Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS

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

Treatment of Severe Plaque Psoriasis in adults AFTER the use of standard systemic treatments has failed (in line with NICE TAs and local guidance)

Updated September 2025

Prescribing notes:

- Prescribe by **brand name** (due to availability of biosimilars#).
- If patients and their clinicians consider there to be a range of suitable treatments, the least expensive should be chosen (taking into account availability of biosimilar products#, administration costs, dosage, price per dose and commercial arrangements). Note – biosimilars# are cost-effective treatment choices.
- **Adalimumab biosimilar** is the usual first line, cost-effective, choice unless contra-indicated or the patient has a preference for oral therapy.
- **Ustekinumab biosimilar** is the most cost-effective choice when treatment with adalimumab biosimilar is unsuitable.
- **Deucravacitinib** would not be a cost-effective use of NHS resources if used when adalimumab, bimekizumab or tildrakizumab are considered to be suitable treatment options (ref NICE TA907).
- Clinicians should refer to the SmPCs for each individual medicine for full prescribing information, noting ▼black triangle status where applicable – click here to access full prescribing information.
- TNF inhibitors should be avoided in patients with any of the following co-morbidities:- Proven malignancy in last 10 years; malignant melanoma at any point; MS; Bronchiectasis; Pulmonary Fibrosis; SLE; Congestive heart failure (NYHA Class III / IV).
- Take into account how skin colour could affect the PASI score and make any adjustments needed.
- Take into account any physical, sensory or learning disabilities, or communication difficulties that could affect the responses to the DLQI and make any adjustments needed.

Adalimumab biosimilar dose escalation or interval reduction (local agreement, September 2025)

- Dose escalation or interval reduction (to 40mg weekly or 80mg every other week) can be considered for patients on adalimumab biosimilar whose psoriasis initially responds adequately but subsequently loses response (secondary failure).
- Following dose escalation or interval reduction, review within 12 weeks and consider a trial of de-escalation back to standard dose. Patients may be re-escalated and maintained on the escalated / interval reduced dose.
- NB: The increased risk of infection and other adverse drug reactions with an escalated dose should be considered.
- The dose escalation outlined above is based on the Hertfordshire and West Essex ICB pathway which is acknowledged with thanks.

Approved by BLMK Area Prescribing Committee: September 2025; Review: September 2028; Version 9

(Previous versions approved by the Bedfordshire and Luton Joint Prescribing Committee, and September 2021 and September 2023 by the BLMK Area Prescribing Committee)

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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Treatment of Severe Plaque Psoriasis in adults AFTER the use of standard systemic treatments has failed (in line with NICE TAs and local guidance), updated September 2025.

This algorithm is only applicable for use in patients who have failed to respond to, who are intolerant of, or who have contraindications to the use of all standard systemic therapies including ciclosporin, methotrexate and phototherapy*. The treatment choices available vary depending on severity of disease (as indicated in the algorithm below).

*NICE has confirmed that the TAs should be interpreted as people having tried ALL standard systemic treatment before progressing to the next stage of the pathway.

Moderate disease
Does not qualify for treatment in this pathway

Severe disease
(PASI ≥10, DLQI >10)

Yes

Very severe disease
(PASI ≥20, DLQI >18)

Yes

First line treatment options include either a biologic or an oral agent (choice is dependent on individual patient factors and patient preference). **NB Adalimumab biosimilar is the usual first line treatment choice (based on cost effectiveness), unless contra-indicated or the patient has a preference for oral therapy.**

Biologic agents (As per individual NICE TAs)

TNF inhibitors

- **Adalimumab#, TA146** Review at 16 weeks

Dose escalation or interval reduction can be considered (see prescribing notes)

- **Certolizumab pegol, TA574** Review at 16 weeks
- **Etanercept#, TA103** Review at 12 weeks

IL-12 & IL-23 inhibitor

- **Ustekinumab#, TA180** Review at 16 weeks

IL-17 inhibitors

- **Bimekizumab, TA723** Review at 16 weeks
- **Brodalumab, TA511** Review at 12 weeks
- **Ixekizumab, TA442** Review at 12 weeks
- **Secukinumab, TA350** Review at 12 weeks

IL-23 inhibitors

- **Guselkumab, TA521** Review at 16 weeks
- **Risankizumab, TA596** Review at 16 weeks
- **Tildrakizumab, TA575** Review at 12- 28 weeks

Oral agents (As per individual NICE TAs)

PDE-4 inhibitor

Apremilast, TA419 Review at 16 weeks

Tyrosine kinase 2 inhibitor

Deucravacitinib , TA907 Review at 16-24 weeks

(Only recommended in certain circumstances - see notes)

Immunomodulator

Dimethyl Fumarate (DMF) Review at 16 weeks

TA475

Consider using an alternative oral agent if appropriate

Infliximab s/c or IV# TA138, local guidance
TNF Inhibitor
Review at 10 weeks

No

Assess patient's response - have they achieved an adequate response (see **box 1**)? Withdraw if adequate response is not maintained and move to next stage in the pathway

Yes

Continue with 6-12 monthly monitoring

No

Box 1- Adequate response Either:

- a 75% reduction in the PASI score (PASI 75) from when treatment started OR
- a 50% reduction in the PASI score (PASI 50) and a 5-point reduction in DLQI from start of treatment.

Note: additional response assessment criteria are in place for tildrakizumab and deucravacitinib.

Second line biologic – CG153/local agreement (April 2019)
Consider changing to an alternative biologic medicine if:

- the psoriasis does not respond adequately to the first biologic
- the psoriasis initially responds adequately but subsequently loses this response (secondary failure)
- the first biologic drug cannot be tolerated or becomes contraindicated

Assess patient's response - have they achieved an adequate response (see box 1)? Withdraw if adequate response is not maintained and move to next stage in the pathway

Yes

No

Consider **apremilast** or **deucravacitinib** (see notes) **or dimethyl fumarate** (if not used earlier in the pathway)

No

Third line biologic - CG153/local agreement (April 2019).
Consider changing to an alternative biologic drug if any of the criteria under "second line biologic" apply.
Treatment should only be initiated following advice from a consultant dermatologist with expertise in biologic therapy.

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