Important New Drugs for 2026: What You Need to Know





Novel Drugs

Relevant for PCP

No "Me Too" Drugs

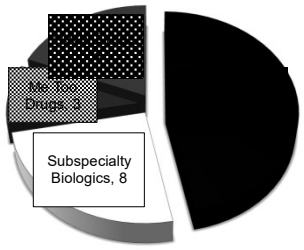




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1

2026 FDA New Drug Approvals to Date: Subspecialty Meds Led the Pack but Novel Drugs for Primary Care as Well



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https://www.fda.gov/drugs/novel-drug-approvals-fda/novel-drug-approvals-2026

2

Four Novel Drugs for Primary Care Practice

1. Tradipitant for motion sickness
2. Baxdrostat for resistant hypertension
3. Enlicitide for elevated LDL cholesterol
4. Remibrutinib for chronic spontaneous urticaria

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Tradipitant for Motion Sickness

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How to Incorporate into Practice?



- FDA approved Dec. 2025
- Available in U.S. pharmacies since May 2026
- Cost is $2500 for 10 capsules in retail pharmacies!
- Manufacturer offering at $850 for 10 capsules directly through their website
- It is an important addition to currently available preventive Rx for motion sickness that I would reserve for Rx failures with existing medications due to cost

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Ms. C. Sique

- 74 year-old woman
- Would like to take a cruise but motion sickness was debilitating in past
- Scopolamine was too sedating
- Anything new to offer?



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Is this You in a Car?



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Motion Sickness is Common

- Discordant sensory input mismatch confuses the brain as to our position in space and the perception of motion
- Occurs in approximately 1/3 of individuals
- Most notable in sea journeys
- May also occur with plane or car travel
- More common among those with migraine
- Incidence greater in females than males
- Nausea is most common symptom
- Dizziness, diaphoresis, fatigue may occur
- Vertigo does not typically occur



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Non-Pharmacologic Prevention Strategies

- Do not read or view screen if possible
- If in car, sit in front seat, look toward horizon or at a fixed object
- On a boat, lower deck cabins mid-ship
- Some evidence that ginger candies may reduce motion sickness based on small trials
- Acupressure to volar wrist manually or by a wrist band – uncertain benefits





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There Have Been No Advances in the Treatment and Prevention of Motion Sickness for > 40 years

- Hydroxyzine (off-label) and meclizine each approved 1957
- Dimenhydrinate (Dramamine ®) approved 1972
- Transdermal scopolamine approved 1979

Efficacy:

- Meclizine ~ 20%
- Scopolamine ~50%

Non-sedating antihistamines and ondansetron do not prevent motion sickness

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Tradipitant is a Novel Neurokinin-1 Antagonist

NEW

- NK1 receptors exist in brainstem nuclei involved in generating nausea and vomiting including nucleus tractus solitarius (NTS)
- Sensory emetogenic and emotional input from brain transmitted to NTS and may cause reflex nausea
- Vestibular centers likewise may send signals to NTS due to visuospatial discordance
- Releases substance P that binds to NK1 receptors in NTS and initiates emetogenic response
- Tradipitant is a NK1 receptor antagonist that blocks this process

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Motion Sifnos Study: RCT of Tradipitant vs. Placebo on Seagoing Trips in Pacific Ocean

- 126 adults with a known history of motion sickness
- Otherwise in good general health
- Randomly assigned to Tradipitant 170 mg or placebo one hour before boat trip
- 4-hour boat trips on monohull boats in Pacific Ocean
- Outcomes were change in Motion Sickness Severity Scale (7-point scale) recorded every 30 minutes
- At end of voyage, completed two other questionnaires: Motion Sickness Assessment Questionnaire (16-item tool), and Patient Global Impression Scale (5-item scale from 0 to 4 each item)

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Polymeropoulos VM, Front. Neurol. 11:563373. doi: 10.3389/fneur.2020.563373

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Motion Sickness Severity Scale

Travel Assessment – 30 minutes

MSSS – Motion Sickness Severity Scale

In the **last 30 minutes**, how severe is your motion sickness?
Please circle the number below that best represents your response:
Please select only one response.

0	1	2	3	4	5	6
No symptoms	Stomach awareness or discomfort	Mild nausea	Moderate nausea	Severe nausea	Retching	Vomiting

Polymeropoulos VM, Front. Neurol. 11:563373. doi: 10.3389/fneur.2020.563373

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Substantially Less Vomiting with Tradipitant, but only for Rough Seas

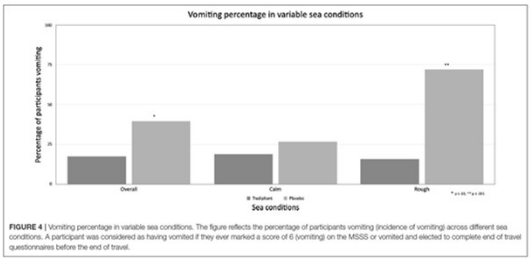
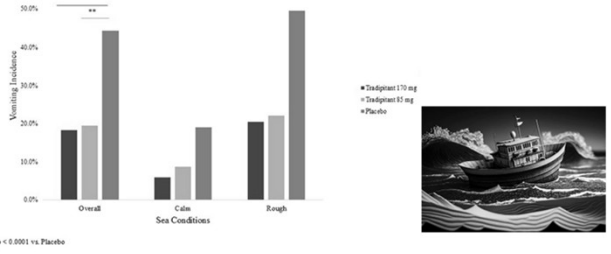


FIGURE 4 | Vomiting percentage in variable sea conditions. The figure reflects the percentage of participants vomiting (incidence of vomiting) across different sea conditions. A participant was considered as having vomited if they ever marked a score of 6 (vomiting) on the MSSS or vomited and elected to complete end of travel questionnaires before the end of travel.

