DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Derbyshire commissioning guidance for the treatment of Psoriatic Arthritis

Use standard treatment for psoriatic arthritis including DMARDs

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

No

Yes

Yes

Is the psoriatic arthritis responding to adequate trials of at least 2 standard DMARDs (administered either individually or in combination)?

No

Does the adult have active and progressive psoriatic arthritis?

Yes

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:

- Adalimumab biosimilar (TNFi) (TA199)

An alternative biologic can be considered if first line biologic is clinically inappropriate

- Infliximab biosimilar (TNFi) (TA199) or
- Etanercept biosimilar (TNFi) (TA199) or
- Upadacitinib (±MTX) (JAK1 or JAK1/3) (TA768) or
- Tofacitinib (+MTX) (JAK1/JAK3) (TA543) or
- Guselkumab* (±MTX) (IL23) (TA815) or
- Risankizumab (±MTX) (IL23) (TA803) or
- Bimekizumab* (±MTX) ((IL17A &17F &17AF) (TA916) or
- Ixekizumab (±MTX) (IL17A) (TA537) or

(cont. after Ixekizumab)

- Secukinumab (±MTX) (IL17A) (TA445) or
- Certolizumab (±MTX) (TNFi) (TA445) or
- Ustekinumab (±MTX) (IL12/23) (TA340) or
- Golimumab (TNFi) (TA220)

- Apremilast (±DMARD) (PDE4i) (TA433) (Local variation) If the pt is needle phobic or unwilling to inject.

Yes – consider alternative biologic agent – (local agreement)

Has the biologic been withdrawn because of an adverse effect?

Yes – maintain treatment and monitor patient at appropriate intervals

No

Has there been an adequate response to treatment at the specified time (see dosing schedule table)?

No

Treatment options (listed in cost effective order) include:

- Upadacitinib (±MTX) (JAK1 or JAK1/3) (TA768) or
- Tofacitinib (+MTX) (JAK1/JAK3) (TA543) or
- Guselkumab* (±MTX) (IL23) (TA815) or
- Risankizumab (±MTX) (IL23) (TA803) or
- Bimekizumab* (±MTX) ((IL17A &17F &17AF) (TA916) or
- Ixekizumab (±MTX) (IL17A) (TA537) or

(cont. after Ixekizumab)

- Secukinumab (±MTX) (IL17A) (TA445) or
- Certolizumab (±MTX) (TNFi) (TA445) or
- Ustekinumab (±MTX) (IL12/23) (TA340)

- *Adalimumab biosimilar (TNFi)(local agreement) or*
- *Etanercept biosimilar (TNFi) (local agreement)*

or if the pt is needle phobic or unwilling to inject

- *Apremilast (±DMARD) (PDE4i)(local agreement)*

Yes – maintain treatment and monitor patient at appropriate intervals

Yes – consider alternative biologic agent – (local agreement)

Has the biologic been withdrawn because of an adverse effect?

No

Has there been an adequate response to treatment at the specified time (see dosing schedule table)?

No

Stop treatment

The ICB will only commission 4 treatment options (3 switches) per patient - this includes 2 treatment failures and 1 intolerance. JAPC recognises the RMOC statement. Further sequential use outside of the commissioning algorithm should be undertaken after advice via MDT in-line with Trust processes but is limited by clinical appropriateness and safety

Date Reviewed: November 2023
Next review date: October 2026

NICE approved treatment

Local variation to NICE

Dosing schedule

Biologic	NICE TA	Loading dose	Maintenance dose	Response measured	
Subcutaneous preparations					
Adalimumab (SC)	TA199	40mg every 2 weeks	NA	12 weeks	Monoclonal antibody that specifically binds to TNF
Bimekizumab (SC)	TA916	160mg every 4 weeks	NA	16 weeks	Bimekizumab is a humanised IgG1 monoclonal antibody that selectively inhibits IL-17F and IL17A, 17AF * Recommended only if they have had 2 conventional DMARDs and: • at least 1 biological DMARD or • tumour necrosis factor (TNF)-alpha inhibitors are contraindicated but would otherwise be considered For psoriatic arthritis patients with coexistent moderate to severe plaque psoriasis, the recommended dose is the same as for plaque psoriasis [320 mg (given as 2 subcutaneous injections of 160 mg each) at Week 0, 4, 8, 12, 16 and every 8 weeks thereafter.
Certolizumab (SC)	TA445	Week 0,2 & 4 - 400mg	200mg every 2 weeks or 400mg every 4 weeks	12 weeks	Recombinant humanised antibody Fab' fragment against TNF alpha
Etanercept (SC)	TA199	50mg once weekly	NA	12 weeks	Recombinant human TNF receptor fusion protein.
Golimumab (SC)	TA220	50mg every month >100kg in body weight, 100mg every month after 3-4 initial doses.	NA	12 weeks	Monoclonal antibody that prevents the binding of TNF to its receptors.
Guselkumab (SC)	TA815	Week 0 – 100mg Week 4 – 100mg	Every 8 weeks thereafter. For patients at high risk for joint damage according to clinical judgement, a dose of 100 mg every 4 weeks may be considered.	**Assess at 16 weeks** **Stop at 24 weeks** if PsA has not responded adequately using the Psoriatic Arthritis Response Criteria	Guselkumab is a human monoclonal antibody that binds selectively to the interleukin 23 (IL-23) protein with high specificity and affinity. Selective blockade of IL-23 normalises production of cytokines that drive inflammatory disease. * Recommended only if they have had 2 conventional DMARDs and: • have had at least 1 biological DMARD, or • tumour necrosis factor (TNF)-alpha inhibitors are contraindicated but would otherwise be considered PsARC; an adequate response is 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 PsARC response does not justify

