SBUHB Rheumatology Advanced therapy pathway for Psoriatic Arthritis

Patient has received an adequate trial of at least two standard disease-modifying anti-rheumatic drugs (DMARDs), administered either individually or in combination AND have ≥3 tender and ≥3 swollen joints.

First line: Anti TNF - adalimumab

Patient with mild disease for whom bDMARD or JAKi inappropriate, consider apremilast

If significant skin involvement consider IL17 inhibitor (Ixekizumab or secukinumab) or referral to dermatology for IL12/23 inhibitor (ustekinumab)

For anti-TNF assess PSARC at 12 weeks, for IL17 assess PSARC at 16 weeks, for ustekinumab assess at 24 weeks.

An adequate response is defined as an improvement in at least 2 of the 4 criteria (1 of which must be joint tenderness or swelling score), with no worsening in any of the 4 criteria. If inadequate PSARC response but PASI 75 response attained then discuss with dermatology.

Primary treatment failure then switch to alternative class e.g. anti-TNF to IL17 or IL12/23 inhibitor, IL inhibitor to anti-TNF.

Secondary treatment failure then switch adalimumab to Benepali, consider switch IL17 or IL12/23 to alternative IL7 inhibitor or IL23 inhibitor (e.g. guselkumab, risankizumab).

Alternatively, consider JAK inhibitor e.g. upadacitinib or tofacitinib (tofacitinib must be co-prescribed with methotrexate)- Only be use in the following patients if no suitable treatment alternatives are available: those aged 65 years or above, current or past long-time smokers, those with a hx of atherosclerotic cardiovascular disease or other cardiovascular risk factors, or those with other malignancy risk factors. Cautious use is also recommended in patients with known risk factors for VTE

NICE approved for psoriatic arthritis: TA199 adalimumab, etanercept, infliximab; TA220 golimumab; TA340 ustekinumab; TA433 apremilast; TA445 secukinumab, certolizumab; TA537 ixekizumab; TA543 tofacitinib; TA768 upadacitinib; TA815 guselkumab.

TA803 risankizumab provided 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)

SPECIAL CONSIDERATIONS

*The choice of treatment should be made after discussion between the clinician and the patient about the advantages and disadvantages of the treatments available. This may include considering associated conditions such as extra-articular manifestations, route of administration etc. If more than 1 treatment is suitable, the least expensive (taking into account administration costs and patient access schemes) should be chosen.

* An alternative first-line may be chosen in specific patient circumstances, the reason for choosing an alternative must be documented in the patient record. In particular, consider Benepali for those with higher risk of infection or TB reactivation.

Consider dose tapering the biologic in patients in persistent remission.

Sequential use of up to 4 biologics in non-responders is permissible, beyond this approval of Clinical lead required.

Prescribe drugs available as biosimilar by brand.

In secondary non-responders to anti-TNF, consider less immunogenic option (e.g.etanercepti).

February 2023. [redacted]