Use of excluded HCDs in the treatment of moderate rheumatoid arthritis in adults. Treatment pathway in line with NICE TAs 676, 715, 744 & local agreement.

Adequate trial of ≥2 conventional DMARDs in combination, including MTX (unless contra-indicated/not tolerated), with at least 2 months at standard dose, unless significant toxicity limits dose or duration?

No → Does not qualify for a high cost drug treatment

Yes ↓

Established moderate disease with a DAS-28 score between 3.2 to 5.1?

No → DAS-28
<3.2 - Does not qualify for a high cost drug treatment
>5.1- Treat as per severe RA pathway

Yes ↓

First line treatment
<u>If more than 1 treatment is suitable, the least expensive should be chosen</u>

Options listed by overall cost [including admin costs]
Usual 1st line choice:
Adalimumab (biosimilar) ± MTX (TNFi)

Alternative choices if adalimumab not suitable:

- **Filgotinib ± MTX (JAKi)**
- **Upadacitinib ± MTX (JAKi)**
- **Etanercept (biosimilar) ± MTX (TNFi)**
- **Infliximab (biosimilar) + MTX (TNFi)**

***Adequate response:** DAS28 improvement ≥0.6.

↓

Assess response by 6 months.
Adequate response achieved* and treatment tolerated?

Yes → Continue treatment with 6-12 monthly monitoring.

Stop treatment if adequate response (DAS28 improvement ≥0.6) not maintained / intolerance and consider second line treatment.

No ↓

Stop treatment if adequate response (DAS28 improvement ≥0.6) not maintained / intolerance.
Consider second line treatment with a different mechanism of action#.
Use least expensive appropriate treatment (see first line treatment box for choices and cost order).

↓

Assess response by 6 months.
Adequate response achieved* and treatment tolerated?

- If adequate response achieved* and treatment tolerated:
  Continue treatment with 6-12 monthly monitoring.
- Stop treatment if adequate response not achieved / maintained or intolerance
- If disease progresses to severe (DAS-28 >5.1) move to the severe RA pathway

#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.

Treatment requests beyond the end of the algorithm are not routinely commissioned

Biosimilars: Prescribing of biologics should be by brand. All new patients should be prescribed biosimilars in accordance with local arrangements.

Conventional DMARDS include: Methotrexate (MTX) (oral and s/c), sulfasalazine, hydroxychloroquine, penicillamine, azathioprine, leflunomide

Key: DMARDs - disease-modifying anti rheumatic drugs ; MTX – methotrexate; TNFi - tumour necrosis factor-alpha inhibitors; JAKi - Janus kinase inhibitors

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.

Version	2.1
Approved by	Hertfordshire & West Essex Area Prescribing Committee
Date approved / updated	December 2022, October 2025, February 2026
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 versions	Use of excluded HCDs in the treatment of moderate rheumatoid arthritis in adults. Treatment pathway in line with NICE TAs 676, 715, 744 & local agreement. v1 APC July 2022 December 2022. Updated to add box to note future updates as prices change or biosimilar medicines become available. APC October 2025 updated with information from British Society of Rheumatology with use of biologics in pregnancy and breastfeeding Use of excluded HCDs in the treatment of moderate rheumatoid arthritis in adults. Treatment pathway in line with NICE TAs 676, 715, 744 & local agreement. v2 APC Dec 2022 February 2026. Updated to reflect that adalimumab dose escalation can be trialled in those on both monotherapy and MTX combination therapy.

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