Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS

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

Treatment Pathway for Moderate to Severe Atopic Dermatitis in Adults (after inadequate response to topical treatments and conventional systemic therapies)

Based on NICE Technology Appraisals

Approved by APC: September 2024

Review Date: September 2027
(Or when new evidence emerges or when new NICE guidance is published)

(Previous version – Approved by the BLMK APC in May 2023)

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 Pathway for Moderate to Severe Atopic Dermatitis in Adults (after inadequate response to topical treatments and conventional systemic therapies)

This pathway is only applicable to adult patients who have moderate to severe atopic dermatitis. This is defined as:

- An Eczema Area and Severity Index (EASI) score of ≥ 16, **and**
- Investigator's Global Assessment (IGA) score ≥ 3, **and**
- Affected body surface area (BSA) of ≥ 10%

The decision to commence a treatment following this pathway should be made by the Consultant Dermatologist responsible for the patient's care and experienced in the diagnosis and treatment of atopic dermatitis.
All treatments included in this pathway are to be used in accordance with the relevant NICE TAs (534, 681, 814, 986).

Has the patient tried the following treatments, or are these contraindicated or not tolerated?

- Emollients and topical corticosteroids (TCS) (NICE TA81, 1st line)
- Topical calcineurin inhibitors (TCI), e.g. topical tacrolimus and pimecrolimus (NICE TA82, 2nd line)
- Phototherapy (3rd line)

No → Review treatment in line with NICE TA81 and TA82.

Yes

Has the disease been unresponsive to optimised treatment with at least 1 of the following systemic immunosuppressant therapies (or these are contraindicated or not tolerated)?

Ciclosporin **Methotrexate** **Azathioprine** **Mycophenolate mofetil**

No → Consider one of the non-biologic systemic therapies listed

Yes

The choice of treatment should be made on an individual basis, taking into account individual patient factors, e.g. therapeutic need, comorbidities, adherence and previous response to treatment (see Box 1).
If more than 1 treatment is suitable, the least expensive should be chosen.
Choices listed in order of increasing acquisition cost (taking into account administration costs & dosing schedules; correct at the time of publication):

- **Abrocitinib** oral (JAK inhibitor) – SPC, TA814
- **Upadacitinib 15mg** # oral (JAK inhibitor) – SPC, TA814
- **Baricitinib** oral (JAK inhibitor) – SPC, TA681
- **Lebrikizumab** S/C injection (IL-13 inhibitor) – SPC, TA986
- **Dupilumab** S/C injection (IL-4 & IL-13 inhibitor) – SPC, TA534
- **Upadacitinib 30mg** # oral (JAK inhibitor) – SPC, TA814
- **Tralokinumab** S/C injection (IL-13 inhibitor) – SPC, TA814

(SPC = Summary of Product Characteristics; JAK = Janus Kinase; IL = interleukin) #Upadacitinib has a dose dependent acquisition cost, consider which dosing would be the more likely maintenance regimen for the patient.

Treatments can be used in conjunction with TCS and TCI (TCI restricted to sensitive areas only, e.g. the face, neck, intertriginous and genital areas).

Assess response to treatment at 16 weeks (for Baricitinib assess response from 8 weeks and at week 16).

Box 1 – Patient factors & Considerations for choice

- **JAK inhibitors** – Note safety warnings & measures from the MHRA and European Medicines Agency (EMA) to minimise risks of serious side effects with JAK inhibitors. Use with caution in patients with risk factors for VTE. JAK inhibitors should only be used if no suitable treatment alternatives are available in certain patient groups. If JAK inhibitors are needed in these patient groups, a lower dose is recommended where possible and if appropriate. If clinical features of DVT or PE occur, treatment should be discontinued regardless of dose.
- **Upadacitinib** – Use with caution in patients with diverticular disease and those on concomitant medications associated with increased risk of diverticulitis.
- **Baricitinib** – Note MHRA advice on risk of VTE and increased risk of diverticulitis particularly in patients with risk factors.
- **Dupilumab** – Note MHRA advice on risk of ocular adverse reactions and need for prompt management.
- Consider **Upadacitinib**, **Baricitinib** or **Dupilumab** if patient has another comorbidity for which one of these agents would also be suitable and licensed.

At the week 16 review, has an adequate response been achieved?
I.e. has the patient achieved the following?

- **At least a 50% reduction** in the EASI score (EASI-50) from when treatment started
  AND
- **At least a 4-point reduction** in the Dermatology Life Quality Index (DLQI) from when treatment started

Yes → Continue treatment and review patient every 6-12 months.

Continue treatment beyond 12 months only if there is clear evidence of adequate response. Review patient every 12 months thereafter. (For **Abrocitinib** and **Baricitinib**, consider dose reduction in patients who are clinically stable on treatment where appropriate.)

If loss of response, consider moving to next line of treatment with a different mode of action *.

No → If no/inadequate response **or** adverse effects/ treatment not tolerated, stop treatment and consider alternative treatment option *.

* A total of 2 lines of treatment with different modes of action per patient will be routinely commissioned. Treatment requests beyond the end of the pathway, where clinical exceptionality can be demonstrated, can be considered via the Individual Funding Request (IFR) route.