DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Derbyshire commissioning guidance on biologic drugs for the treatment of Rheumatoid arthritis with methotrexate

This algorithm is a tool to aid the implementation of NICE guidance on biologic drugs for the treatment of rheumatoid arthritis. It includes all of the biologic drugs approved by NICE for treatment and local variations for the commissioning algorithm.

Use standard DMARD treatment(s) for Rheumatoid arthritis

Is DAS28 score > 5.1?

No

Yes

Yes

Has the disease responded to intensive therapy with a combination of DMARDS?

No

If more than 1 treatment is suitable, the least expensive should be chosen.
Choices are listed in most cost effective order.
First line biologic agent:

- Etanercept biosimilar + MTX (TA375)

Alternative biologic can be considered if first line biologic is clinically inappropriate:

- Infliximab biosimilar + MTX (TA375) or
- Certolizumab pegol + MTX (TA375) or
- Sarilumab + MTX (TA485) or
- Golimumab + MTX (TA225, TA375) or
- Adalimumab + MTX (TA375) or
- Abatacept +MTX (TA375) or
- Tocilizumab + MTX (TA247, TA375) (as SC)
- Baricitinib + MTX (TA466) or
- Tofacitinib + MTX (TA480)

- *Rituximab + MTX (local agreement)*

Yes – consider alternative biologic agent

Has the biologic drug been withdrawn because of an adverse event?

No

Adequate response to treatment at 6 months (DAS28 score improved by ≥ 1.2)?

No

Yes – maintain same treatment and monitor patient every 6 months

If rituximab is **not** contra-indicated

- Rituximab + MTX (as per TA195) or

OR

- *Abatacept + MTX (TA195) (local agreement)*
- *Baricitinib + MTX or (local agreement)*
- *Tofacitinib + MTX (local agreement)*

If rituximab is contra-indicated

- Etanercept biosimilar + MTX (TA375) or
- Infliximab biosimilar + MTX (TA375) or
- Certolizumab pegol + MTX (TA375) or
- Sarilumab + MTX (TA485) or
- Golimumab + MTX (TA225, TA375) or
- Adalimumab + MTX (TA375) or
- Tocilizumab + MTX (TA247, TA375) (as SC)

Has the biologic drug been withdrawn because of an adverse event?

Yes

No

Adequate response to treatment at 6 months (DAS28 score improved by ≥ 1.2)?

No

Yes – maintain same treatment and monitor patient every 6 months

If rituximab is contra-indicated

- Etanercept biosimilar + MTX (TA375) or
- Infliximab biosimilar + MTX (TA375) or
- Certolizumab pegol + MTX (TA375) or
- Sarilumab + MTX (TA485) or
- Golimumab + MTX (TA225, TA375) or
- Adalimumab + MTX (TA375) or
- Abatacept +MTX (TA375) or
- Tocilizumab + MTX (TA247, TA375) (as SC)

- *Rituximab + MTX (local agreement)*
- *Baricitinib + MTX (local agreement)*
- *Tofacitinib + MTX (local agreement)*

Yes – maintain same treatment and monitor patient every 6 months

Adequate response to treatment at 6 months (DAS28 score improved by ≥ 1.2)?

No

Stop treatment

The CCG's will only commission 6 treatment options (5 switches) per patient - this includes 2 treatment failures and 1 intolerance

Local variation to NICE

NICE approved treatments

Date reviewed: October 2018
Review due: September 2020

Derbyshire commissioning guidance on biologic drugs for the treatment of Rheumatoid arthritis without methotrexate

This algorithm is a tool to aid the implementation of NICE guidance on biologic drugs for the treatment of rheumatoid arthritis. It includes all of the biologic drugs approved by NICE for treatment and local variations for the commissioning algorithm.

* *Patients who have had a proven malignancy in the last 10 years or those with significant pulmonary fibrosis may be offered rituximab instead of TNF inhibitor*

Use standard DMARD treatment(s) for Rheumatoid arthritis

Is DAS28 score > 5.1?

No

Yes

Has the disease responded to intensive therapy with a combination of DMARDS?

Yes

No

Is the patient intolerant to MTX, or is treatment with MTX considered to be inappropriate?

No

Use RA pathway **with** methotrexate

Yes

If more than 1 treatment is suitable, the least expensive should be chosen.
Choices are listed in most cost effective order for monotherapy.
First line biologic agent:

- Etanercept biosimilar (TA375)

Alternative biologic can be considered if first line biologic is clinically inappropriate:

- Certolizumab pegol (TA375) or
- Sarilumab (TA485) or
- Adalimumab (TA375) or
- Tocilizumab (TA247, TA375) (as SC)
- Baricitinib (TA466) or
- Tofacitinib (TA480)

- *Rituximab + MTX (local agreement)*

Yes – maintain same treatment and monitor patient every 6

Yes – consider an alternative biologic agent

Has the biologic drug been withdrawn because of an adverse event?

No

Adequate response to treatment at 6 months (DAS28 score improved by ≥ 1.2)?

