective JAK inhibitors or biologics[15](Table 2).

The expert panel agreed that abrocitinib is suitable for AD patients who remain uncontrolled on conventional systemic therapies, regardless of disease severity or comorbidities.

Table 2 Summary of the Published Evidence on Abrocitinib in Different Patient Profiles

Patient Profile	Supporting Evidence	Key Findings
Pruritus-dominant AD	Silverberg et al, Skin Health Dis. 2024; 4(4): e382[12]	• Rapid and sustained itch relief; significant improvements as early as Week 2 • 86%–87% and 62%–67% of patients had no itch-moderate itch and clear-moderate lesions by weeks 24 and 48.
Moderate-to-severe head and neck dermatitis	Liu, Chuan et al Clinical, cosmetic and investigational dermatology vol. 18 3093–3102. 20 Nov. 2025[13]	• Rapid improvement in SCORAD, EASI, and DLQI after 4 weeks.
Hand eczema in patients with atopic dermatitis	E. Kamphuis et al Acta Derm Venereol 2024; 104: adv19454.[14]	• At week 28, the EASI-50/75/90 was achieved by 81.8%, 57.6%, and 18.2%, respectively, and the weekly average pruritus numerical rating scale ≤4 by 62.9%.
AD in elderly, multimorbid patient	Skin Therapy Letter. Supplement. January 2024. Editor-in-Chief: Richard Thomas, MD[15]	• Good control of AD, itch, and tolerability with 100 mg Abrocitinib. • After 2 weeks on 100 mg abrocitinib, patient's EASI was reduced to 6.4, DLQI to 6, IGA to 2, PP-NRS to 1.5, and BSA to 10%.
Conventional therapies non-responders	Skin Therapy Letter. Supplement. January 2024. Editor-in-Chief: Richard Thomas, MD[15]	• After 4 weeks of abrocitinib 100 mg daily use, the patient no longer required use of TCS and had an EASI of 1.2, IGA of 2 and PP-NRS of 4.
Nonresponder to other selective or PAN JAK inhibitor	Skin Therapy Letter. Supplement. January 2024. Editor-in-Chief: Richard Thomas, MD[15]	• Abrocitinib 200 mg results for faster control of AD. • Abrocitinib is a good treatment option for patients who had adverse reactions to another JAKi.
Biologic non-responders	Skin Therapy Letter. Supplement. January 2024. Editor-in-Chief: Richard Thomas, MD[15]	• Faster itch reduction and stronger early efficacy vs dupilumab; beneficial for inadequate responders

Abbreviations: SCORAD-Scoring Atopic Dermatitis; EASI, Eczema Area and Severity Index; DLQI, Dermatology Life Quality Index; IGA, Investigator's Global Assessment; AD- Atopic Dermatitis; PP-NRS- Peak Pruritus Numerical Rating Scale; TCS- Topical Corticosteroid; JAKi, Janus Kinase inhibitor.

Diagnostic Evaluation

If abrocitinib is considered an appropriate treatment, a complete blood count (including platelet count, absolute lymphocyte count [ALC], absolute neutrophil count [ANC], and hemoglobin), lipid parameter measurements, measurements of transaminases, renal function testing, and screening for hepatitis B or C and HIV in accordance with clinical guidelines and local treatment protocols prior to immunosuppressive treatment should be performed.[6] Patients should also be evaluated and tested for tuberculosis before initiating abrocitinib; yearly screening should be considered, especially in patients from highly endemic areas. Screening tests, including interferon-γ-release assays (eg. QuantiFERON), tuberculin skin tests, enzyme-linked immunosorbent assay (ELISA) tests, and/or chest X-rays, should be performed before initiating treatment in both adult and adolescent patients.[6]

Chest radiography may be used along with the QuantiFERON test or only if a patient tests positive using the QuantiFERON test as per the diagnostic criteria. In JADE clinical trials, including adult and adolescent patients, a dose-dependent decrease in platelet count was noted at week 4.[6] The median platelet counts subsequently increased and attained a plateau at week 12, and the final 12-week values remained below baseline but were within the normal range. Thrombocytopenia (< 75×103 platelets/mm3) is rare but is more commonly observed in patients aged ≥65 years with an abrocitinib dosage of 200 mg OD. No change over time was observed in ANC, ALC, or hemoglobin; however, in rare cases, lymphopenia has been observed.[6]

Blood lipid levels should be evaluated before initiating abrocitinib and at week 4 following treatment initiation and managed as needed in consultation with the physician.[6] In the JADE clinical trials, abrocitinib was associated with a dose-dependent increase in low-density lipoprotein cholesterol (LDL-C) levels from baseline to week 16, with no notable change in the LDL-C/high-density lipoprotein cholesterol (HDL-C) ratio over 16 weeks.[6]

It is recommended that patients be evaluated periodically (4 weeks after treatment initiation or 4 weeks after dose increase) during abrocitinib treatment to assess any changes from the baseline, as shown in (Table 3).

