Approved by Hertfordshire and West Essex Area prescribing Committee

Pathway for treatment of Psoriatic Arthritis in adults.

Key to terms:
DMARD: disease-modifying anti-rheumatic drug
ILi: interleukin inhibitors that target type 17,12 or 12/23 interleukins.
JAKi: Janus kinase inhibitor
MTX: methotrexate
PASI 75 response: reduction in psoriasis area severity index (PASI) score of at least 75% from baseline
PsARC: psoriatic arthritis response criteria
TA: NICE technology appraisal
TNFi: tumour necrosis factor inhibitor

Has the patient had adequate trials of at least 2 conventional DMARDs (administered either individually or in combination)

No → Trial of conventional DMARDs

YES, but failing to respond or patient cannot tolerate or has contraindications

Does the patient have peripheral arthritis, with 3 or more tender joints **and** 3 or more swollen joints?

No → Patient does not meet pathway criteria. Use standard systemic treatments and best supportive care.

YES

1. Adalimumab biosimilar is the best value biologic and preferred 1st line
2. For every line of therapy, the least expensive appropriate treatment should be chosen
3. If treatment is not tolerated or response is inadequate consider changing to an alternative treatment from a different class.

NOTE If, however, intolerance occurs within the first 3 months, another agent from that class can be trialled prior to moving to next line.

4 If the patient has both psoriatic arthritis and psoriasis, take into account both conditions before initiating or making changes to treatment with high cost drugs. The specialty for the more severe condition would generally be expected to take responsibility for prescribing high cost drug treatment *Note tofacitinib and golimumab are not commissioned for psoriasis.*

BOX 1. First line biologic treatment options

Usually start treatment with least expensive appropriate treatment
Options listed by mechanism of action and overall cost from left to right

TNFi: Adalimumab biosimilar TA199 – usual first line choice, Etanercept biosimilar TA199, Golimumab biosimilar TA220, Infliximab biosimilar TA199, Certolizumab TA445,

IL-12 /IL-23i: Ustekinumab biosimilar TA340 **see Note 1**

JAKi: Upadacitinib TA768, Tofacitinib (with MTX) TA543

IL-17i: Secukinumab 150mg TA445, Bimekizumab TA916, Ixekizumab TA537, Secukinumab 300mg TA445 **see Note** 2

IL-23i: Guselkumab NICE TA 815 **see Note 3**

Box1.a First line apremilast

Apremilast (TA433) oral tablet

Apremilast is a clinically effective treatment compared with placebo but not as clinically effective as TNFis.
For use in patients who are needle phobic for whom JAKi (oral tablets) are not appropriate or are contra-indicated.
In line with TA433 apremilast is NOT commissioned for use after TNFi.

Assess Response. Relevant NICE TAs state that the first response should be measured at 12 weeks - 24 weeks depending on treatment modality.
Adequate response to treatment is defined as:

- improvement in at least 2 of the 4 PsARC Criteria (**see Note 4**), 1 of which must be the joint tenderness or swelling score

AND

- no worsening in any of the 4 criteria

For patients whose PsARC response does not justify continuation of treatment but who have psoriasis and a PASI 75 response, treatment should be assessed by a dermatologist to determine whether continuing is appropriate on the basis of skin response. **(See Note 5)**

BOX 2. Second line treatment options

Consider alternative treatment from a different class.
The least expensive appropriate treatment should be chosen.
TNFi listed in BOX 1 may be used second line (local agreement) also **see Note 6**

IL-12 /IL-23i: Ustekinumab biosimilar TA340

JAKi: Upadacitinib TA768, Tofacitinib (with MTX) TA543

IL-17i: Secukinumab 150mg TA445, Bimekizumab TA916, Ixekizumab TA537, Secukinumab 300mg TA445 **see Note 2**

IL-23i: Guselkumab TA815, Risankizumab TA803 **see Note 7**

Assess response as for first line. Stop treatment if adequate response not maintained / intolerance and consider next pathway step.

If treatment not tolerated, or no response or inadequate response, or loss of response move to next line in pathway#

If treatment is tolerated and there is adequate response
Maintain same treatment and monitor patient and PsARC. Clinical review to be carried out at 6-12 monthly intervals.
Stop treatment if adequate response not maintained / intolerance and consider next pathway step

BOX 3. Third, fourth- and fifth-line treatment options (TAs and local agreement)

Consider alternative treatment from a different class.
The least expensive appropriate treatment should be chosen

IL-12 /IL-23i: Ustekinumab biosimilar TA340

JAKi: Upadacitinib TA768, Tofacitinib (with MTX) TA543

I IL-17i: Secukinumab 150mg TA445, Bimekizumab TA916, Ixekizumab TA537, Secukinumab 300mg TA445 **see Note 2**
IL-23i: Guselkumab TA815, Risankizumab TA803 **see Note 7**

Assess response as for first line. Stop treatment if adequate response not maintained / intolerance and consider next pathway step.

