Moderately to Severely Active Ulcerative Colitis Biologic Pathway

NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

NICE criteria for initiation: Patients with moderately to severely active UC, whose disease has responded inadequately to conventional therapy (including corticosteroids/ mercaptopurine/azathioprine), or who cannot tolerate, or have medical contraindications for such therapies.

1ST LINE TREATMENT OPTIONS

Adalimumab biosimilar is the least expensive and preferred 1st line option. Vedolizumab can be used 1st line, however in practice it is anticipated that an anti-TNF will be trialled first unless otherwise inappropriate. NICE recommends if more than one treatment is suitable the least expensive should be chosen.

TA329

Adalimumab (TNF inhibitor) BIOSIMILAR (prescribe by brand) S/C 160mg loading then 80mg week 2 then 40mg every 2 weeks. Review week 12. blueteq

TA329

Infliximab (TNF inhibitor) BIOSIMILAR (prescribe by brand) IV 5mg/kg at 0, 2, and 6 weeks then either IV every 8 weeks or S/C 120mg every 2 weeks. Review week 12 to 14. Prescribe with immunosuppressant. blueteq

2ND LINE TREATMENT OPTIONS

NICE does not make any specific recommendations regarding sequential use of anti-TNFs for UC. The greatest evidence base for 2nd line anti-TNFs relates to adalimumab. Infliximab & golimumab as 2nd line treatments should be reserved for those patients who have had adalimumab as a 1st line anti-TNF ONLY. Ustekinumab or Vedolizumab may be a suitable alternative for patients who experience intolerance, primary or secondary failure to anti-TNF. Use of an Anti-TNF as a 3rd line biologic for patients who have experienced treatment failure or intolerance to a 2nd biologic is not recommended.

TA329

Alternative TNF inhibitor Adalimumab OR Infliximab OR Golimumab (TNF inhibitor) < 80mg/kg 200 mg s/c wk 0, then 100 mg at wk 2, then 50 mg every 4 wks. >80mg/kg mg, 200mg wk 0 then 100 mg at wk 2, then 100 mg every 4 wks. Review week 12 to 14. blueteq

TA633

Ustekinumab (IL12 & IL23 inhibitor) BIOSIMILAR IV loading then 90mg s/c at wk 8 then every 8 or 12 wks. Review week 16 blueteq

≤55kg	260mg	2 vials of 130mg
> 55 kg to ≤ 85 kg	390mg	3 vials of 130mg
> 85 kg	520mg	4 vials of 130mg

TA342

Vedolizumab IV 300mg at week 0, 2 and 6 then every 8 weeks or S/C 108 mg once every 2 weeks as maintenance following IV loading. Review week 14 to 16 blueteq

3RD LINE TREATMENT OPTIONS

To be used when alternative options contraindicated, or patient has experienced inadequate/lost response or intolerance to 1st and 2nd line options. Recommended by NICE only when treatment with a TNF inhibitor has failed, cannot be tolerated or is contraindicated.

TA925

Mirikizumab (IL23 inhibitor) IV loading 300mg at week 0, 4 and 8. Maintenance: 200mg S/C every 4 weeks. Review week 12. If inadequate response IV induction may be extended to week 12, 16 and 20. blueteq

TA998

Risankizumab (IL23 Inhibitor) 1200mg IV week 0, 4 and 8 followed by 180mg or 360mg SC at week 12 and every 8 weeks thereafter. Review week 12. blueteq

ORAL TREATMENT OPTIONS

Can be used PRE or POST biologics

Choice will be driven by patient factors e.g. co-morbidities, age, pregnancy, alongside any previously tried therapies, including lost response or intolerance. Where a range of suitable options is available the least expensive should be chosen.