The expert panel reached a high level of agreement that abrocitinib therapy requires baseline monitoring of lab investigations like hematologic, hepatic, renal, infections, cardiovascular, thrombotic and lipid parameters, followed by

Table 3 Baseline Investigations and Monitoring Suggestion for Oral Abrocitinib[5,6]

Parameter	Baseline Investigations	Periodic Follow-Up
CBC	Not recommended in patients with: Platelet count <150,000/mm^3; Absolute lymphocyte count <500/mm^3; Absolute neutrophil count <1,000/mm^3; Hemoglobin <8 g/dL	Repeat at 4 weeks; Repeat 4 weeks after dose increase
RFT	Not recommended in patients with eGFR <15 mL/min or severe renal impairment	Baseline RFT to be done to rule out renal dysfunction
LFT	Not recommended in severe hepatic impairment	Baseline LFT to rule out hepatic dysfunction
TB evaluation	Rule out active TB; not recommended in active TB; Preventive anti-TB therapy for latent/high-risk; Monitor TB signs yearly	Monitor yearly TB signs; continue preventive measures for high latent TB risk
Viral hepatitis screening	Not recommended in active Hep B or C; Monitor HBV DNA in inactive Hep B; consult hepatologist if elevated	Periodically monitor HBV DNA levels in inactive Hep B
Cardiovascular Risk (MACE)	Use caution in patients with CV risk or smoking history; Inform patients of serious symptoms	Monitor for MACE at 4 weeks and 4 weeks after dose increase
Thrombosis risk	Avoid patients with increased thrombosis risk	Monitor for signs of thrombosis periodically
Blood lipid levels	Check baseline levels	Repeat at 4 weeks and again 4 weeks after dose increase

Abbreviations: CBC, Complete Blood Count; RFT, renal function test; LFT, liver function test; TB evaluation, tuberculosis evaluation; Hep B or C, Hepatitis B or C infection; DNA, hepatitis B virus deoxyribonucleic acid; CV risk, cardiovascular risk; MACE, Major Adverse Cardiovascular Events.

focused monitoring at 4 weeks and after dose adjustments. Also, periodically monitor for the sign of cardiovascular events, thrombosis, and lipid changes.

Vaccination

Prior to initiating treatment with abrocitinib, it is recommended that all patients should complete appropriate vaccines including non-live HZ vaccination (eg. Zoster Vaccine Recombinant, Adjuvanted) approximately 2–4 weeks before abrocitinib initiation, especially those who are at a higher risk of HZ (≥50 years old, immunosuppressed, or immunodeficient).[6]

In patients who already receive abrocitinib, non-live vaccines can be administered at any point during therapy without stopping treatment. Patients should avoid live vaccines immediately starting with, during, and immediately after abrocitinib treatment. It was recommended stopping Live vaccines should be stopped up to at least 1 week before starting abrocitinib and should wait for at least 2–4 weeks after stopping treatment, depending on the vaccine product label.[6]

Preferred Dosing as Monotherapy and Concomitant Medications

In clinical practice, decisions on appropriate dosing are governed by many clinical factors and patient considerations. However, the overarching goal for both clinicians and patients are to achieve long-term control of AD symptoms, which improves the quality of life with minimal safety concerns.[6]

Considerations for Abrocitinib as Monotherapy

Patients who present with moderate-to-severe AD for more than 1 year have a recent history of inadequate response to topical medications (topical corticosteroids or topical calcineurin inhibitors administered for ≥4 weeks), history of topical AD treatments being considered medically inadvisable, or requiring systemic therapies to control their disease.[15] In these patients, a starting dose of abrocitinib 200-mg once daily should be considered to achieve rapid control. For patients with tolerability concerns or age over 65 years with comorbid conditions such as renal, cardiovascular, and hepatic conditions, a starting dose of 50 or 100 mg of abrocitinib once a day may provide effective disease control while minimizing safety risks.[6]