NOTE 1: Ustekinumab biosimilar is only commissioned as a first line option if TNFi are contra-indicated.
NOTE 2: Cost order is dependent on dose :secukinumab 150mg maintenance dose is less expensive than bimekizumab and ixekizumab, secukinumab 300mg maintenance dose is more expensive than bimekizumab and ixekizumab.
NOTE 3: Guselkumab is only commissioned as a first line option if TNFi are contra-indicated.
NOTE 4: The PsARC comprises:

- A patient global self-assessment (on a 0–5 Likert scale); a physician global assessment (on a 0–5 Likert scale) with improvement defined as a decrease by at least 1 unit, and worsening defined as an increase by at least 1 unit)
- A tender joint score: a swollen joint score (with improvement defined as a decrease of at least 30%, and worsening defined as an increase of at least 30% from baseline.

NOTE 5: see local pathway and TAs103,134,146,180,350, 419,442,574,521 and 596 for guidance on the use of biologic drugs for the treatment of Psoriasis
NOTE 6: certolizumab is only commissioned second line if disease has stopped responding **after** the first 12 weeks of 1st line TNFi
NOTE 7: Risankizumab is only commissioned for patients who have had at least one biologic treatment and also have 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. If both guselkumab and risankizumab are suitable the least costly treatment should be chosen.
Local Agreement – For those on adalimumab and experiencing a loss of response, dose escalation can be considered i.e. 40 mg every week or 80 mg every other week. This should be reviewed within 12 weeks and a trial of de-escalation back to standard dose considered.

Maximum of five sequential treatments per patient are routinely commissioned.

Treatment Choice in Pregnancy and Breastfeeding– updated guidance from BSR

• Women with no/low disease activity established on a TNF inhibitor with known placental transfer (infliximab, adalimumab, golimumab) do not need to be switched to an alternative TNF inhibitor with established minimal placental transfer (certolizumab) either before or during pregnancy (GRADE 1B, Strength of agreement 100%).

• Certolizumab is compatible with all three trimesters of pregnancy, has no to minimal placental transfer compared with other TNF inhibitor, and does not require any alteration to the infant vaccination schedule (GRADE 1B, Strength of agreement 100%).

• Women considered to have low risk of disease flare on withdrawal of TNF inhibitor in pregnancy could stop infliximab at 20 weeks, adalimumab and golimumab at 28 weeks, and etanercept at 32 weeks so that a full-term infant can have a normal vaccination schedule, with rotavirus vaccination at 8 weeks as per the UK schedule (GRADE 1B, Strength of agreement 99.5%).

• Infliximab, adalimumab, etanercept or golimumab may be continued throughout pregnancy to maintain maternal disease control; in these circumstances, live vaccines should be avoided in infants until they are 6 months of age (GRADE 1B, Strength of agreement 100%).

• If a TNF inhibitor is stopped in pregnancy, it can be restarted as soon as practical post-partum in the absence of infections or surgical complications, regardless of breastfeeding status, to ensure control of maternal disease (GRADE 1C, Strength of agreement 100%).

• TNF inhibitors are compatible with breastmilk exposure (GRADE 1C, Strength of agreement 100%).

Individual patient characteristics, shared decision-making including views on live vaccinations, and treatment options should be accounted for. If a patient needs to switch to an alternative therapy due to confirmation of pregnancy, and the drug is used for a planned duration, this will not count as a new line of therapy. The drug should be reviewed post partum, to ensure the patient is on a clinically and cost-effective treatment. If a change in the live vaccination schedule is required, ensure clear communication with both the patient and primary care provider.

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Developed by	Pharmacy and Medicines Optimisation Team Hertfordshire and West Essex (HWE) ICB with relevant HWE ICS stakeholders.
Review Date	This HWE APC recommendation is based upon the evidence available at the time of publication. This recommendation will be reviewed upon request in the light of new evidence becoming available
Superseded version	V1.0 Risankizumab added up to 5th line and guselkumab criteria amended, in line with NICE TA 803 and 815 and existing pathway principles. V2.0 Bimekizumab added up to 5th line in line with NICE TA 916 and existing pathway principles. Nov 2023 V3.0 Amended to remove note 7 'reduced dose interval of 4-weekly is not routinely commissioned for guselkumab'. Wording aligned with psoriasis pathway and text box advising updates to pathway.June 2024 V4.0 Addition of ustekinumab biosimilar and corresponding adjustment of order of choice according to cost Nov 2024 V5.0 APC October 2025 updated with information from British Society of Rheumatology with use of biologics in pregnancy and breastfeeding, and to reflect introduction of golimumab biosimilar. V5.1 APC February 2026 updated to reflect that adalimumab dose escalation can be trialled in those experiencing a loss of response.

NICE recommends if patients and their clinicians consider a medicine to be one of a range of suitable treatments, the least expensive treatment should be chosen, taking into account administration costs, dosage, price per dose and commercial arrangements. Therefore, in line with this recommendation and HWE APC agreed principles the order of preference of treatments within this pathway will be updated accordingly as prices change or biosimilar medicines become available.