Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS

BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE (APC)

Treatment of Moderate to Severe Ulcerative Colitis after failure of conventional therapy

This treatment pathway is applicable for use in patients whose disease has not responded to conventional therapy or who are intolerant of or have contraindications to conventional therapy as per NICE NG 130)

General Prescribing points:

- Clinicians should refer to the SmPCs for each individual drug for full prescribing information, noting that some of the drug choices offer different maintenance dosing regimens depending on the initial response to the induction therapy regimen (i.e.guselkumab, risankizumab); and some offer an extended induction regimen / re- induction regimen.(i.e. mirikizumab). – to access SmPCs click here
- Clinicians should also note ▼black triangle status where applicable.
- Always prescribe by brand name
- Biosimilar biologics, where available, are preferred over the originator brand (more cost effective)
- Switching from originator brand to a biosimilar should be carried out as per locally agreed switching protocols

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Treatment requests beyond the end of the pathway, where clinical exceptionality can be demonstrated, can be considered via the Individual Funding Request (IFR) route.

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The following organisations contribute to and participate in the BLMK APC – Bedfordshire, Luton and Milton Keynes Integrated Care Board; Bedfordshire Hospitals NHS Foundation Trust; Cambridgeshire Community Services NHS Trust; Central and North West London NHS Foundation Trust; East London NHS Foundation Trust; Milton Keynes University Hospital NHS Foundation Trust

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Bedfordshire, Luton and Milton Keynes ICS Local Commissioning Policy

Treatment of Moderate to Severe Ulcerative Colitis AFTER failure of conventional therapy

(September 2025 update, ratified by BLMK Area Prescribing Committee September 2025)

This algorithm is only applicable for use in adult patients who have failed to respond to, or who are intolerant of, or who have contraindications to, or for whom where it is deemed clinically inappropriate, to use conventional therapies (aminosalicylate, corticosteroids, thiopurines) or ciclosporin (acute exacerbation of severely active disease only) as per NICE NG 130

The choice of treatment should be made on an individual basis, taking into account individual patient factors such as therapeutic need, co-morbidities and adherence. If more than 1 treatment is suitable, the most appropriate, **least expensive** should be chosen (taking into account administration costs, dosage and price per dose). **Biosimilars# are cost-effective treatment options.**

Moderate to severe active ulcerative colitis

First line treatment options:
The most cost-effective, suitable treatment option should be chosen.
NB: TNF inhibitors are the preferred 1st line choice and are most cost effective.

TNF inhibitors (TNFi) (TA 329)
- Adalimumab# Review at 8 weeks
- Infliximab# (s/c or IV) Review at 14 weeks
- Golimumab Review at 12-14 weeks

A switch from Adalimumab to Infliximab biosimilars, or vice versa, can be undertaken (with TDM) in line with BSG IBD Guidelines.

Sphingosine 1-phosphate receptor modulator
- Etrasimod Review at 12 weeks (TA 956)

JAK inhibitors (TA 547, TA 792, TA 856)
- Tofacitinib Review at 8-16 weeks
- Filgotinib Review at 10 weeks
- Upadacitinib Review at 8-16 weeks

See MHRA advice on measures to consider before considering prescribing a JAK inhibitor.

α4β7 integrin inhibitor (TA 342)
- Vedolizumab (s/c or IV)Review at 10 weeks

Alternative first line treatment option only if TNFi is unsuitable (see note 1)

Interleukin IL-12/23 inhibitor
- Ustekinumab#(TA 633) Review at 16 weeks

Interleukin IL-23 inhibitors
- Guselkumab (TA 1094) - review at week 12 and 24 (NB: available with s/c or IV induction regimen)
- Mirikizumab (TA 925) Review at week 12 and week 24
- Risankizumab (TA 998) Review at 12 and week24

Sphingosine 1-phosphate receptor modulator (TA 828)
- Ozanimod **(only if infliximab is not suitable)** Review at 10 weeks

Acute exacerbation of severely active ulcerative colitis

Consider, in line with TA 163: **Infliximab (3 doses only).** Continued treatment indicated when criteria for moderately to severely active UC fulfilled after induction (a new funding request would be required).

Assess patient's response after 1st line treatment
If clinical response achieved (see **note 2**), follow maintenance advice (see **note 3**). Consider dose escalation if appropriate (see **page 1**).
Treatment Failure - Withdraw and move to subsequent treatment line.

Second line treatment options:
Consider changing to an alternative treatment option if:
- the patient does not respond adequately to the first treatment (primary failure)
- the patient initially responds adequately but subsequently loses this response (secondary failure)
- the first treatment cannot be tolerated or becomes contraindicated

Consider switching to an alternative drug with a different mode of action which has not yet been tried previously.