This recommendation is consistent with the findings from JADE MONO I and II clinical trials; patients initiated on abrocitinib 200 mg demonstrated higher response rates than those initiated on 100 mg as the starting dose.[16,17] By week 12, 61.0%, 44.5%, and 10.4% of patients in the abrocitinib 200 mg, 100 mg OD, and placebo groups achieved ≥75% improvement in the Eczema Area and Severity Index (EASI-75).[16,17] Similarly, EASI-90 responses were achieved by 37%, 23.9%,3.9% of patients in the 200 mg, 100 mg OD, and placebo groups, respectively. A comparable trend was observed in pruritus reduction, with 57%, 38%, and 15% of patients in the abrocitinib 200 mg, 100 mg OD, and placebo groups, respectively, achieving a PP-NRS4 score by week 12.[16,17]

Considerations When Using Abrocitinib in Combination Approaches

In patients with a clinical diagnosis of moderate-to-severe atopic dermatitis for at least 6 months, treatment with systemic therapies for the control of atopic dermatitis within the past year or had an inadequate response to at least 4 consecutive weeks of treatment with medicated topical therapy for atopic dermatitis within the past 6 months.[16,18] Patients with moderate-to-severe atopic dermatitis, defined as an affected body surface area of 10% or more, investigator's Global Assessment of 3 or higher, EASI of 16 or higher, and PP-NRS of 4 or higher at baseline.[18] In these patients, topical corticosteroids (TCS), topical calcineurin inhibitors (TCI), and moisturizers may be used in combination with abrocitinib 200 mg to enhance the treatment response and optimal control of the disease.[18]

As the combination of abrocitinib with other systemic therapies has not been studied, its concomitant use is not recommended in clinical practice because of the potential risk of additive immunosuppression.[6] Likewise, no clinical evidence exists for combination phototherapy, and this approach is not recommended because of the potentially increased risk of malignancies such as melanoma or non-melanoma skin cancer.[6]

The expert panel agreed with above discussion and further emphasized that abrocitinib 200 mg should be considered for moderate to severe with disease duration more than 1 year, while 100 mg for those with moderate disease severity and disease duration under one year.

A structured induction plan for abrocitinib treatment was planned to use personalized dosing and careful baseline and follow-up monitoring (Figure 2).