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Similar Findings in a RCT of 365 Adults under Variable Sea Conditions and 2 Different Drug Doses



**p < 0.0001 vs. Placebo

Polymeropoulos VM, et al. Front. Neurol. 16:1550670. doi: 10.3389. March 2025

15

Minor Adverse Events were Common: No Serious AE's Observed

AE %	Placebo	Tradipitant 170 mg	Tradipitant 85 mg
Headache	2.5	8.3	5.7
Somnolence	0.8	8.3	6.5
Fatigue	0	8.3	4.1

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Other Observations

- Study populations all had prior history of motion sickness, unknown if similar benefit would exist for patients with no prior h/o motion sickness
- No comparisons to other drugs used for motion sickness but indirect comparisons suggest likely more effective than all existing Rx's
- Given the observation that tradipitant reduces vomiting in this setting, the manufacturer has explored other potential indications:
  - Gastroparesis
  - GLP-1 induced vomiting

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Tradipitant Did not Reduce Daily Nausea Score in RCT of Patients with Diabetic or Idiopathic Gastroparesis

- N=201 adults
- Documented delayed gastric emptying
- Average daily nausea score ≥ 2.5 (6-point score)
- Tradipitant 85 mg bid or placebo for 12 weeks
- High placebo effect observed
- Some benefit in post-hoc analyses subgroups

	Tradipitant	Placebo	P value
Daily nausea score – baseline	3.46	3.36	
Week 2	-0.68	-0.52	NS
Week 12	-1.55	-1.49	NS
Patient Global Impression of Change			
Week 2	2.91	3.21	0.02
Week 12	2.46	2.59	0.54

Clinical Gastroenterology and Hepatology 2024;22:2506–2516

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Tradipitant Reduces Nausea among Patients Taking Semaglutide for Obesity

- Press release only – no peer reviewed data yet
- New starts with semaglutide 1 mg
- Pre-Rx with either tradipitant or placebo
- Vomiting reduced from 59% to 29%
- Unexpectedly high vomiting rates among placebo treated patients compared with 9% in semaglutide studies in package insert
- Larger phase 3 trials planned

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Press Release Nov. 17, 2025

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Key Points

- FDA approved at 85 or 170 mg daily dose **only** for motion sickness
- Sustained efficacy persists for at least 12 months of intermittent use in open label trial
- FDA denied request to approve for gastroparesis as of Sept. 2024
- Manufacturer disputes decision
- Potential use to minimize nausea and vomiting due to GLP-1RA not yet fully studied and remains off label but shows promise in early trials.
- Future approved indications may emerge
- Would not recommend off-label use at this time for non-motion sickness
- Minor adverse events are common but generally not a barrier to use
- FDA warning for potential impairment for driving safety due to somnolence

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How to Incorporate into Practice?



- FDA approved Dec. 2025; not yet in pharmacies
- Cost not yet disclosed
- Several online estimates propose that cost may exceed $500 for an 8-tablet bottle; not yet confirmed by manufacturer
- Expect to see in pharmacies by spring 2026
- If cost estimates prove accurate, this would be a second line drug and most likely will require prior authorization
- It is an important addition to currently available preventive Rx for motion sickness that I would reserve for Rx failures with existing medications

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Ms. C. Sique



- Let's first consider meclizine or dimenhydrinate if not already tried
- If both ineffective or poorly tolerated, then would recommend tradipitant
- Check your 401k balance first…

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Baxdrostat for Resitant Hypertension

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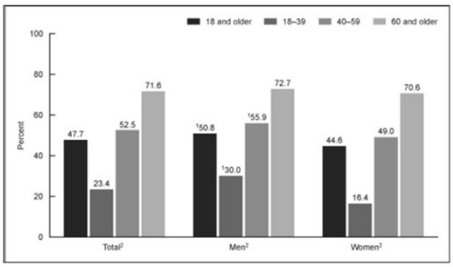
Doris



- 71 y.o. woman
- 20 yr h/o HTN
- Multiple intolerances
- On chlorthalidone, lisinopril, amlodipine
- Didn't tolerate spironolactone
- Bp still 155/95
- What about this new drug?

