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

Treatment Pathway for Active Psoriatic Arthritis (after inadequate response to DMARDs)

(Based on NICE TAs and locally agreed APC guidance)

(Updated December 2023)

General Prescribing notes

- Clinicians should refer to the SmPCs for each individual drug for full prescribing information, noting ▼black triangle status where applicable. – **click here**
- **TNF inhibitors should be avoided in patients with any of the following co-morbidities:- (∆ Specific patient population)** Proven malignancy in last 10 years; malignant melanoma at any point; MS; Bronchiectasis; Pulmonary Fibrosis; SLE; Congestive heart failure (NYHA Class III / IV).
- **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.
- Always prescribe by brand name.
- Biosimilar biologics are preferred over the originator brand (cost effective).
- Switching from originator brand to a biosimilar should be carried out as per locally agreed switching protocols.

Document history
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The following organisations contribute to and participate in the BLMK APC – Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB); 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

Treatment Pathway for Active Psoriatic Arthritis (after inadequate response to DMARDs):-based on NICE TAs and locally agreed APC guidance

Treatment Criteria:

Presence of peripheral arthritis with ≥3 tender joints (TJC) and ≥3 swollen joints (SJC) **AND** Psoriatic arthritis has not responded to adequate trials of at least 2 standard DMARDs (individually or in combination)

First line Treatment Options*:

- **TNF Inhibitor (**Adalimumab (biosimilar), Infliximab (biosimilar) s/c or IV, Etanercept (biosimilar), Golimumab, Certolizumab pegol) **+/- Methotrexate (MTX) or**
- **IL-17A inhibitor** (Secukinumab***, Ixekizumab**) **+/- MTX or**
- **Apremilast** (**+/- MTX or another oral DMARD**) **or**
- **JAK Inhibitor** ∞ (Tofacitinib **+ MTX,** Upadacitinib +/- MTX)

If a TNF inhibitor is contra-indicated / not suitable due to other co-morbidities∞
- consider IL-17A inhibitor (Secukinumab***, Ixekizumab**, Bimekizumab) +/- MTX, **or** IL-12/23 inhibitor (Ustekinumab) +/- MTX **or** JAK Inhibitor ∞ (Tofacitinib **+** MTX , Upadacitinib **+/-** MTX) **or** Apremilast (+/- MTX or another oral DMARD) **or** Guselkumab +/- MTX

∞ avoid **TNFi s** in Δ**specific patient population;** Proven malignancy in last 10 years; malignant melanoma at any point; MS; Bronchiectasis; Pulmonary Fibrosis; SLE; Congestive heart failure (NYHA Class III / IV)

∞ **JAK inhibitors have a▼**status. The MHRA have also issued a Drug safety update (DSU) regarding advice to consider before prescribing a JAKi - see **MHRA advice**

Assess Treatment Response (see Figure 1)

If adequate response achieved: Continue therapy and review every 6 months
If treatment failure or intolerance: Consider second line treatment options as stated below

Second line treatment options* in the following scenarios a) to e):

a) If previously treated with TNF Inhibitor +/- MTX AND inadequate response at 12 week review:
Consider switching to an IL-17 inhibitor (Secukinumab***, Ixekizumab**, Bimekizumab) +/- MTX **or** Ustekinumab +/- MTX **or**JAK Inhibitor ∞ (Tofacitinib **+** MTX, Upadacitinib +/- MTX) **or** Apremilast +/-MTX or other oral DMARD **or IL- 23 inhibitor (**Guselkumab , Risankizumab) +/- MTX (N.B. additional criteria for use of Risankizumab - moderate to severe psoriasis (a body surface area of at least 3% affected by plaque psoriasis and a Psoriasis Area and Severity Index [PASI] score greater than 10)

b) If previously treated with TNF inhibitor +/- MTX AND intolerance (NOT class effect) occurs within the first 12 weeks:
Consider switching to an alternative TNF inhibitor +/- MTX, **or** consider the treatment options listed in scenario '**a**'.