TA792

1st line – treatment naïve

Filgotinib (JAK inhibitor) 200mg once daily. Review week 10, the induction dose may be extended for an additional 12 weeks (total 22 weeks). Not rec > age 75 yrs. MHRA update blueteq

TA828

Ozanimod (S1P agonist) For anti-TNF naive patients ozanimod should only be offered if infliximab unsuitable. 0.23mg once daily days 1-4 , then 0.46mg once daily days 5-7 , then 0.92mg once daily day 8 and thereafter. Review week 10. Baseline ECG required blueteq

TA856

1st line – treatment exposed

Upadacitinib (JAK inhibitor) 45mg once daily for 8 wks, induction dose may be extended for a further 8 wks if required. Review week 16. Maintenance dose 15-30mg once daily. Age> 65 yrs 15mg once daily. MHRA update blueteq

TA547

Tofacitinib (JAK inhibitor) 10mg twice daily for 8 wks, induction dose may be extended for a further 8 wks if required. Review week 16. Maintenance dose 5mg twice daily. MHRA update blueteq

TA956

Etrasimod (S1P agonist) 2mg once daily. Review week 12. Baseline ECG required blueteq

NICE criteria for continuation: Therapy should be given as a planned course of treatment until treatment failure (including the need for surgery) or until 12 months after starting, whichever is shorter, then discuss the risks and benefits of continued treatment. Continue treatment only if there is clear evidence of response as determined by clinical symptoms, biological markers and endoscopy if necessary. Reassessed at least every 12 months to determine whether ongoing treatment is still clinically appropriate. Consider a trial withdrawal for all patients who are in stable clinical remission. People whose disease relapses have the option to start treatment again.

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Oct 2024

Crohn's Disease Biologic Pathway

NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

NICE criteria for initiation: Patients with severe active CD, which has responded inadequately to conventional therapy (steroids, 5-ASA, immunosuppressant) or who cannot take/tolerate or have medical contraindications for these are eligible for treatment with a biologic. Severe CD is defined as very poor general health & 1 or more symptoms e.g. weight loss, fever, severe abdominal pain and usually frequent (3–4 or more) diarrhoeal stools daily. This normally, but not exclusively, corresponds to a Crohn's Disease Activity Index (CDAI) score of 300 or more, or Harvey- Bradshaw score of 8 to 9 or more.

1ST LINE TREATMENT OPTIONS

Adalimumab biosimilar is the least expensive and preferred 1st line option. Ustekinumab can be used 1st line, however in practice it is anticipated that an anti-TNF will be trialled first unless otherwise inappropriate. NICE recommends if more than one treatment is suitable the least expensive should be chosen (taking into account drug administration costs, required dose and product price per dose).

TA187

Adalimumab (TNF inhibitor) BIOSIMILAR (prescribe by brand) S/C 160mg loading then 80mg week 2 then 40mg every 2 weeks. Review at week 12 bluteq

OR

TA187

Infliximab (TNF inhibitor) BIOSIMILAR (prescribe by brand) IV 5mg/kg at 0, 2, and 6 weeks then either IV every 8 weeks or S/C 120mg every 2 weeks. Review week 12 to 14. Prescribe with immunosuppressant. bluteq

2ND LINE TREATMENT OPTIONS

NICE does not make any specific recommendations regarding sequential use of anti-TNFs. For patients who experience intolerance, secondary failure or primary failure with a 1st Anti-TNF, a 2nd approved Anti-TNF may be tried. Ustekinumab may be a suitable alternative for patients who experience intolerance, primary or secondary failure to anti-TNF.

TA187

Alternative TNF inhibitor – Adalimumab **OR** Infliximab BIOSIMILAR. Review week 12 to 14. bluteq

OR

TA456

Ustekinumab (IL12 & IL23 inhibitor) BIOSIMILAR IV loading then 90mg s/c at week 8 then every 8 or 12 wks. Review week 16. bluteq

≤55kg	260mg	2 vials of 130mg
> 55 kg to ≤ 85 kg	390mg	3 vials of 130mg
> 85 kg	520mg	4 vials of 130mg

3RD LINE TREATMENT OPTION

To be used when alternative options contraindicated, or patient has experienced inadequate/lost response or intolerance to 1st and 2nd line options. Use of an Anti-TNF as a 3rd line biologic for patients who have experienced treatment failure or intolerance to a 2nd biologic is not recommended.

