Rheumatoid Arthritis Biologic Drug Treatment Pathway

Approved by Prescribing Clinical Network Sept 2014- East Surrey CCG, Guildford & Waverley CCG, North West Surrey CCG, Surrey Downs CCG, Surrey Heath CCG, North East Hamp & Farnham CCG, Crawley CCG

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**Trial of 2 oral DMARDs (and preferably s.c. methotrexate)**

Yes → **DAS 28 score >5.1 confirmed on at least 2 occasions at least 1 month apart (NOTE: certolizumab is the preferred first-line choice) consider sc tocilizumab** if pt unable to take methotrexate

No → **Trial of DMARD**

Yes → **Trial of TNF inhibitor** / sc tocilizumab** for an initial 3 months for certolizumab (6 months for other TNF-inhibitors / tocilizumab).

# See rituximab option if TNF inhibitor is contraindicated

No → **Continuing good response but delayed adverse effects (at any time)**

**OR**

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

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**Adequate response- improvement in DAS 28 of ≥1.2 points at 6 months (3 months for certolizumab)?**

Yes → Continue with 6 monthly monitoring. Withdraw if adequate response is not maintained (secondary failure). If DAS score ≤2.5 on 2 consecutive occasions 3 months apart then it would be appropriate to consider increasing the dosing interval / decreasing the dose of the anti-TNF

No → **Consider trial of second anti-TNF*/sc abatacept/ sc tocilizumab** instead of rituximab (if not already tried)

Only continue if adequate response- improvement in DAS 28 of ≥1.2 points at 6 months (3 months for certolizumab).

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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 (3 months for certolizumab).

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**Is the patient RF/ anti-CCP antibody positive?**

No → **Trial of second anti-TNF** (consider certolizumab as preferred choice if hasn’t been used 1st line or etanercept as second line preferred choice) or sc abatacept

Yes → **Trial of rituximab** (note Hep B screening & preferably with methotrexate or another DMARD) for patients unable to take methotrexate a second line anti-TNF / 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.

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**If rituximab contra-indicated or withdrawn due to ADR**

**Trial of a second TNF inhibitor**, 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 (3 months for certolizumab).

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**Trial of 4th line 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 (3 months for certolizumab).
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*Use the most cost-effective anti-TNF drug (currently certolizumab) 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

# Patients with contraindications to anti-TNF therapy (e.g. those who have had a proven malignancy in the last 10 years or those with multiple sclerosis) may be offered rituximab as first-line biologic treatment instead if there are no contraindications.

**Subcutaneous tocilizumab is the preferred route of administration. For patients with poor dexterity IV tocilizumab is a treatment option – appropriate facilities must be available for administration. A case of fatal anaphylaxis has been reported in a patient treated with tocilizumab. Healthcare professionals are advised to be vigilant for signs of hypersensitivity or anaphylaxis in all patients receiving the drug, both during and following its administration. Appropriate treatment should be available for immediate use in the event of an anaphylactic reaction during treatment. If anaphylaxis or any other serious hypersensitivity/infusion reaction occurs, treatment should be stopped immediately, appropriate medical management initiated and tocilizumab permanently discontinued.

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