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NHANES 2024: Nearly One Half of U.S. Residents are Hypertensive (>130/80 or on BP Meds)



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https://www.cdc.gov/nchs/products/databriefs/db511.htm

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Burden of Resistant Hypertension

- 45% of US residents have hypertension based on definition of > 130/80
- Resistant hypertension is bp above goal despite 3 drugs; one of which should be a diuretic
- Don't forget to consider white coat, secondary causes, and medication non-adherence before diagnosing resistant hypertension
- 24-hour ABPM before considering treatment resistance
- Approximately 12% of hypertensive patients have resistant hypertension
- A substantial public health burden and a core part of primary care practice

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How Common is Apparent Treatment Resistant HTN? Prevalence among Patients Taking Antihypertensive Therapy

Subgroup	% of Patients
Overall	19.7%
Age group (years)	
• 20-49	10.8%
• 50-59	14.0%
• 60-69	19.9%
• ≥ 70	28.8%
Male sex	19.6%
Female sex	19.8%
Non-Hispanic white	18.9%
Non-Hispanic black	27.3%



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Hypertension. 2019;73:424

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Most Common Causes of Secondary Hypertension among Patients with Hypertension

- Pseudo-hypertension
- OSA – in as many as 25-50% of patients with TRH
- Primary aldosteronism 5-25%
  - Only ½ of patients will have spontaneous hypokalemia
- CKD 15%
- Drug or alcohol related
- Renovascular <5%
- Hyperthyroidism < 1%
- Pheochromocytoma <0.6%
- Cushing's syndrome < 0.1%



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Most Common Causes of Secondary Hypertension among Patients with Hypertension

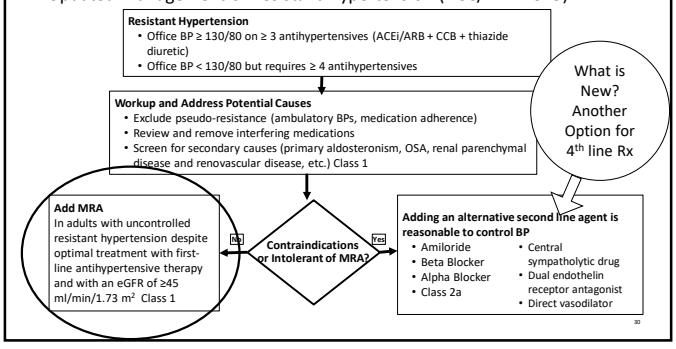
- Pseudo-hypertension
- **OSA – in as many as 25-50% of patients with TRH**
- **Primary aldosteronism 5-25%**
  - **Only ½ of patients will have spontaneous hypokalemia**
- **CKD 15%**
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- Hyperthyroidism < 1%
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- Cushing's syndrome < 0.1%



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Updated Management of Resistant Hypertension (ACC/AHA 2025)



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Baxdrostat is the First FDA Approved Aldosterone Synthase Inhibitor: A Novel Drug Class

- Several drugs under study that work by this mechanism
- Inhibit the final step in aldosterone production: aldosterone synthase that converts 11-deoxycorticosterone to aldosterone
- Baxdrostat has a highly selective mechanism of action, half-life of 30 hours
- Not expected to have anti-androgen effects such as gynecomastia that may occur with spironolactone
- Two small phase 2 trials showed conflicting results regarding benefit
- Has been studied only for uncontrolled and resistant hypertension

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BaxHTN: The Key RCT in Patients with Uncontrolled or Resistant Hypertension

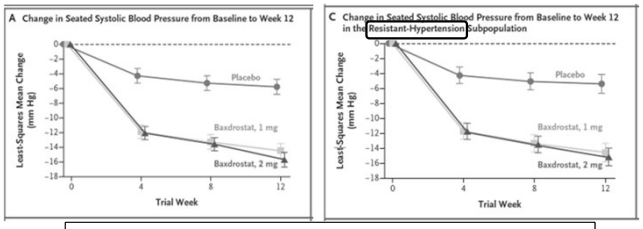
- 794 adults with mean seated sbp 140-170 mm Hg despite 2 drugs (uncontrolled) or 3 drugs (resistant) that include a diuretic
- Randomly assigned to baxdrostat 2 mg qd, 1 mg qd, or placebo
- Baseline characteristics similar among 3 groups: mean age 61 years, 62% male.
- Excluded if baseline eGFR < 45
- No concomitant use with MRAs or K+ sparing diuretics allowed
- Primary endpoint change in sbp at week 12
- Open label safety data collection phase extending to 52 weeks
- All patients continued their usual background bp meds

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N Engl J Med 2025;393:1363

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Both Doses Substantially More Effective than Placebo for all Subjects and if Resistant HTN

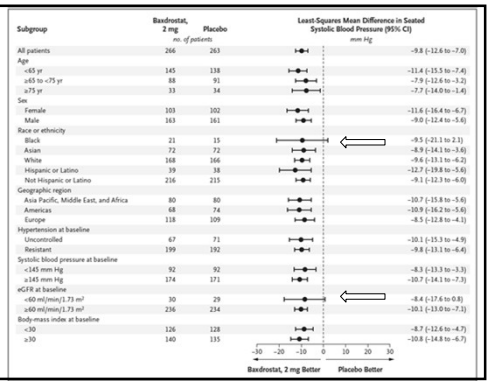


Placebo corrected reduction in sbp for 2 mg dose was 9.8 mm Hg

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In Subgroup Analysis, Placebo Controlled Reduction in BP for all Subgroups except African-American and those with Baseline eGFR < 60