					continuing treatment but there is a PASI 75 response, a dermatologist should decide whether continuing treatment is appropriate based on skin response.
Ixekizumab (SC)	TA537	Week 0 – 160mg For patients with moderate to severe plaque psoriasis Week 0 – 160mg Week 2 - 80mg Week 4 – 80mg Week 6 – 80mg Week 8 – 80mg Week 10 – 80mg Week 12 – 80mg	Every 4 weeks Every 4 weeks thereafter.	16 weeks	Ixekizumab is an antibody that inhibits IL-17A (interleukin-17A, a pro-inflammatory cytokine).
Risankizumab (SC)	TA803	Week 0 – 150mg Week 4 – 150mg	150mg every 12 weeks thereafter	16 weeks	Risankizumab is a humanised immunoglobulin G1 (IgG1) monoclonal antibody selective to the interleukin (IL)-23
Secukinumab (SC)	TA445	For patients with concomitant moderate to severe plaque psoriasis or patients whose disease has responded inadequately to TNF alpha inhibitors: Week 0,1,2 & 3 – 300mg For other patients: Week 0,1,2 & 3 – 150mg	Week 4 – 300mg & then continue every month. Followed by monthly maintenance dosing 150mg starting at week 4.	16 weeks	Secukinumab is a high-affinity, fully human monoclonal antibody that binds to and neutralises interleukin-17A
Ustekinumab (SC)	TA340	Week 0 & 4 - 45mg or >100kg in body weight – 90mg	Every 12 weeks thereafter.	24 weeks	Ustekinumab is a fully human monoclonal antibody that targets interleukin-12 (IL-12) and IL-23
Intravenous infusion					
Infliximab (IV)	TA199	Week 0, 2 & 6 - 5mg/kg IV	5mg/kg IV every 8 weeks thereafter	12 weeks	Chimeric monoclonal antibody, with high affinity to TNF.
Oral preparations					
Apremilast (PO)	TA433	• Day 1 - 10mg am • Day 2 - 10mg am & pm • Day 3 - 10mg am, 20mg pm • Day 4 - 20mg am & pm • Day 5 - 20mg am & 30mg pm	Day 6 and thereafter - 30mg am & pm	16 weeks	Apremilast is an oral small-molecule inhibitor of phosphodiesterase 4 (PDE4), works intracellularly to modulate a network of pro-inflammatory and anti-inflammatory mediators
Tofacitinib (PO)	TA543	• 5mg twice daily	NA	12 weeks	Inhibitor of JAK1 and JAK3. Treatment should be interrupted if a patient develops a serious infection until the infection is controlled. MHRA Oct 2021 - Tofacitinib should not be used in patients older than 65 years of age, people who are current or past smokers, or individuals with other cardiovascular (such as

					diabetes or coronary artery disease) or malignancy risk factors unless there are no suitable treatment alternatives
Upadacitinib (PO)	TA768	• 15mg once a day	• 15mg once a day	12 weeks	Upadacitinib is a selective and reversible Janus kinase (JAK) inhibitor that preferentially inhibits signalling by JAK1 or JAK1/3. Interrupt treatment if lymphopenia, neutropenia or anaemia occur; see SPC.

Adequate response - PsARC criteria

Only continue treatment if there is clear evidence of response, defined as an improvement in at least 2 of the 4 Psoriatic Arthritis Response Criteria (PsARC), 1 of which must be joint tenderness or swelling score, with no worsening in any of the 4 criteria.

Swollen joint count (3 or more)
Tender joint count (3 or more)
Patient global assessment score (on 0-5 Likert scale)
Physicians global assessment score (on 0-5 Likert scale)