No

If rituximab* as monotherapy is **not contra-indicated**

- *Rituximab (local agreement) or*
- *Baricitinib (local agreement)or*
- *Tofacitinib (local agreement)*

If rituximab **is contra-indicated**

- Etanercept biosimilar (TA195) or
- Certolizumab (NICE TA415) or
- Sarilumab (TA485) or
- Adalimumab (TA195) or

- *Tocilizumab (as SC) (local agreement)*

Yes - maintain same treatment and monitor patient every 6 months

Monotherapy options:

- Etanercept biosimilar (TA375) or
- Certolizumab (NICE TA415) or
- Sarilumab (TA485) or
- Adalimumab (TA375) or

- *Tocilizumab (as SC) (local agreement)*
- *Baricitinib (local agreement)or*
- *Tofacitinib (local agreement)*

Has the biologic drug been withdrawn because of an adverse event?

Yes

No

Adequate response to treatment at 6 months (DAS28 score improved by ≥ 1.2)?

No

Yes - maintain same treatment and monitor patient every 6 months

Adequate response to treatment at 6 months (DAS28 score improved by ≥ 1.2)?

No

Stop treatment

The CCG's will only commission 6 treatment options (5 switches) per patient - this includes 2 treatment failures and 1 intolerance

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Drug Intravenous therapies		NICE TA	TA details	Route	Dose
Abatacept (+MTX)	Selective T-cell stimulation modulator	NICE TA195 NICE TA375	Disease has not responded to conventional DMARDS – 1st line and May also be used if disease has not responded to a previous TNF inhibitor.	SC or IV	**SC** – 125mg once weekly **IV for pts:** <60kg – 500mg dose 60-100kg - 750mg dose >100kg - 1000mg dose Given initially at week 0, 2, and 4 and then every 4 weeks thereafter.
Adalimumab (±MTX)	Monoclonal antibody that specifically binds to TNF	NICE TA195 NICE TA375	Disease has not responded to conventional DMARDS - 1st line and Inadequate response/ intolerance to TNF inhibitor and CI/intolerance to rituximab therapy	SC	40mg every other week For monotherapy – dose may increase to 40mg per week, if patient experiences a decrease in response.
Certolizumab (±MTX)	Recombinant humanised antibody Fab' fragment against TNF alpha	NICE TA415 NICE TA375	Disease has not responded to conventional DMARDS - 1st line and Inadequate response/ intolerance to TNF inhibitor and CI/intolerance to rituximab therapy	SC	Initially 400mg given at Week 0, 2 and 4 and then 200mg every 2 weeks thereafter Or 400mg every 4 weeks, once clinical response confirmed.
Etanercept Biosimilar (±MTX)	Recombinant human TNF receptor fusion protein.	NICE TA195 NICE TA375	Disease has not responded to conventional DMARDS - 1st line and Inadequate response/ intolerance to TNF inhibitor and CI/intolerance to rituximab therapy	SC	50mg every week Or 25mg twice weekly

Golimumab (+MTX)	Monoclonal antibody that prevents the binding of TNF to its receptors.	NICE TA225 NICE TA375	Disease has not responded to conventional DMARDS - 1st line and May also be used if disease has not responded to a previous TNF inhibitor.	SC	For pts < 100kg - 50mg every month For pts >100kg - 100mg every month, if inadequate clinical response after 3-4 doses.)
Infliximab biosimilar (±MTX)	Chimeric monoclonal antibody, with high affinity to TNF.	NICE TA195 NICE TA375	Disease has not responded to conventional DMARDS - 1st line and Inadequate response/ intolerance to TNF inhibitor and CI/intolerance to rituximab therapy	IV	3mg/kg IV dose, given at week 0, 2, 6 and then every 8 weeks thereafter. If there is an inadequate response or loss of response after 12 weeks of treatment, consider increasing dose step-wise by approximately 1.5mg/kg up to a maximum of 7.5mg/kg every 8 weeks or 3mg/kg every 4 weeks
Rituximab Biosimilar (+MTX)	Chimeric monoclonal antibody – depletes B-cell population.	NICE TA195	If pt has had an inadequate response or intolerant of DMARDS and at least one TNF inhibitor.	IV	2x 1000mg given 2 weeks apart, repeated no less than 16 weeks.
Sarilumab (±MTX)	Human monoclonal antibody selective for the IL-6 receptor	NICE TA485	Active RA for pts who have had an inadequate response to DMARDs and/or 1 biological DMARD , only if they cannot have rituximab And Disease responded inadequately to rituximab and at least 1 biological DMARD	SC	200mg once every 2 weeks. Reduce the dose to 150mg once every 2 weeks for patients with neutropenia, thrombocytopenia and increased LFTS.
Tocilizumab (±MTX)	Monoclonal antibody – inhibits interleukin-6 (IL-6) receptor	NICE TA375 NICE TA247	Disease has not responded to conventional DMARDS - 1st line And	SC or IV	**SC** - 162mg once weekly (as per SPC) or **IV** - 8mg/kg every 4 weeks

			May also be used if disease has not responded to a previous TNF inhibitor and the pt cannot receive rituximab because of CI or adverse event to rituximab		For patients >100kg, doses exceeding 800mg are not recommended
Oral therapies					
Baricitinib (±MTX)	Selective JAK1 and JAK2 inhibitor	NICE TA466	Active RA for pts who have had an inadequate response to DMARDs and/or 1 biological DMARD (only if they cannot have rituximab)	PO	4mg once daily. 2mg once daily is appropriate for pts ≥75 years and over
Tofacitinib (±MTX)	Inhibitor of JAK1 and JAK3.	NICE TA480	Active RA for pts who have had an inadequate response to DMARDs and/or 1 biological DMARD (if they cannot have rituximab)	PO	5mg taken twice daily