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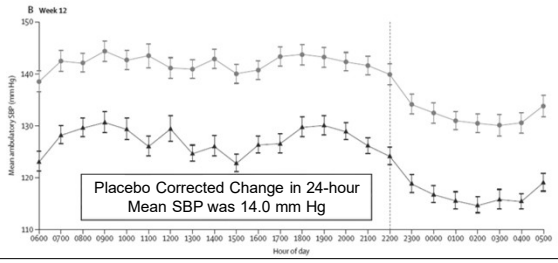
Hyperkalemia was the Most Important Adverse Event

Adverse Event	Baxdrostat 1 mg	Baxdrostat 2 mg	Placebo
Rx d/c due to AE	2.7%	4.5%	1.9%
Na+ < 135	19.1%	22.8%	7.0%
Hyponatremia requiring Rx	0.8%	2.3%	0.4%
Hypotension	1.9%	2.3%	0.8%
Potassium > 6.0	2.3%	3.0%	0.4%
Muscle spasms	1.8%	2.9%	0.7%

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Bax24 2mg Dose RCT: Greater Placebo Corrected Systolic ABPM for Resistant Hypertension

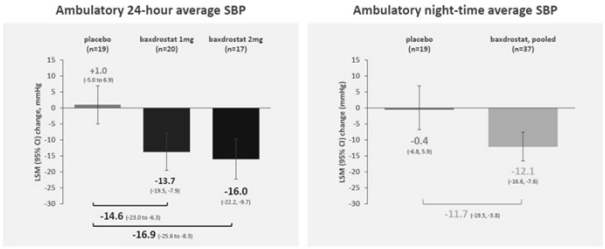


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Lancet 2026;407:988

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Both 24-Hour and Night-time BP Reductions by ABPM

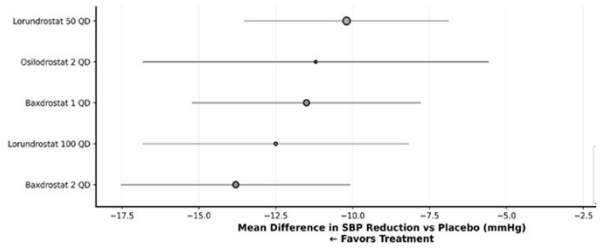


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Source: Manufacturer

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Meta-Analysis: Similar Result with Lorundrostat, FDA Decision Anticipated Dec. 2026



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J Clin Med 2026;15:4477

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Costs of Add-On Meds for Resistant HTN

Drug	30-Day Supply Cost
Spironolactone 25 mg qd	$10
Baxdrostat 2 mg qd	$900
Lorundrostat 50-100 mg	Not yet approved
Amiloride 5 mg qd	$10
Aprocitentan 12.5 mg qd	$950

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Other Observations

- In a smaller trial of patients with eGFR 25-75, similar bp benefits seen, also reduction in ACR, but higher rates of hyperkalemia and modest eGFR reductions*
- Not recommended during pregnancy given limited data
- Measure baseline and periodic Na+ and K+ levels
- Mean eGFR reduction of 7.0 that generally resolves after stopping Rx c/w hemodynamic effects on GFR
- Approved dose is 2 mg qd
- 1 mg qd if increased risk of hyperkalemia or hyponatremia (> 65 y.o., DM, CKD, other meds that increase K+ levels)
- No dose adjustment required for older age

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* JASN 37: 299–311, 2026

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Key Points



- Follow ACC AHA pathway for resistant hypertension first
- Baxdrostat is an important first of kind novel drug for this indication
- If resistant HTN on 3 meds including a diuretic, preferred next addition is spironolactone
- If spironolactone not effective or tolerated (usually due to gynecomastia), then baxdrostat is a reasonable alternative
- Don't use together with an MRA
- Amiloride is another inexpensive alternative if spironolactone not effective or tolerated
- Renal denervation and aprocitentan are both less effective than baxdrostat

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Doris

- Bp still too high at 155/95 and above goal
- If didn't tolerate add-on spironolactone, next add-on options would be amiloride or baxdrostat



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Enlicitide for Elevated LDL Cholesterol

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Elle Dielle

- 66 year-old woman
- Hypertension, diabetes
- Maximally tolerated statin is simvastatin 40 mg
- Myalgias to all higher intensity statin trials
- What can I add next?
- I don't want to have an MI like my father did…

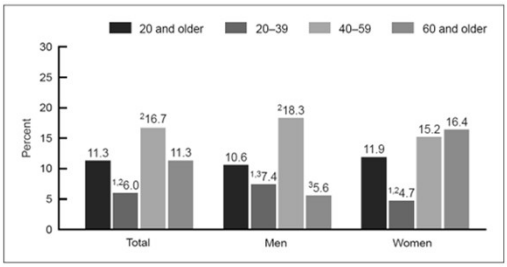


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* JASN 37: 299–311, 2026

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NHANES 2023: Prevalence of Total Cholesterol > 240 mg/dl in the U.S. Adults