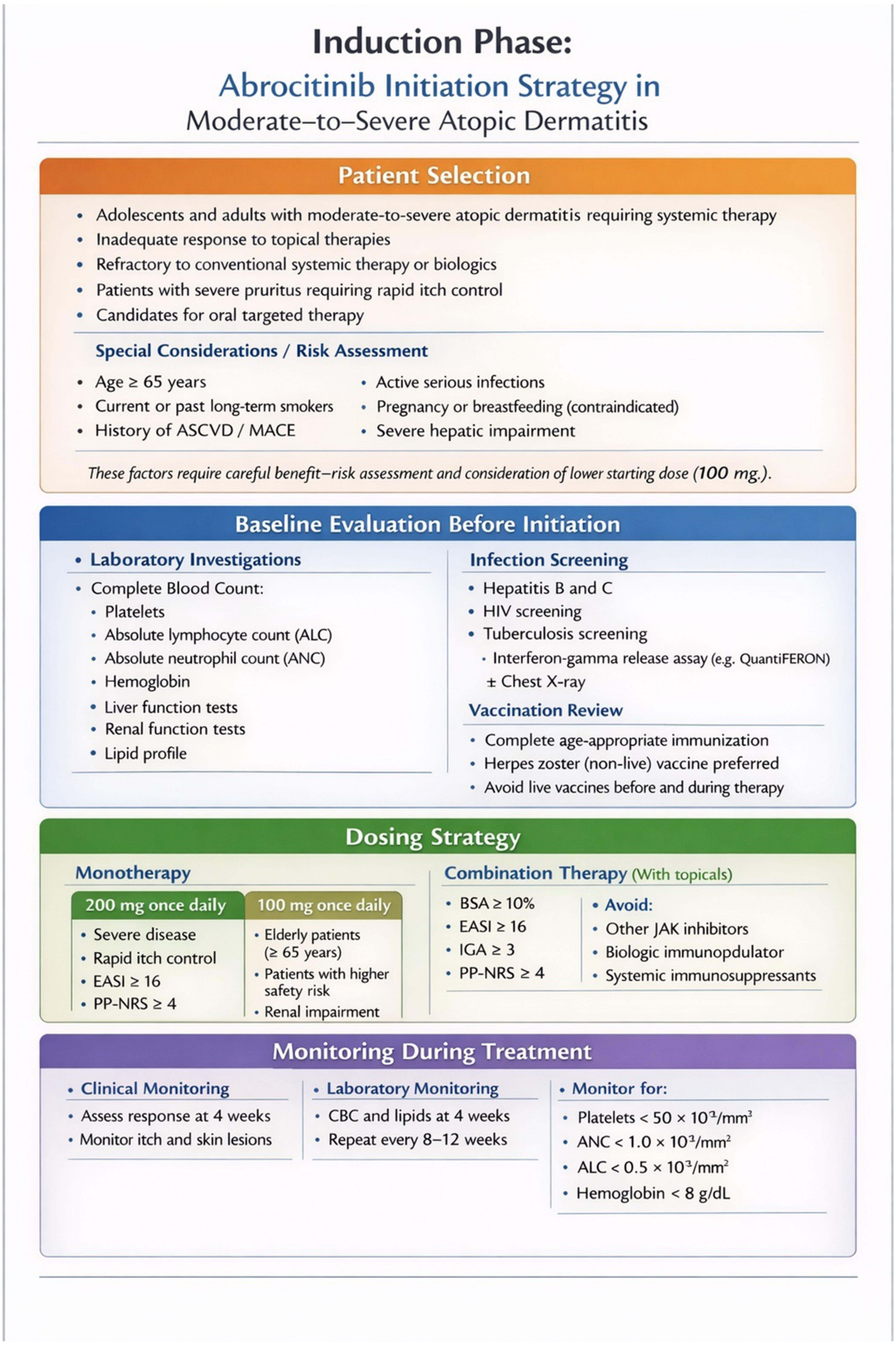

Figure 2 Induction phase: Abrocitinib initiation strategy in moderate to severe atopic dermatitis.