TA905

Upadacitinib (JAK inhibitor) **Oral option** 45mg once daily for 12 wks. Review at 12 wks. Maintenance dose 15-30mg once daily. Age> 65 yrs 15mg once daily. MHRA update bluteq

OR

TA352

Vedolizumab IV 300mg at week 0, 2 and 6 then every 8 weeks or S/C 108 mg once every 2 weeks as maintenance following IV loading. Review week 14 to 16 bluteq

OR

TA888

Risankizumab (IL23 Inhibitor) 600mg IV week 0, 4 and 8 followed by 360mg SC at week 12 and every 8 weeks thereafter. Review at week 12. bluteq

NICE criteria for continuation: Treat for 12 months or until treatment failure (including the need for surgery), whichever is shorter, then review and discuss the risks and benefits of continued treatment. Continue only if there is evidence of response as determined by clinical symptoms, biological markers and investigation, including endoscopy if necessary. Reassess at least every 12 months to determine whether ongoing treatment is still clinically appropriate. Consider a trial of withdrawal for patients who are in stable clinical remission. If disease relapses after treatment is stopped patients should have the option to start treatment again.

Use of Biologics Post Surgery: Routine use of biologics as post-surgery prophylaxis in CD is not recommended (insufficient evidence). In patients at high risk of recurrence (e.g. more than one resection, or penetrating or fistulising disease), prophylaxis with thiopurine should be considered where appropriate. An approved biologic may be considered in these high-risk patients upon recurrence, or if thiopurine treatment is not tolerated

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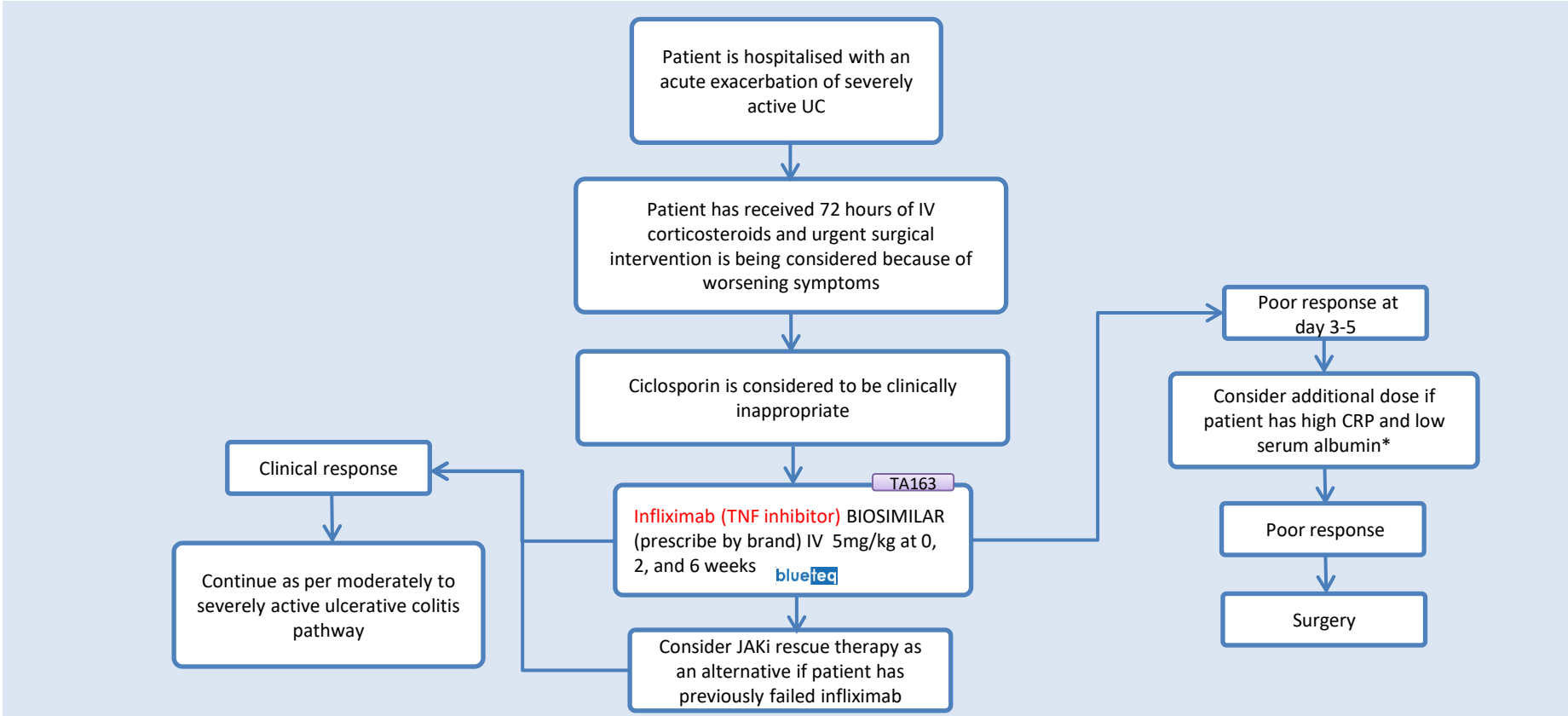
Oct 2024