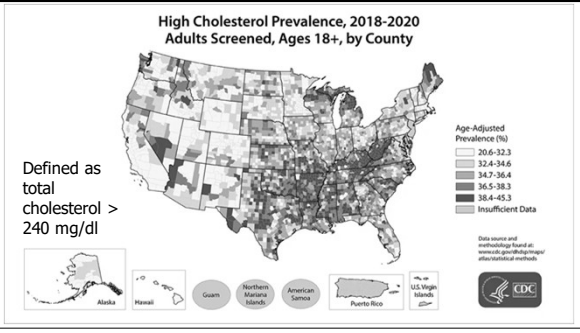
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NCHS Data Brief No. 515, Nov. 2024

45

High Cholesterol Prevalence, 2018-2020 Adults Screened, Ages 18+, by County

Defined as total cholesterol > 240 mg/dl



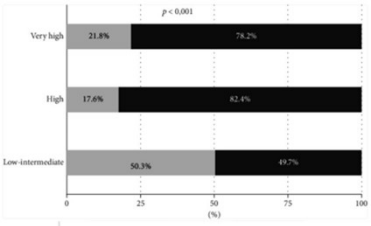
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https://www.cdc.gov/cholesterol/data-research/facts-stats/index.html

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Even in High-Risk Secondary Prevention Settings, Most Patients do not Achieve Target LDL

- 933 patients
- Drug Rx for LDL for at least 6 months
- Mean age 68 years
- 36% with DM
- 10% with known CAD
- Among high to very high risk patients, only ~20% achieved guideline based LDL target



Grey bar = % who achieved target LDL

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Cinza-Sanjurjo, et al. Cardiovasc Ther July 3, 2024

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New 2026 ACC AHA Lipid Guidelines Substantially Expand Pool of Patients Eligible for LDL Lowering Meds

- Uses PREVENT rather than PCE to estimate CVD risk
- Statin eligibility potentially now begins at age 30 years
- Return to LDL target and % reduction concept, not just statin intensity (back to the future…)
- Increased recommendation for statins from weak to moderate for borderline risk patients
- Redefine borderline risk as 3-5% 10-year CVD risk
- Low or optimal risk now < 3% 10-year CVD risk
- Overall population now eligible for statins has increased from 25% (2018 guideline) to 39% (2026 guideline)

NEW

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Circulation 2026;153:e1154
JAMA 2026;336:557

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Monoclonal Antibodies to PCSK-9



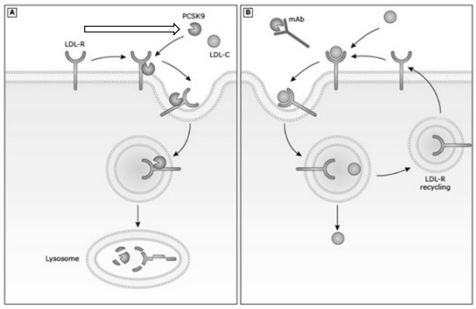
- First FDA approved in 2015
- Bind to PCSK-9 in plasma, inhibit binding of PCSK-9 to hepatic LDL receptor, increase LDL receptor expression, and lower plasma LDL levels (a very basic primer on this…)
- Slow uptake in the primary care community due to worries about unfamiliarity with biological Rx, cost, and prior authorization hurdles including eligibility requirements
- As of 2022, only 5% of PCP prescribers had ever prescribed a PCSK-9 monoclonal antibody*
- Have you prescribed one of these monoclonals yet?
- PCSK-9 based small interfering RNA injections and recombinant fusion protein injections also largely outside of the PCP realm

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* J Am Heart Assoc 2025;14:e040768

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Mechanism of Action of Monoclonal Antibodies to PCSK-9



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Source: UpToDate

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Enlicitide is a Novel Oral PCSK-9 Inhibitor



- Orally administered
- Macrocyclic peptide
- Blocks the interaction between circulating PCSK-9 and hepatic LDL receptors
- Increases receptor recycling and clearance of LDL from plasma
- Works by similar mechanism to monoclonals, but as an orally available peptide
- Has the potential to gain greater use than monoclonal injections with greater acceptance by both patients and PCPs

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CORALreef Trial: RCT of Enlicitide vs. Placebo Added to Usual Statin Care

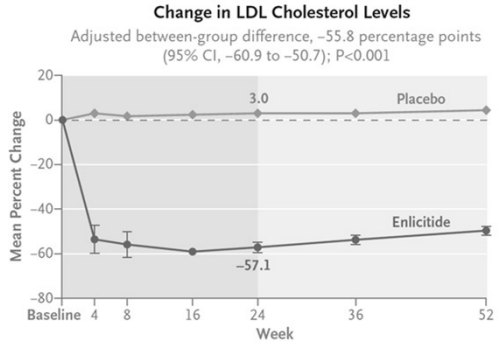
- 2909 adults
- Either a prior ASCVD event (secondary prevention) or intermediate to high risk of 1st event (primary prevention)
- LDL cholesterol ≥ 70 mg/dl despite stable dose of at least a moderate intensity statin unless documented statin intolerance
- Randomly assigned to enlicitide 20 mg qd or placebo for 52 weeks
- Primary endpoint was mean % change in LDL levels
- Also measured change in other lipid components
- Mean age 63 years, 61% male, 58% prior ASCVD event
- Trial not long enough to assess for CVD outcomes

