Dorset Medicines Advisory Group

The use of biologic agents (including biosimilars) for rheumatoid arthritis in Dorset

Background to the Pathway
Patients with active rheumatoid arthritis (RA) are eligible for a first biologic treatment when the following criteria are met: • The disease is severe, that is, a disease activity score (DAS28) greater than 5.1 **and** • Their disease has not responded to intensive therapy with a combination of conventional disease-modifying antirheumatic drugs (DMARDs)
Assessment and review
• Treatment with biologic therapies at any stage in the pathway should only continue if there is at least a moderate response measured using European League Against Rheumatism (EULAR) criteria at 6 months after starting therapy. • After initial response, all treatment should be monitored at appropriate regular intervals with assessment of response. Treatment should be withdrawn if a EULAR moderate response is not maintained.
1st Line Biologic (in accordance with NICE TA 375)
TNF-inhibitors, Tocilizumab and Abatacept are all considered appropriate 1st line biologics for treating RA. Adalimumab, Etanercept, Certolizumab pegol and Tocilizumab can be used as monotherapy. Clinicians should start treatment with the most cost-effective drug (including biosimilar options where they are available). In addition to administration costs, dosing, and product price, the decision regarding which biologic/biosimilar to prescribe should take into account clinically relevant co-morbid conditions and the specific risks/ benefits of the chosen treatment. Patient preference regarding mode of administration and treatment schedules should also be considered. In certain circumstances it may be appropriate to use rituximab as a 1st line biologic, particularly in patients who have an absolute or relative contra-indication to other available biologics.
2nd Line Biologic (in accordance with NICE TAs 195, 225, 247)
Generally, class-switching should be preferred when deciding on a 2nd line biologic taking into account relevant clinical and patient-specific factors. Where no significant clinical or patient factors exist rituximab should be the default second-line biologic. <u>Points to consider:</u> • Usually, a second TNF-inhibitor should not be considered for patients who did not respond to a 1st TNF-inhibitor (primary failure). A second TNF-inhibitor can be considered for patients who have experienced sustained benefit from a 1st TNF inhibitor but lose efficacy over time (secondary failure)**.**
Subsequent Biologic Therapy
Class-switching should be preferred for subsequent lines of biologic therapy. All classes of biologics can be considered.