Psoriatic Arthritis (PsA) Treatment Pathway in Adults

Approved by Surrey & North West Sussex Area Prescribing Committee Feb 2019 (updated September 2019)

Patient must be treated by a specialist

AND

Have had an adequate trial of at least two standard disease-modifying anti-rheumatic drugs (DMARDs) administered either individually or in combination

AND

Have ≥ 3 tender joints and ≥ 3 swollen joints

→ Carry out pre-screen tests and advise patient on the most appropriate agent (see overleaf).

If no clear indication for a specific agent, then use the most cost-effective.

Currently this is biosimilar adalimumab or apremilast

→ **1st LINE**

START TREATMENT

Monitor patient for initial treatment period as defined by NICE TA.

For primary intolerance/adverse effects, see notes below.. Withdraw treatment if **response** is not maintained (secondary failure).

Monitor patient every 12 months ongoing

YES

Continue treatment & monitor patient every **12 months.** For primary intolerance/adverse effects, see notes below.

Withdraw treatment if response is not maintained (secondary failure).

NO

Primary failure

2nd LINE

Start treatment & monitor patient for initial treatment period as defined by NICE TA.

For primary intolerance/adverse effects, see notes below.. Withdraw treatment if **response** is not maintained (secondary failure).

Monitor patient every 12 months ongoing

Primary failure

Secondary failure or secondary intolerance—see notes below

3rd LINE

Start treatment & monitor patient for initial treatment period as defined by NICE TA.

For primary intolerance/adverse effects, see notes below.. Withdraw treatment if **response** is not maintained (secondary failure).

Monitor patient every 12 months ongoing

Primary failure

Secondary failure or secondary intolerance—see notes below

4th LINE

Requests for 4th line choice are subject to Surrey Rheumatology Network agreement or consider IFR

Secondary failure or secondary intolerance—see notes below

Initial Treatment length as defined by NICE TA

Class	Initial treatment length (weeks)
PDE4 inhibitor	16 weeks
TNFα inhibitor	12 weeks
IL17A inhibitor	16 weeks
IL-12/IL-23 inhibitor	24 weeks
JAK inhibitor	12 weeks

Continuation criteria as defined by NICE

Continue treatment only if there is an improvement in at least 2 out of 4 PsARC criteria (1 of which has to be joint tenderness or swelling score with no worsening in any of the 4 criteria). In patients whose disease has a PASI 75 response but whose PsARC response does not justify continuation of treatment should be assessed by a dermatologist to determine whether continuing treatment is appropriate.

Notes to the pathway and agreed definitions:

Primary Failure – occurs when the response criteria (as defined within the NICE TA) is not fully met when response to treatment is assessed at the time interval defined within the NICE TA. **Move to the NEXT treatment line / mode of action** (if one is available)

Secondary Failure – occurs when the response to treatment (as defined within the NICE TA) is no longer met. **Move to the NEXT treatment line / mode of action** (if one is available)

Primary intolerance/adverse effects – An occurrence that causes discontinuation of treatment, due to inability to tolerate side-effects of that treatment that occurs during the initial time period defined by the NICE TA. **Use another option from the SAME treatment line.**

Secondary intolerance/adverse effects— An occurrence that causes discontinuation of treatment, due to inability to tolerate side effects of that treatment that occurs after the initial time period defined by the NICE TA. **Move to the NEXT treatment line OR discuss at RN meeting.**

Conception –if conception plans or pregnancy indicate a change of drug is advisable, it is agreed that this does not constitute a change in line of treatment. Please update Blueteq accordingly.

When guiding on patient choice, consider the following:

Patient considerations: device, level of dexterity, frequency, route, adherence to drug.

Clinical considerations: disease characteristics, concomitant medication, IG levels, co-morbidities, antibody status, serological status (acute phase), absolute/relative contra-indications, previous history of malignancy, mode of action of chosen drug.

Drug-specific considerations: Bearing the above in mind, choose most appropriate agent from table below for patient and if no clear indication for a specific agent then use the least expensive.

The most cost-effective drugs currently for 1st line use are biosimilar adalimumab and apremilast.