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N Engl J Med 2026;394:529

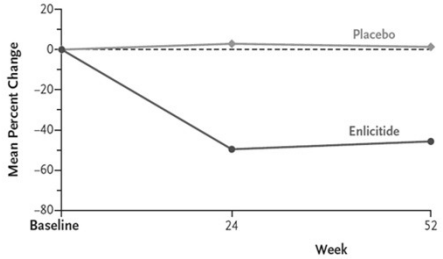
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Marked LDL Reduction by Week 4



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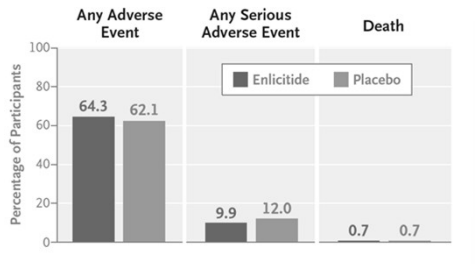
Similar Degree of Reduction in Apolipoprotein B Levels



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Overall Burden of Adverse Events Was Similar to Placebo



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Specific Adverse Events – No Statistically Significant Difference for Any Event c/w Placebo

Adverse Event	Enlicitide %	Placebo %
Any	64.3	62.1
Serious AE	9.9	12.0
Rx d/c due to AE	3.1	4.1
Death	0.7	0.7
Liver injury	0	0
New diabetes	4.1	4.2
URI symptoms	3.8	4.1
Headache	2.6	2.6
Diarrhea	2.5	2.8

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RCT#2: Enlicitide versus Other Oral Non-Statin Therapies

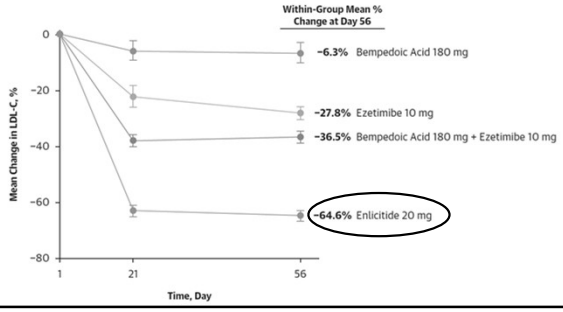
- 310 adults: all of whom were taking statins
- LDL ≥ 55 mg/dl and a prior ASCVD event
- Or LDL ≥ 70 mg/dl and intermediate to high CVD risk
- Randomly assigned to:
  - Enlicitide 20 mg qd
  - Bempedoic acid 180 mg qd
  - Ezetimibe 10 mg qd
  - Bempedoic acid plus ezetimibe
- Primary outcome mean % change LDL at 56 days

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JACC 2026;88:340

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Substantial LDL Reduction was Greatest for Enlicitide Treated Patients



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Author Conclusions

- In statin-treated adults with a history of a major ASCVD event or at increased risk for a first event, enlicitide achieved greater reductions in LDL-C, ApoB, and non-HDL-C compared with bempedoic acid, ezetimibe, and bempedoic acid plus ezetimibe.
- Enlicitide may offer a highly effective oral option for patients who require additional LDL-C lowering beyond statins to reach lipid goals.
- Broader use of effective oral LDL-C–lowering therapies could help address the global burden of the cardiovascular disease epidemic.

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Available PCSK-9 Based Drugs and Monthly Cost

Drug	Type	Typical dose	LDL Reduction	Monthly cost (WAC)
Enlicitide	Macrocyclic peptide	20 mg PO qd	55-60%	$315
Alirocumab	Monoclonal antibody	300 mg SC monthly	50-60%	$537
Evolocumab	Monoclonal antibody	420 mg SC monthly	55-60%	$876
Lerodalcibep	Recombinant fusion protein	300 mg SC monthly	55-60%	$450
Inclisiran	Small interfering RNA	284 mg SC at 0, 3 mos, then q 6 months	40-50%	$647

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Medical Letter Aug. 31, 2026

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Add-On Options if LDL Target Not Achieved with Maximal Tolerated Statin Intensity: Ranked by Effect

Drug	Route	Additional LDL Reduction	Evidence for CVD Reduction
Enlicitide	PO	55-60%	Not yet
Lerodalcibep: PCSK-9 Recombinant fusion protein	SC	55-60%	Not yet
Monoclonal antibodies to PCSK-9	SC	50-60%	Yes
Inclisiran: PCSK-9 Small Interfering RNA	SC	40-50%	Not yet
Ezetimibe	PO	18-25%	Yes
Bempedoic acid	PO	17-24%	Yes

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Other Observations

- A large (n=14,500) ongoing study will assess impact on CV outcomes
- Wait > 30 minutes after pill before eating or beverages other than water, black coffee, or plain tea
- FDA approved dose 20 mg po qd
- In a 3rd trial, similar degree of LDL reduction seen in heterozygous familial hypercholesterolemia*
- Diarrhea (7%) and dizziness (7%) reported in this trial
- In up to 1 year of use, safety profile similar to placebo
- Safety in pregnancy or during lactation are unknown
- No drug interactions known