Assess patient's response after 2nd line treatment option
If clinical response achieved (see **note 2**), follow maintenance advice (see **note 3**). If treatment failure, withdraw and move to subsequent treatment line, consider switching to a drug with a different mode of action which has not yet been tried previously.

Two further treatment options with different modalities may be considered. A TOTAL OF 4 OPTIONS (3 SWITCHES) WITH DIFFERENT MODES OF ACTION per patient will be routinely commissioned – this includes treatment failure and contraindication/intolerance, but excludes an initial anti-TNF switch. Review as per 1st and 2nd line treatment options.
Treatment requests beyond the end of the pathway, where clinical exceptionality can be demonstrated, can be considered via the Individual Funding Request (IFR) route.

Note 1 – Patients unsuitable for TNFi
Proven malignancy – see ECCO Guidelines, malignant melanoma at any point, bronchiectasis, pulmonary fibrosis, multiple sclerosis, SLE, cardiac failure.

Note 2 – Adequate response
Improvement in clinical symptoms and progression towards mucosal healing.

Note 3 – Continuation of treatment
Give as a planned course of treatment until treatment fails (including the need for surgery) or until 12 months after starting treatment, whichever is shorter. Review within 12 months, and 12 monthly intervals thereafter. Continue treatment only if there is clear evidence of response as determined by clinical symptoms, biological markers and investigation, including endoscopy if necessary.
For patients in stable clinical remission, consider stopping treatment, resuming if relapse occurs.

Supporting Notes:

Specific MHRA advice:

- **JAK inhibitors** – The MHRA have issued a drug safety update (DSU) bulletin (April 2023) detailing new measures to reduce risks of major cardiovascular events, malignancy, venous thromboembolism, serious infections and increased mortality with JAK inhibitors. See **MHRA advice** on measures to consider before considering prescribing a JAK inhibitor.

Drug Specific information:

TNF inhibitors (Specific to Adalimumab & Infliximab)

- If at any point before 12 months of treatment has passed, and treatment has failed (including the need for surgery), consider TNF inhibitor drug and antibody levels to support a decision to dose escalate or switch.

Il23 Inhibitors (Guselkumab , Mirikizumab , Risankizumab)

- Initial response should be assessed at week 12. Different maintenance dose schedules are available depending on the response achieved by week 12 (see individual SmPCs for specific dosing information).
- Consideration should be given to discontinuing treatment in patients who have shown no evidence of therapeutic benefit by Week 24.

Specific to Mirikizumab:

- Patients should be evaluated after the 12-week induction dosing and if adequate therapeutic response not achieved by week 12, induction can be extended for an additional 12 weeks (300mg IV infusion for three doses, at weeks 12, 16 and 20) – this is an *extended induction therapy*. Mirikizumab should be discontinued if no evidence of response to extended induction therapy by week 24.
- Patients with loss of response during maintenance treatment may receive *re-induction therapy* (300mg IV infusion every 4 weeks, for 3 doses) to recapture response. Only 1 re-induction therapy is supported. If clinical benefit is achieved, resume S/C maintenance dosing.

Dose escalation Regimens (routinely commissioned)

adalimumab / infliximab / tofacitinib/ ustekinumab

- When response to induction and maintenance treatment but then loss of response, an attempt to recapture response with temporary period of increased dose / shortened interval between doses may be made:
  - **Infliximab** – 1 dose of 10mg/kg, or 3 doses of 5mg/kg given 4-6 weekly and then stretch back to 8 weekly (NB: Infliximab dose escalation for UC is off label use.)
  - **Adalimumab** – 40mg weekly for up to 8 weeks then stretch back to every other week
  - **Tofacitinib** – 10mg twice daily for 8 weeks then reduce back to 5mg twice daily (refer to SPC and Drug Safety Updates for restrictions for 10mg twice daily dose)
  - **Ustekinumab** – 2 doses 8 weekly, then stretch back to 12 weekly
- Consider trial of maintenance escalated dose for patients with clear objective evidence of response to escalated dose & loss of response on de-escalation to standard dose. Alternatively consider other treatment options as per the pathway. Reassess the patient after 6 months and then at least every 12 months to determine if ongoing escalated dose is still clinically appropriate. Patients without active disease in stable clinical remission should undergo a trial of de-escalation. Patients whose disease has relapsed after trial de-escalation may continue on escalated dose.

- The dose escalation regimens outlined above is based on the Hertfordshire and West Essex ICB pathway which is acknowledged with thanks.