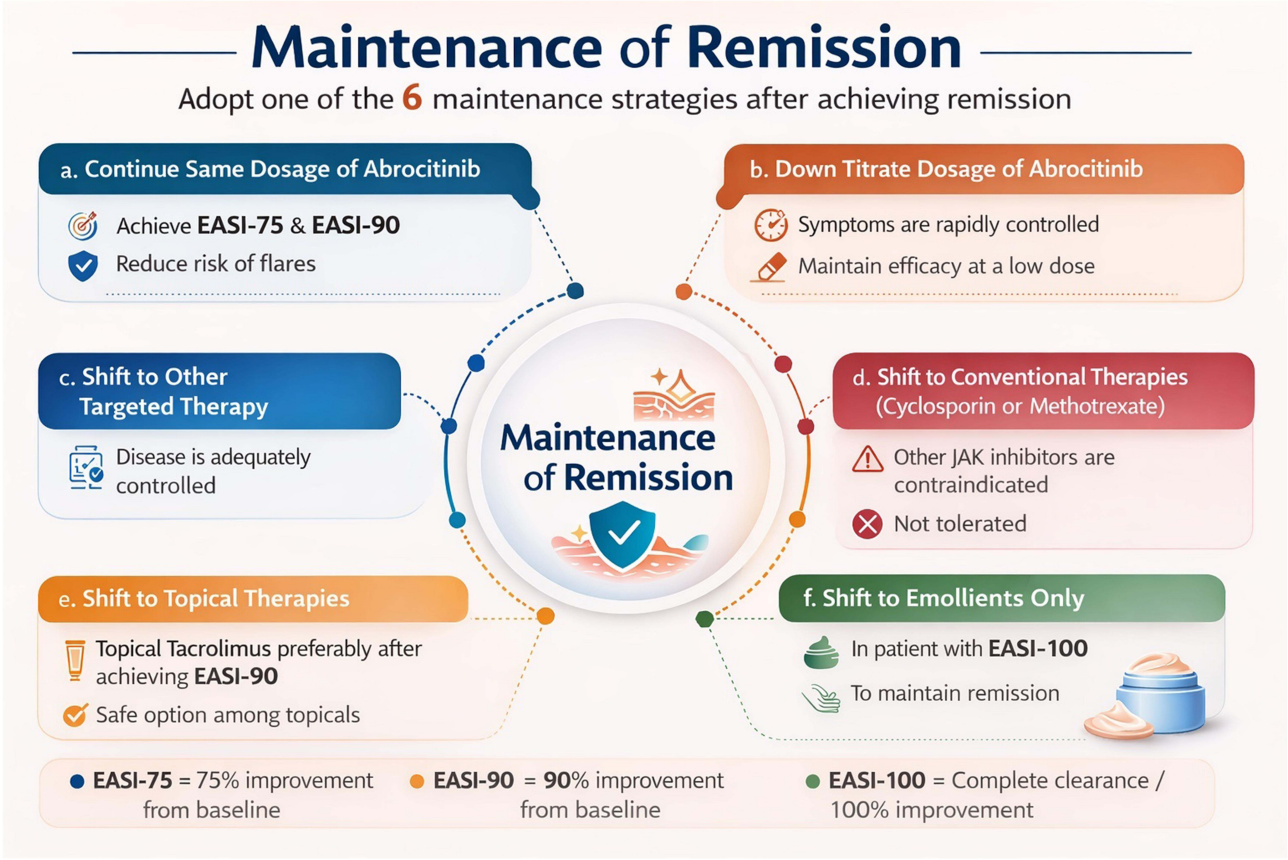

Figure 3 Maintenance of remission.

Maintenance of Remission

Published data from the JADE clinical development program supports multiple dosing strategies for both treatment and maintenance phases. Dermatologists can adapt these strategies for long-term disease management to achieve sustained remission (Figure 3).

Maintain the Same Starting Dose of Abrocitinib

In the JADE REGIMEN trial, the maintenance therapy of abrocitinib 200 mg significantly reduced the risk of flares and loss of IGA 0/1 response compared with 100 mg and placebo over 40 weeks, with relative risk reductions of 90% and 78%, respectively.[19] Hence, abrocitinib 200 mg is preferred to attain EASI-75 and EASI-90 and evidence from clinical trials shows better maintenance of response and lower risk of flare with a higher dose.[19]

Down Titrate the Starting Dosage of Abrocitinib

In the JADE REGIMEN trial, out of 1233 patients who entered the open-label phase of JADE REGIMEN and received the abrocitinib 200-mg dose, 798 (64.7%) patients achieved response per protocol, of which 265 were randomly allocated (down-titrated) to 100 mg.[19] Response rates with abrocitinib 200 mg to 100 mg down-titration were greater compared to treatment withdrawal (placebo) through the maintenance period from week 4 after randomization up to week 40. For example, the EASI-75 response rate at the end of the 40-week maintenance period was 46.5%, which was substantially higher than that of the placebo (14.0%).[19] Among patients who were down-titrated from 200-mg dose to 100 mg, 60.8% were also able to maintain a response for the 40-week maintenance period without a flare or need for rescue treatment, compared with 23.6% of patients in the placebo (treatment withdrawal) arm. Henceforth, considering the above evidence, if symptoms are rapidly controlled clinically, stepping down to 100 mg may be a viable option for maintaining efficacy at a low dose.[19,20]

https://doi.org/10.2147/CCID.S611587

Shift From Abrocitinib to Other Targeted Therapy

In a 16-week retrospective study of moderate-to-severe AD comparing abrocitinib, tofacitinib, and cyclosporine, abrocitinib demonstrated greater reductions in mean scores, with EASI improvements of 87% versus 64% and 51%, and NRS improvements of 85% versus 62% and 51%, respectively.[21] Hence, in patients with financial constraints or whose disease is adequately controlled, a switch to more affordable targeted therapies such as generic upadacitinib, baricitinib, or tofacitinib should be considered.[21]

Shift From Abrocitinib to Conventional Therapies

From clinical data and case reports, it has been observed that conventional therapies such as cyclosporine and methotrexate may be used as maintenance therapy at the lowest effective dose to sustain disease control while minimizing risks*.[22] Some dermatologists have also shared real-world experiences suggesting that methotrexate can be combined with abrocitinib as an exit strategy for abrocitinib after remission and may be preferable for long-term maintenance. Hence, in patients with financial constraints or in whom other JAK inhibitors are contraindicated or not tolerated, switching to conventional therapies such as cyclosporine or methotrexate may be considered, as these agents have been reported to be relatively safe drugs to maintain the long-term management of moderate-to-severe AD patients.[23]

* Robust evidence is lacking in adults; further research studies are required to evaluate the safety and tolerability of intermittent or other maintenance cyclosporine strategies in patients with AD.