Acute Exacerbation of Severely Active Ulcerative Colitis Biologic Pathway

NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

NICE criteria for initiation: An acute exacerbation of severely active ulcerative colitis requires hospitalisation and urgent consideration for surgery and is defined by the following symptoms (Truelove & Witts) • Bowel movements > 6 plus at least one of the features of systemic upset (marked with *) • Blood in stools – visible blood • *Pyrexia (temperature greater than 37.8C) • *Pulse > 90 bpm • *Anaemia < 10g/100ml • *ESR > 30 mm/hr.



Acceleration & Continuation

*Patients who are not responding sufficiently to a 5mg/kg dose of infliximab **after 3–5 days can be treated with an early repeat infusion at week 1**, particularly in those with a low albumin (below 35g/L). Some clinicians use an initial 10mg/kg dose as salvage therapy but there is as yet insufficient data to demonstrate the value of this in comparison to a 5mg/kg dose. Accelerated dosing should only be given after colorectal surgical review, with agreement that colectomy is not required imminently. BSG IBD Guidelines 2019

Continue as per moderately to severely active ulcerative colitis criteria only if there is evidence of response as determined by clinical symptoms, biological markers and investigation. Review post induction at weeks 12-14.

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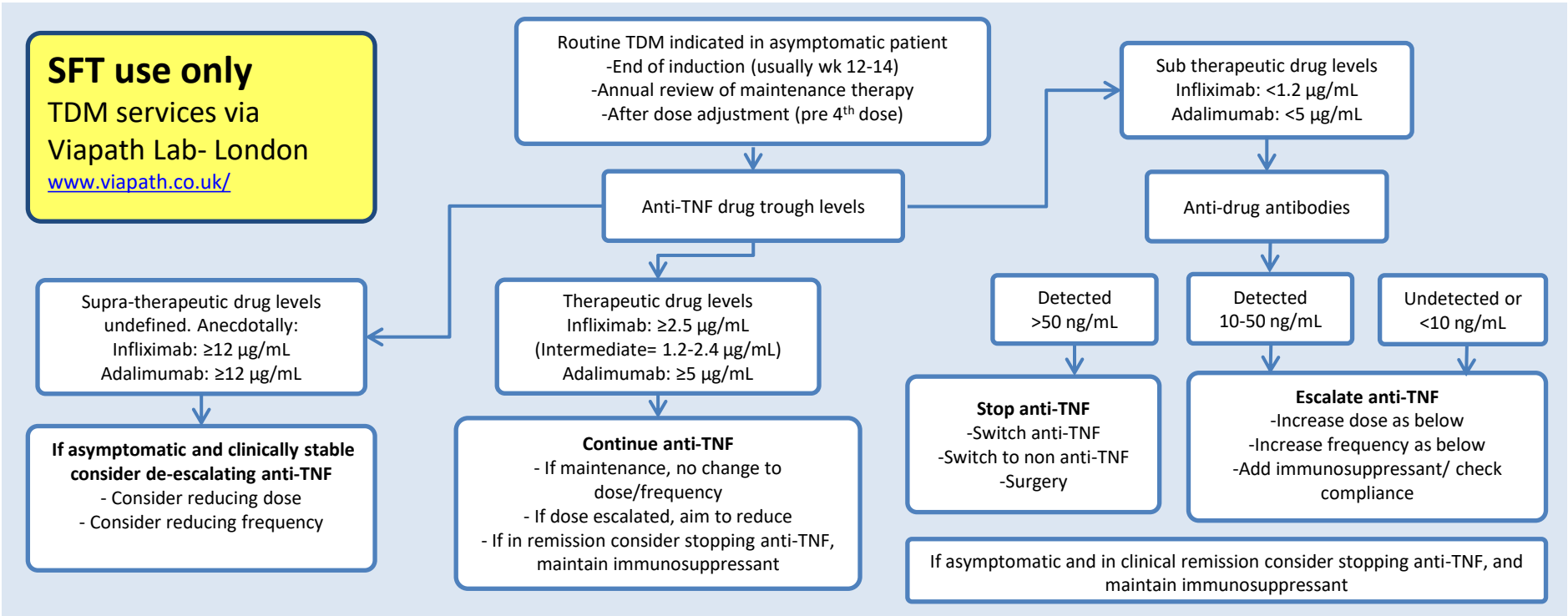
Proactive IBD TDM – Post-induction /maintenance review of anti-TNF therapy