c) If previously treated with TNF Inhibitor+/- MTX AND inadequate response after 12 weeks:
Consider the treatment options stated in scenario '**b**'

d) If previous treatment was not a TNF Inhibitor +/- MTX, AND inadequate response after 12 weeks:
Consider switching to a TNF inhibitor +/- MTX **or** the alternate treatment options stated in scenario '**a**'

e) If TNF inhibitor is contra-indicated:
Consider IL-17A inhibitor (Secukinumab***, Ixekizumab**, Bimekizumab) +/- MTX, **or** IL-12/23 inhibitor (Ustekinumab) +/- MTX **or** JAK Inhibitor∞ (Tofacitinib + MTX, **or**, Upadacitinib +/- MTX) Apremilast (+/- MTX or another oral DMARD) **or** IL-23 inhibitor (Guselkumab , Risankizumab) +/- MTX (See above – additional criteria apply to Risankizumab)

Assess Treatment Response (see Figure 1)

If adequate response achieved: Continue therapy and review every 6 months.
If treatment failure or intolerance: Consider third line treatment options as stated below

Third and Fourth line treatment options*:

- Treat as per scenarios **a)** to **e)** stated in the 'second line treatment options' section, based on previous treatment choices.
- Consider a drug with different mode of action if failed therapy.

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

Figure 1: Biologic response assessment - Review PsARC and PASI response

Treatment review at	Drug regimen
12 weeks	Adalimumab (biosimilar), Etanercept (biosimilar), Certolizumab pegol, Golimumab, Infliximab (biosimilar), Tofacitinib, Upadacitinib
16 weeks	Secukinumab***, Apremilast Ixekizumab** Guselkumab, Risankizumab, Bimekizumab
24 weeks	Ustekinumab

Parameter	Adequate response defined as
PsARC	Improvement in ≥2 of 4 PsARC criteria ≥1 to be tender or swollen joint and no worsening in any of the 4 criteria
PASI	75% reduction in the PASI score (PASI 75) from when treatment started
N.B. If an adequate PASI 75 response is achieved but the PsARC score has not met the required threshold as stated above, consider referral to or discussion with consultant dermatologist for assessment to determine whether continuation appropriate on basis of clinical response.	

Treatment choice considerations:

* Drug with the lowest acquisition cost should be used first line if possible; this may vary from person to person because of differences in how the drugs are taken and treatment schedules, and patient/clinical factors.

**The marketing authorisation for Ixekizumab states that some patients with initial partial response may subsequently improve with continued treatment beyond 20 weeks

*** Check compliance/adherence/dose weight-adjusted? If compliant, consider increasing dose (if on 150mg dose of Secukinumab can increase to 300mg, or if >90kg with concomitant moderate to severe plaque psoriasis and on 300mg 4-weekly (Q4W) can increase to 300mg2-weekly (Q2W). If >100kg can double dose of Golimumab. Can increase Guselkumab to Q4W.

Patient/clinical factors to consider:

Axial SpA: TNFi or IL-17i or Upadacitinb
Enthesitis: TNFi (especially Certolizumab), IL-17i, Ustekinumab, Upadacitinib, IL-23 inhibitor
Dactylitis: TNFi, IL-17i, Ustekinumab, Upadacitinib,Guselkumab
Crohn's: Adalimumab, Infliximab, Ustekinumab (not IL-17i), Upadacitinib
Ulcerative Colitis: Adalimumab, Infliximab, Golimumab, Ustekinumab, Tofacitinib (not IL-17i), Upadacitinib
Severe Psoriasis: IL-17i, Ustekinumab,TNFi , IL-23 inhibitor (NB Golimumab & Tofacitinib are not licensed or NICE approved for Psoriasis). Consider discussion with Dermatology & review local Psoriasis pathway.
Uveitis: Adalimumab, has NICE TA, but data exists for Infliximab and Certolizumab
Pregnancy & Breastfeeding: Certolizumab can be used in all 3 trimesters & breastfeeding
Hydradenitis Suppurativa: Adalimumab
Needle phobic: JAKi or Apremilast
Severe depression: safety alert with Apremilast
Weight ≥ 100kg: Golimumab or Ustekinumab doses can be doubled, Secukinumab to Q2W (with concomitant moderate to severe psoriasis)
VTE/high lipids risk: caution with JAKi