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* JAMA 2026;335:129

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Key Points



- This is a major advance in the management of hyperlipidemia
- Monoclonals to PCSK-9 have not been widely used in PCP practice
- One of the rare instances in which a novel drug (novel formulation) is actually less expensive than alternatives
- While CV outcome data do not exist yet, the degree of LDL reduction is the most important predictor of CV benefit
- Monoclonals to PCSK-9 have shown CV risk reduction
- Enlicitide is safe and more effective than other oral add-ons to statins
- Pending guideline updates, suggest enlicitide as the preferred add-on Rx for patients whose LDL is above goal despite max tolerated statin
- Ezetimibe is an alternate option depending on the degree of LDL reduction required and cost concerns

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Elle Dielle

- I don't want to have an MI like my father did…
- How high is your LDL on simvastatin?
- So, you prefer pills?
- Either ezetimibe if 10-20% more LDL reduction required
- Or enlicitide if need more LDL reduction than that
- This won't break the bank…



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Remibrutinib for Chronic Spontaneous Urticaria

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Art E. Charya

- 34 year old man
- Recurrent disabling urticaria for several years
- Loratadine and hydroxyzine helped only a little
- Doesn't want to be on long term steroids
- Is there a new oral Rx option?



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What is Chronic Spontaneous Urticaria?

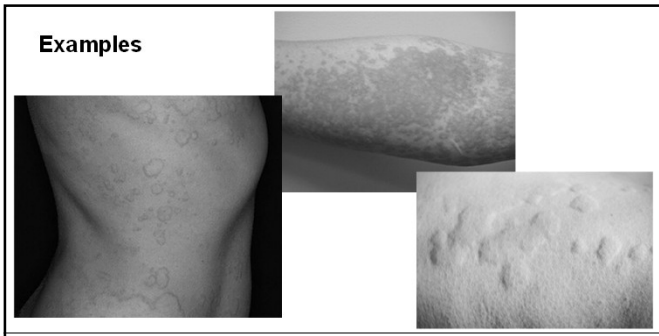


- Recurrent urticaria (hives/wheals) for at least 6 weeks
- May also be associated with angioedema
- Not due to known allergic or other cause
- Distinct and separate from physical urticaria, such as that due to heat, pressure to skin
- Individual lesions last typically for 1 to several hours
- Generally lasts for several years but can extend longer
- Estimated prevalence 1% of the U.S. population
- May be debilitating due to disruption of work, school, relationships

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Examples



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Initial Treatment

- Exclude specific etiologies (new medications, ACEi, topical products, etc)
- Avoid physical causes (topical pressure, cold, sunlight, etc) if exist
- Avoid NSAIDs, minimize alcohol use
- Non-sedating antihistamines: may use doses in excess of standard dose if tolerated
- Add H2-blocker such as cimetidine or famotidine
- Leukotriene inhibitors such as montelukast
- Add sedating antihistamine or hydroxyzine at bedtime

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Management of Refractory Chronic Spontaneous Urticaria

- Until now, next steps have typically been:
- Allergy referral
- Short courses of glucocorticoids for flares only
- Consideration of biologics such as omalizumab and dupilumab
- Biologics typically not in the realm of primary care practice
- But now, we have a new option

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Remibrutinib is a Selective Tyrosine Kinase Inhibitor

- Orally administered
- Highly selective Bruton tyrosine kinase (BTK) inhibitor
- BTK is a protein in mast cells, basophils, B cells, and macrophages
- BTK leads to intracellular signaling via specific receptors
- Remibrutinib inhibits BTK, which inhibits mast cell and basophil degranulation
- Inhibits release of histamine and inflammatory mediators of urticaria and itching mediated by IgE or IgG

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REMIX-1 and 2 Studies: Pivotal RCTs

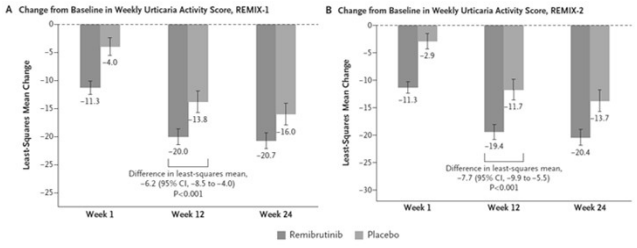
- 925 patients with chronic spontaneous urticaria
- 67% female, ~50% also with angioedema, mean duration 6 years, one third prior anti-IgE biologic trial
- Symptomatic despite non-sedating antihistamines
- 2:1 random assignment to either remibrutinib 25 mg PO bid or placebo
- Primary endpoint changes in urticaria activity scale at week 12
- Secondary endpoints were % of patients who become symptom free, and safety evaluations

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N Engl J Med 2025;392:984

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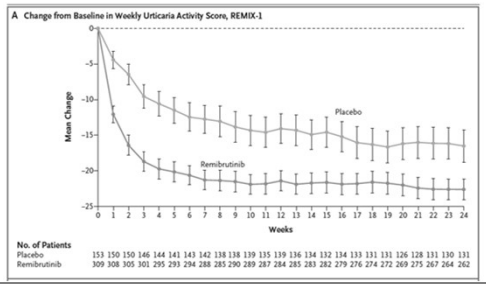
Substantial Reduction in Weekly Urticaria Activity Score in both Trials Maintained at Week 24: Strong Placebo Response