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Therapeutic Drug Monitoring (TDM) is a helpful tool for optimising the use and effectiveness of TNF inhibitors and can identify patients in whom it may be possible to reduce or even withdraw anti-TNF biologic treatment without adversely affecting clinical outcomes. Results should be interpreted alongside other relevant clinical findings and assessments to aid clinical decision making, evidence for clinical management based on TDM results alone has not been established. Please note that in the presence of therapeutic drug levels, free anti-drug antibody cannot be detected and therefore its measurement is not indicated.



Trial Dose Escalation:
For patients who have responded to induction and maintenance treatment regime but then lost response, the following temporary dose escalations may be indicated in an attempt to recapture response:

Drug	Standard dosing	Commissioned dose escalation
Adalimumab	40mg every 2 weeks	40mg every week or 80mg every 2 weeks
Infliximab	5mg/kg every 8 weeks	5mg/kg every 6 weeks or 10mg/kg every 8 weeks or 10mg/kg every 6 weeks (off licence) No dose escalation for S/C
Ustekinumab	90mg every 8 or 12 weeks	90mg every 6 weeks (off licence) (On MDT agreement) Blueteq dose escalation form required
Vedolizumab	300mg IV every 8 weeks	300mg IV every 4 weeks (On MDT agreement) Blueteq dose escalation form required. No dose escalation for S/C

NB. Dose escalations not listed above are not routinely commissioned and therefore require an IFR.

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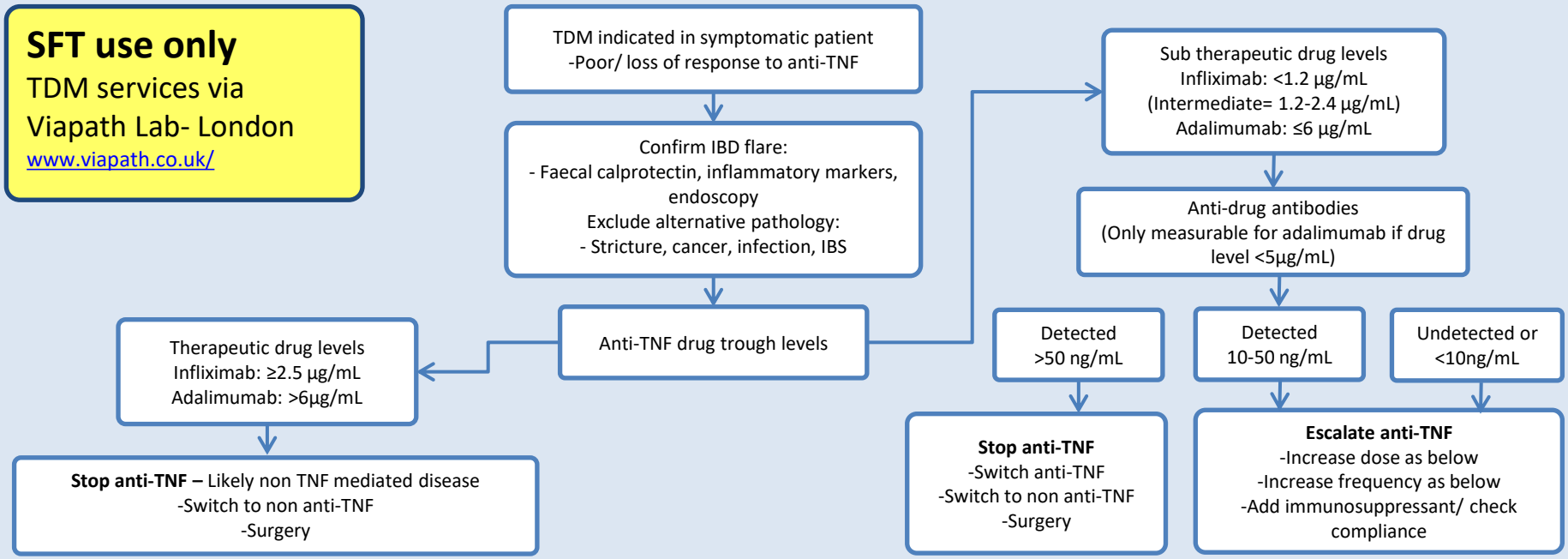
Oct 2024

