Rheumatoid Arthritis Biologic Drug Treatment Pathway

Approved by Prescribing Clinical Network Dec 2016- East Surrey CCG, Guildford & Waverley CCG, North West Surrey CCG, Surrey Downs CCG, Surrey Heath CCG, Crawley CCG and Horsham & Mid Sussex CCG

Trial of 2 oral DMARDs including combination therapy when possible (and preferably s.c. methotrexate)

Yes

Disease is severe, that is, a disease activity score (DAS28) > 5.1

Yes

Trial of most cost effective biologic treatment for 6 months – currently biosimilar etanercept* preferably in combination with methotrexate but if methotrexate contraindicated can be used as monotherapy. Tocilizumab sc is a treatment option if anti-TNF therapy is contraindicated

Yes

Adequate response- improvement in DAS 28 of ≥1.2 points at 6 months

Yes

Continue with 6 monthly monitoring. Withdraw if adequate response is not maintained (secondary failure). For stable patients follow the anti-TNF interval extension protocol.

No

Consider trial of second anti-TNF (certolizumab preferred second line anti-TNF) /sc abatacept/ sc tocilizumab

Yes

Consider trial of second anti-TNF (certolizumab preferred second line anti-TNF) /sc abatacept/ sc tocilizumab instead of rituximab. Only continue if adequate response-improvement in DAS 28 of ≥1.2 points at 6 months (3 months for certolizumab).

No

If inadequate response, trial of second anti-TNF*, sc tocilizumab or sc abatacept (preferably with methotrexate or another DMARD). Only continue if adequate response- improvement in DAS 28 of ≥1.2 points at 6 months

No

Is the patient RF/ anti-CCP antibody positive?

Yes

Trial of second anti-TNF (certolizumab preferred second line anti-TNF), sc abatacept or sc tocilizumab (preferably with methotrexate or another DMARD). Only continue if adequate response- improvement in DAS 28 of ≥1.2 points at 6 months

No

Trial of biologic treatment (choice dependent on the previous lines of biologic treatment patient received) after agreement by the Surrey Rheumatology Network: second anti-TNF, sc tocilizumab or sc abatacept (preferably with methotrexate or another DMARD). Only continue if adequate response - improvement in DAS 28 of ≥1.2 points at 6 months

Trial of DMARD

Does not qualify for biologic treatment

Continuing good response but delayed adverse effects (at any time)

OR

Has adverse effects to the TNF inhibitor chosen before response can be assessed

Trial of rituximab (preferably with methotrexate or another DMARD), for patients unable to take methotrexate certolizumab or sc tocilizumab are alternative treatment choices Treatment to be continued only if adequate response (improvement in DAS 28 of ≥ 1.2 points). Minimum treatment interval 6 months.

If rituximab contra-indicated or withdrawn due to ADR

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*Use the most cost-effective biologic (currently biosimilar etanercept) where appropriate without jeopardizing patient outcomes or efficacy. Infliximab should only be used if there are compliance problems with self-injection OR patient is unable or unwilling to self inject e.g. needle phobia, severely impaired manual dexterity

Dosage reduction or interval increase in clinically appropriate stable patients should be done gradually and tapered according to continued response: please notify the commissioner and provide update (for audit purposes only)

Golimumab is recommended as a treatment option if used as described in NICE TA130/195 (NICE TA225–June 2011). It should be considered as a treatment option for individual patients e.g. severe needle phobia

Patients who have responded to treatment with a reduction in DAS of >1.2 but who still have high disease activity (DAS ≥3.6) may progress through this pathway and can revert to their original treatment if progression through the pathway leads to worsening of disease activity.

FURTHER BIOLOGIC THERAPY OUTSIDE OF THIS TREATMENT PATHWAY IS NOT ROUTINELY FUNDED.

References