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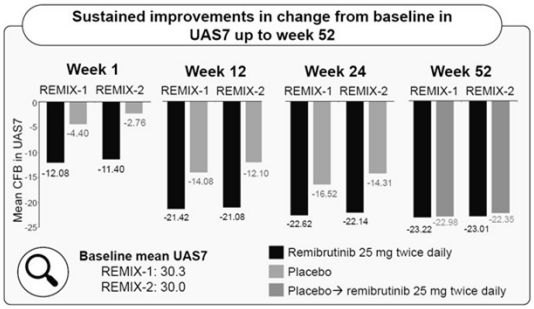
Change Over Time: Responses within 1-2 Weeks



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Sustained improvements in change from baseline in UAS7 up to week 52



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J Allergy Clin Immunol 2026; 157:143-54

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Safety Profile: Only Petechiae and Mucosal Bleeding More Common with Rx than Among Placebo

	Remibrutinib %	Placebo %
At least one AE	64.9	64.7
Serious AE	2.8	2.9
AE leading to Rx d/c	2.8	2.9
COVID-19	10.7	11.4
URI	6.6	6.2
Headache	6.3	6.2
Petechiae	3.8	0.3
Mucosal bleeding	9.0	2.0

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Other Observations

- Most petechiae were mild and transient
- No severe bleeding episodes, 0.5% d/c study due to mucosal bleeding
- No change in platelet counts, coag studies, chemistries, LFTs
- At week 24, one third of patients receiving remibrutinib had complete absence of urticaria and itch
- Placebo response thought potentially due to requirement for daily antihistamines during trial
- Equally effective across sex, racial, age, and ethnicity subgroups
- Will want more post-marketing experience with safety beyond 52 weeks but no safety signals to date

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Indirect Comparisons to Biologics: Omalizumab > Remibrutinib > Dupilumab

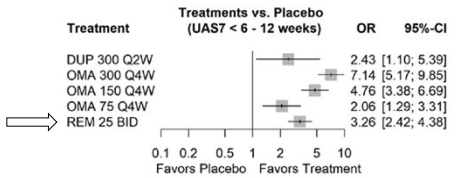


Figure 4. Forest plot depicting odds of disease control compared to placebo at week 12 of dupilumab 300 mg biweekly, omalizumab 300 mg, 150 mg, or 75 mg every four weeks, and remibrutinib 25 mg twice daily.

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J Dermatol Treatment 2025;36:1

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Cost Compared To Biologics: All are Very Expensive
(Remibrutinib would be the most expensive drug in primary care practice)

Drug	WAC cost for 30-Days
Omalizumab	$1472
Dupilumab	$3992
Remibrutinib	$4521

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Medical Letter Jan. 5, 2026

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Use in Clinical Practice



- Dose is 25 mg PO bid
- No routine lab monitoring required
- Drug interactions exist
- Avoid live vaccines while on Rx
- Should not be used if significant liver disease
- Stop 3-7 days before surgery, resume 3-7 days after surgery
- This drug is highly effective and may be preferred by patients who choose oral Rx over injectable biologics
- We can safely prescribe in primary care practice once prior auth hurdles overcome, which represent a barrier
- Manufacturer will offer cost assistance, but only if commercial insurance

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Art E. Karya

- Yes, you are a candidate for 3rd line therapy for urticaria
- Options would be remibrutinib if you prefer pills…
- Or omalizumab if you don't mind monthly injections
- Both are likely to be very effective, but your wallet may not like you…



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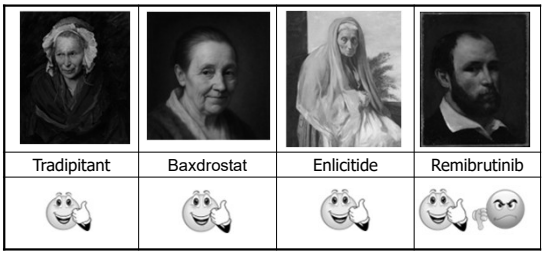
Other Recently Approved Novel Drugs that are Potentially Relevant for Primary Care

1. Centanafadine, a norepinephrine-dopamine-serotonin reuptake inhibitor and stimulant for Rx of ADD
2. Oveporexton for narcolepsy
3. Ensitrelvir for post-exposure prophylaxis to reduce the risk of COVID-19 infection
4. Orforglipron, a new oral GLP-1 RA for patients with obesity or overweight
5. Zoliflodacin for uncomplicated GC infection
6. Widaplik ®, a triple pill antihypertensive medication

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Scorecard for Our Patients



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Summary

- Tradipitant is effective for prevention of motion sickness but should be second line due to cost
- Baxdrostat is an important new option for resistant hypertension, but spironolactone should generally be tried first
- Enlicitide is a major advance and will be an important addition to add-on Rx for LDL elevation in primary care practice
- Remibrutinib is highly effective for chronic spontaneous urticaria, can cause minor bleeding, and is expensive

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A Final Thought…

"For some patients, though conscious that their condition is perilous, recover their health simply through contentment with the goodness of their physician."

Hippocrates

(460-375 BC)

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