Reactive IBD TDM - Poor response or loss of response to anti-TNF therapy

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Therapeutic Drug Monitoring (TDM) is a helpful tool for optimising the use and effectiveness of TNF inhibitors and can identify patients in whom dose escalation may benefit clinical outcomes and help recapture response to treatment. Results should be interpreted alongside other relevant clinical findings and assessments to aid clinical decision making, evidence for clinical management based on TDM results alone has not been established. Please note that in the presence of therapeutic drug levels, free anti-drug antibody cannot be detected and therefore its measurement is not indicated.

SFT use only
TDM services via
Viapath Lab- London
www.viapath.co.uk/



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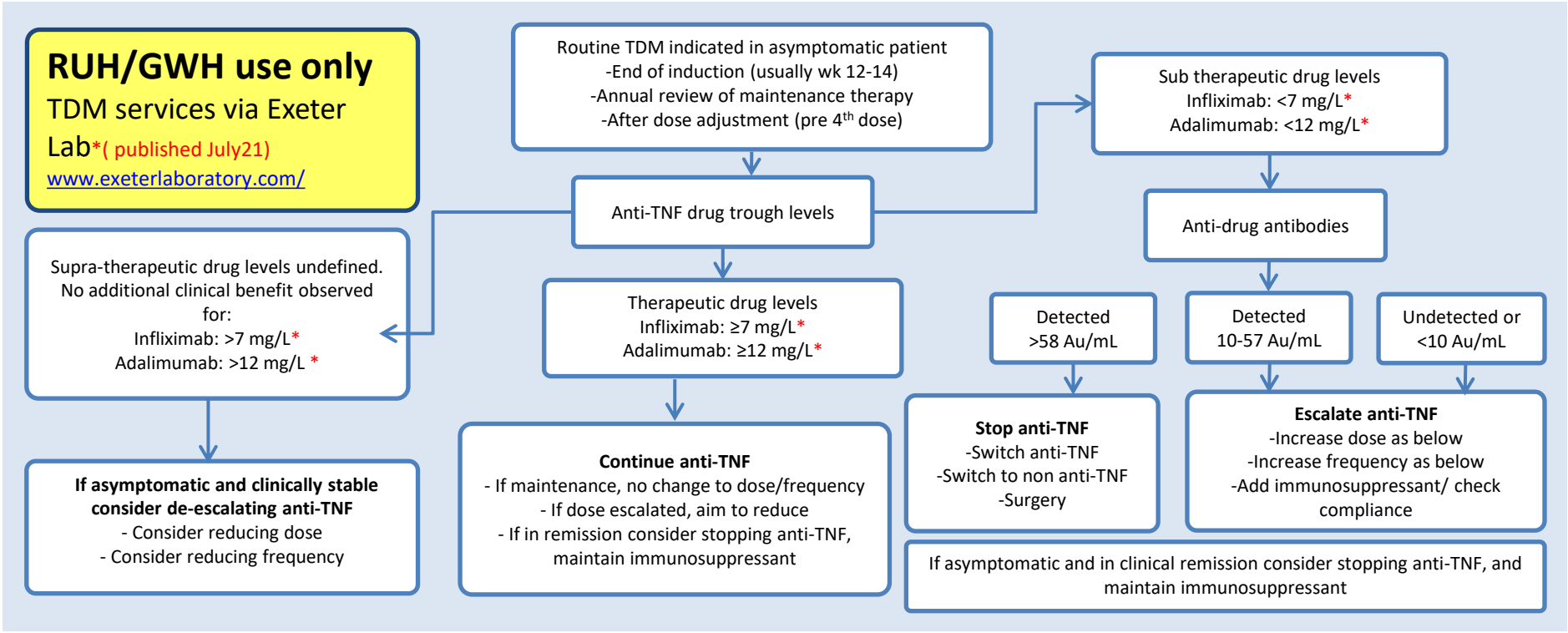

