NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Psoriatic arthritis (peripheral disease) (PsA) Biologic Guideline

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Greater Glasgow and Clyde Biologic Guideline: Psoriatic arthritis (peripheral disease) (PsA)

1. Eligibility

Clinical Guidelines have recently been updated for the management of peripheral psoriatic arthritis from the British Society for Rheumatology (BSR). NHS GGC clinicians follow BSR advice, but due to the addition of several new drugs since guidelines were last developed, local interpretation is required.
NICE Biologic eligibility requires:

- The person has peripheral arthritis with three or more tender joints and three or more swollen joints, **and**
- The psoriatic arthritis has not responded to adequate trials of at least two standard disease-modifying antirheumatic drugs (csDMARDs), administered either individually or in combination.
- Treatment choices should be made after discussion between the clinician and patient about the advantages and disadvantages of treatments available. This may include considering associated conditions such as extra-articuar manifestations. Treatment as described above should normally be started with the least expensive drug (taking into account drug administration costs, required dose and product price per dose). This may need to be varied for individual patients because of differences in the method of administration and treatment schedules.

2. Choice of Drug

A number of drugs with mechanisms of action and preferred positioning are available as shown in table 1:

				3rd line		
			2nd line			
		1st line				
Drug class	**TNF Blockade**	**JAK Inhibitors**	**IL-17A Blockade**	**IL-12/23 Blockade**	**PDE4 Inhibitor**	**IL-23 blockade**
Most cost effective drug in class	Amgevita - Adalimumab*	Upadicitinib	Secukinumab	Ustekinumab	Apremilast	Guselkumab Rizankizumab
Alternatives	Etanercept*	Tofacitinib	Ixekizumab			
	Infliximab IV*					
	Golimumab					
	Certolizumab					
	Infliximab s/c*					

Table 1

*Biosimilar agents are available for these originator products.

- Eligibility for the newer agents follows the same criteria as for TNF blockade outlined above in BSR guidance.
- **Starting therapy should be the most cost effective TNFi (currently biosimilar adalimumab)** given efficacy for joints, GI, eye and skin disease, and lack of superiority of other agents.
- Where TNFi is contraindicated, an alternative second line therapy should be considered.

- Where TNFi is not contraindicated but the clinician wishes to commence an alternative agent, this should progress with one of the 2nd line therapies and the rationale for expected superiority over TNFi should be documented regarding the likely advantage. (eg severe psoriasis)
- **2nd Line therapies should include an alternative TNFi (for secondary non-response), IL-17Ai, and Upadicitinib**
- **3rd line therapies include the above for 1st/2nd line and the most cost effective drug across all other mechanisms of action, noting the BSR advice regarding preference.**
- Medicine costs, inclusive of impact of any patient access schemes or discounts, are made available to the service in strict confidence to assist in identifying preferred treatment options.

3. Withdrawal

Treatment should be discontinued in people whose psoriatic arthritis has not shown an adequate response using the Psoriatic Arthritis Response Criteria (PsARC). An adequate response is defined as an improvement in at least two of the four PsARC criteria, (one of which has to be joint tenderness or swelling score) with no worsening in any of the four criteria.

However, it is recognised that PsARC is not widely used: comparable assessment tools are acceptable in assessing response

Treatment	**Time to assess response**
Etanercept, adalimumab, certolizumab, golimumab or infliximab	12 weeks
Secukinumab	16 weeks
Ixekizumab	*16-20 weeks*
Apremilast	24 weeks
Ustekinumab	28 weeks
Upadicitinib/Tofacitinib	12 weeks
Guselkumab/rizankizumab	16-24 weeks

4. Off-label dosing and drug monitoring

- A decision to prescribe a biologic drug for an approved condition but using doses that are lower than licenced doses or frequency (e.g. tapering), is a decision for the rheumatologist and patient, but may be implemented by other members of the MDT.
- Increasing the interval of dosing or dose reduction at same frequency could be considered when:

    1. patients have maintained remission/LDA for a sustained period
    2. Infection concerns have developed
    3. Tolerability/patient request

- All bDMARDS and tsDMARDS are not included in near patient testing arrangements. Responsibility for any blood monitoring remains with the prescriber.
- Use of biologic drug level monitoring (for infliximab and adalimumab) could be considered when adjusting dose, or where secondary failure has occurred to inform choice of subsequent therapy. Advice can be found at:

https://www.nhsggc.org.uk/about-us/professional-support-sites/laboratory-medicine/laboratory-disciplines/biochemistry/biological-therapy-monitoring/

Appendix 1: BSR Guidance on bDMARD/tsDMARD therapy in PsA
https://academic.oup.com/view-large/figure/371023401/keac295f1.tif