Shift From Abrocitinib to Topical Therapies

Patients who are in remission phase after abrocitinib monotherapy but experience intermittent flares, and in whom systemic therapies and long-term continuous use of TCS are not recommended. Among them, abrocitinib 200 mg plus medicated topical therapy was an acceptable approach to regain response in patients who experienced a flare, as supported by the JADE REGIME trial during the rescue treatment period. Another way is to adopt sequential therapy with TCS and TCI. This concept is aligned with published systematic reviews and meta-analyses pooling data from two trials and found that sequential therapy with TCS TCI was comparable to monotherapy (TCS or TCI) or emollients. This approach emphasizes not only targeting active lesions but also adopting sequential therapy with an acceptable safety profile.[24] A large cohort study by Koo et al and Hanifin et al reported significant findings on tacrolimus ointment for atopic dermatitis, with Koo's large trial showing effectiveness and good safety over nearly two years in almost 8000 patients, and Hanifin's study demonstrated benefits for up to four years, highlighting tacrolimus as a valuable long-term option for moderate-to-severe eczema, especially for sensitive areas such as the face. Hence, after attaining EASI, 90 patients can be maintained on other topical therapies, such as tacrolimus, for a longer duration as the safest option in topicals.[25]

Shift to Emollients Only

According to a recent review article, regular use of emollients prolongs flare-free periods and alleviates symptom intensity during remission in adults. Therefore, once a patient achieves EASI-100, transition to emollient-only therapy is recommended to maintain remission.[26] Similar evidence has also been highlighted in the recently published AD consensus by Sarkar et al that moisturizers form the cornerstone of management and offer steroid-sparing benefits in the management of AD.[11] The following summarizes the six key strategies for effective maintenance in atopic dermatitis. The findings in these expert recommendations are also aligned with emerging international and European guidelines, which increasingly support the positioning of abrocitinib in patients requiring rapid symptom control or those inadequately managed with other systemic agents. Real-world expert consensus data, including the Italian Delphi consensus (Gargiulo et al, 2024), further reinforce the role of JAK inhibitors in routine clinical practice, particularly emphasizing individualized treatment decisions and safety monitoring.[27] Long-term safety considerations remain critical, particularly with respect to cardiovascular events, thromboembolic risks, malignancies, and laboratory abnormalities. Treatment adherence may be positively influenced by the rapid onset of itch relief and the oral route of administration.[27] In the Indian context, cost-effectiveness and treatment accessibility are important factors influencing therapeutic decisions. In addition, potential differences in disease phenotype, comorbidities, and environmental exposures between Asian and Western populations highlight the need for region-specific clinical guidance. Finally, the incorporation of treat-to-target strategies in atopic dermatitis management represents an

evolving paradigm, emphasizing predefined goals such as itch reduction, improvement in EASI scores, and quality-of-life outcomes, with treatment optimization based on patient response.

Conclusion

Abrocitinib, a highly selective JAK1 inhibitor, offers rapid itch relief, sustained skin clearance, and improved quality of life in patients with moderate-to-severe atopic dermatitis. The expert recommends initiating therapy with 200 mg for severe diseases, followed by titration to the lowest effective dose for maintenance. Regular monitoring of laboratory parameters and individualized risk assessments are essential for safe use. Maintenance strategies include dose adjustment, switching to other targeted or conventional therapies, and transitioning to topical agents or emollients after remission is achieved. These recommendations provide a practical framework for optimizing long-term management of AD in clinical practice.

Ethics Statement

According to the Indian Council for Medical Research (ICMR) guidelines, research involving educational practices such as instructional strategies, evaluation of teaching effectiveness, or comparison of instructional techniques, curricula, or classroom management methods may be exempt from an ethics committee review. Therefore, ethics committee approval was not required for this study.

The ICMR guidelines also state that voluntary informed consent may be waived when the research involves no more than minimal risk, when there is no direct interaction between the researcher and the participants, or when the consent waiver is justified. Based on these provisions, informed consent was not required for this study. The study was conducted in accordance with the principles of the Declaration of Helsinki.

Disclosure

Rickson Pereira reports Honoraria from Received for presentations, outside the submitted work. Soumya Jagadeesan reports Honoraria from Pfizer, Glenmark; Data safety/advisory board participation from Pfizer, outside the submitted work. The authors report no other conflicts of interest in this work.

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