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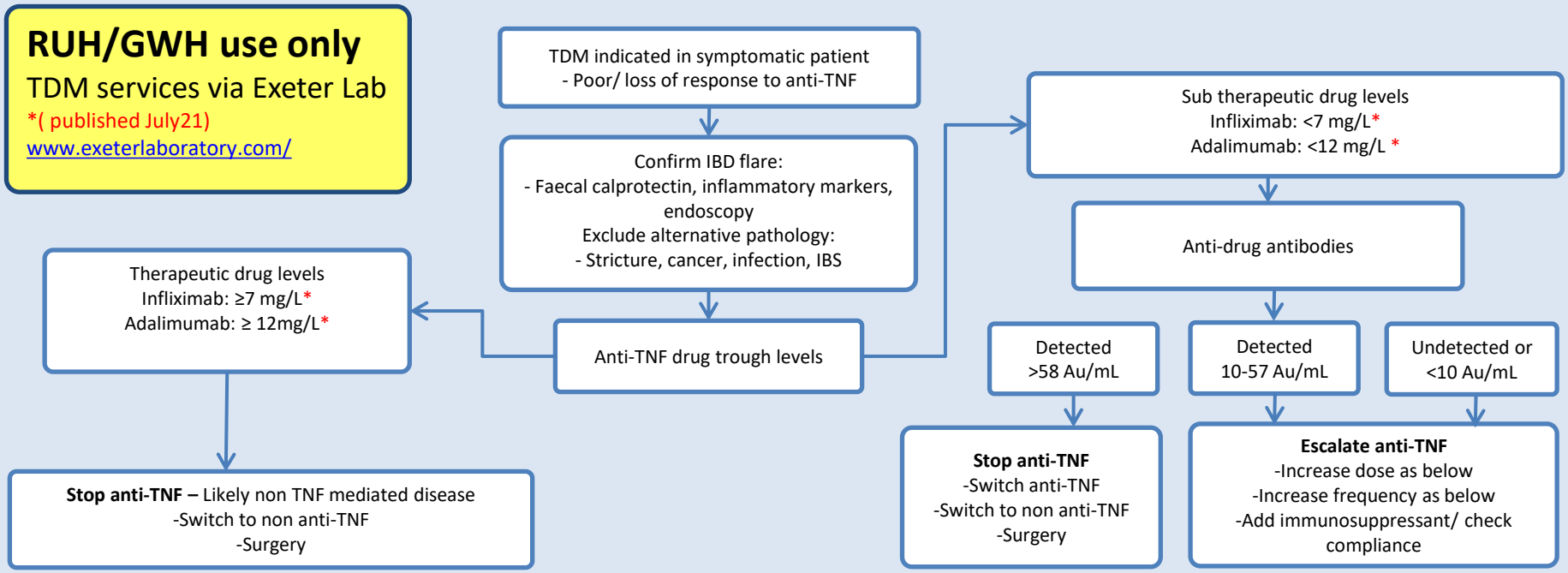
RUH/GWH use only
TDM services via Exeter Lab
*(published July21)
www.exeterlaboratory.com/



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