Drug	Mode of action	Below are specific circumstances that may suggest the use of a specific agent. With all biologics there may a generalised increased risk of infection. In specific circumstances such as interstitial lung disease (ILD), careful assessment prior to treatment and respiratory opinion is advised regardless of chosen biologic.
***Apremilast +/- methotrexate TA 433	PDE4 inhibitor	**ONLY** routinely commissioned for use **BEFORE** other treatment options in this pathway. Not as clinically effective as the TNF alpha inhibitors. Taken orally therefore some patients may be willing to accept a certain level of reduced effectiveness.
Adalimumab TA 199	TNF alpha inhibitor	Psoriasis (TA 146), Crohn's (TA 187), Ulcerative colitis (TA 329) Hidradenitis suppurativa (TA 392) Uveitis (Level II evidence) Women of child-bearing age (compatible with first and second trimester of pregnancy Dactylitis, Enthesitis, Nail psoriasis (Level III evidence)
Certolizumab +/- methotrexate TA 445	TNF alpha inhibitor	Women of child-bearing age (compatible with all three trimesters of pregnancy (low placental transfer) Dactylitis, Enthesitis, Nail psoriasis (Level III evidence)
Etanercept +/- methotrexate TA 199	TNF alpha inhibitor	Potential risk of TB Women planning a pregnancy in near future (shortest time of discontinuation prior to conception) Consider if potential serious infection risk Dactylitis, Enthesitis, Nail psoriasis (Level III evidence)
*Golimumab +/- methotrexate TA 220	TNF alpha inhibitor	Consider if patient over 100kg (patient access to double dose) Needle phobia/compliance issues/patient convenience* Ulcerative colitis (TA 329) Dactylitis, Enthesitis (Level III evidence), Nail psoriasis (Level I evidence)
**Infliximab +/- methotrexate TA 199	TNF alpha inhibitor	Compliance issues/needle phobia** / Severely impaired manual dexterity** Ulcerative colitis (TA 329 / 140), Psoriasis (TA 134) Uveitis (Level II evidence), Dactylitis, Enthesitis (Level III evidence), Nail psoriasis (Level I evidence) Women of child-bearing age (compatible until 16 weeks of pregnancy)
*Ixekizumab +/- methotrexate TA 537	IL-17A inhibitor	Moderate to severe plaque psoriasis (TA 442) Needle phobia/compliance issues/patient convenience* **There is NO NICE TA for the use of IL-12 / IL-23 after IL-17A or vice versa**
*Secukinumab +/- methotrexate TA 445	IL-17A inhibitor	Needle phobia/compliance issues/patient convenience* (monthly maintenance dosing) Moderate to severe plaque psoriasis (TA 350), Ankylosing spondylitis (spondyloarthritis) (TA 407). **There is NO NICE TA for the use of IL-12 / IL-23 after IL-17A or vice versa**
Ustekinumab +/- methotrexate TA 340	IL-12 / IL-23 inhibitor	Only routinely commissioned for use **AFTER** TNF alpha inhibitor (unless patient contra-indicated to TNF alpha therapy) (TA 340) Needle phobia/compliance issues/patient convenience (3 monthly dosing) Psoriasis (TA 180) Dactylitis, Enthesitis, Nail Psoriasis
***Tofacitinib with methotrexate TA543	JAK inhibitor	Only routinely commissioned in line with NICE TA i.e. after use of a TNF alpha inhibitor (primary or secondary failure) or if TNF alpha inhibitors are CI. Ulcerative Colitis (TA 547)

* monthly dosing,** intravenous infusion (IV), *** oral dosing

Produced by: Surrey Rheumatology Network : March 2011 (updated Sept 2015, Nov 2016, March 2017, Jan 2019).
Takes into account NICE TA 199 / TA 433 / TA 445 / TA 220 / TA 537/ TA 340 / TA 445 / TA 543, Manchester Academic Health Science Centre (MAHSC) Harmonised biologics pathway for AS and PsA
Agreed Date: Surrey & North West Sussex APC (formerly PCN) May 2017, July 2017, Nov 2018, Feb 2019, September 2019
Review Date: Feb 2022