NHS
Cheshire and Merseyside

High Cost Drugs Pathway for Psoriatic Arthritis

(For predominantly axial disease refer to axial spondyloarthritis pathway)

NICE criteria for high-cost therapy for psoriatic arthritis (PsA): peripheral arthritis with three or more swollen* and three or more tender joints; failure of at least two disease modifying antirheumatic drugs (DMARDs) including methotrexate if not contraindicated or unsuitable. Note: if not contraindicated, consider leflunomide and methotrexate in combination.

Drug selection based on individual characteristics: including psoriasis severity, axial disease, co-morbidities, inflammatory bowel disease and contraindications (see box 1).

If more than one treatment is suitable choose the least expensive.

Adalimumab[1] (£); certolizumab[2] (£££); etanercept[1] (££); golimumab[3] (£££); infliximab[1] (SC ££/IV £££); secukinumab[2] (££/£££ dose dependant); ixekizumab[4] (£££); apremilast[5](££); tofacitinib[6] (££)

Consider certolizumab in women considering conception or breastfeeding.

OR

If tumour necrosis factor -α antagonist (TNFi) has failed or is contraindicated: ustekinumab[7] (£/££); upadacitinib[8] (££); guselkumab[9] (£££); bimekizumab[10] (£££)

If at least 1 biological DMARD has failed and psoriasis is moderate to severe (BSA> 3% and PASI score > 10): risankizumab[11] (£££)

Assess response to treatment at 12-16 weeks or as recommended by NICE guidance (see box 2)

Is there an adequate response to treatment?: improvement in at least two of the four PsARC criteria (one of which has to be the joint/dactylitis tenderness or swelling score) and no worsening in any of the four PsARC criteria?

No

PsA inadequate joint/dactylitic response: does the patient have a skin response that would warrant continuation of drug?

Yes

Continue treatment on the basis of the skin response in line with NICE guidance (NICE TA103, TA134, TA146, TA180 & TA445)

Yes

Maintain same treatment and reassess every 6-12m. **If skin continues to be problematic referral to dermatology MDT**

Secondary loss of efficacy or intolerance.

No

Switch - aiming for change in mode of action in secondary inefficacy to an alternate agent from above list.

*areas of dactylitis should be included in the swollen joint count where appropriate

Box 1

Drug selection based on individual patient characteristics: including psoriasis severity, axial disease, co-morbidities, inflammatory bowel disease and contraindications.
If severe skin disease (e.g., PASI > 10) or areas of high impact (face, groin, hands, feet) consider referral to dermatology for MDT.
Axial disease: TNFi, bimekizumab, secukinumab, ixekizumab, upadacitinib and guselkumab
Psoriasis skin disease: bimekizumab, ustekinumab, interleukin (IL) 17i and guselkumab
IBD: MAB TNFi and JAKi, - note: aim to avoid IL17i
Uveitis: MAB TNFi

Box 2

Assessment of efficacy:
TNFi, tofacitinib: 12 weeks
Ustekinumab: 24 weeks (skin at 16 weeks)
Bimekizumab, secukinumab, ixekizumab, risankizumab, guselkumab and apremilast: 16 weeks

Box 3

Allow "switching" between agents in case of initial or subsequent agent failure as follows:
Primary inefficacy – can consider an alternative within mode of action
Secondary inefficacy – another approved high cost drug may be used. Where secondary failure of efficacy may be a class effect, use another drug from an alternative drug class. Avoid using more than two TNFi agents unless involvement of anti-drug antibodies is the cause of failure.
Adverse effect – another approved high cost drug may be used. Where adverse effect may be a class effect use another drug from an alternative drug class.

Box 4

£/££/£££ indicates price bracket of maintenance treatment (excluding loading dose).
Costs for infusions vary due to administration costs and supply mechanism (e.g. external supplier costs).
Infusion costs are inclusive of VAT.
The estimated cost assumes that a biosimilar will be used where available.

References

1. NICE TA199 (2010) Etanercept, infliximab and adalimumab for the treatment of psoriatic arthritis
2. NICE TA445 (2017) Certolizumab pegol and secukinumab for treating active psoriatic arthritis after inadequate response to DMARDs
3. NICE TA220 (2011) Golimumab for the treatment of psoriatic arthritis
4. NICE TA537 (2018) Ixekizumab for treating active psoriatic arthritis after inadequate response to DMARDs
5. NICE TA433 (2017) Apremilast for treating active psoriatic arthritis
6. NICE TA543 (2018) Tofacitinib for treating active psoriatic arthritis after inadequate response to DMARDs
7. NICE TA340 (2015) Ustekinumab for treating active psoriatic arthritis
8. NICE TA768 (2022) Upadacitinib for treating active psoriatic arthritis after inadequate response to DMARDs
9. NICE TA815 (2022) Guselkumab for treating active psoriatic arthritis after inadequate response to DMARDs
10. NICE TA916 (2023) Bimekizumab for treating active psoriatic arthritis
11. NICE TA803 (2022) Risankizumab for treating active psoriatic arthritis after inadequate response to DMARD