

South East Regional Medicines Optimisation Group (SERMOG) policy recommendation

Title:	High-cost immunomodulator drug pathway for adults with psoriatic arthritis
Number:	SERMOG-09
Category:	Treatment pathway
Date determined by SERMOG:	November 2025

Introduction

This pathway is a guideline for the initiation and maintenance of high-cost drugs (biologics and small molecules) for the treatment of psoriatic arthritis (PsA) in adults. The pathway follows NICE Technology Appraisal (TA) guidance, alongside additional recommendations for dose formulations approved by the SERMOG. The use of high-cost drugs for the treatment of PsA is only approved in line with this pathway and the dosing regimens outlined in table 3. Any dose regimens outside of these recommendations are not routinely funded, as detailed in SERMOG-02 (Overarching policy on licensed doses or dosing schedules of high-cost drugs not considered in NICE Technology Appraisal (TA) guidance). Definitions for terms used within the pathway are set out in table 1. Where biosimilars are available, these should be used, as detailed in SERMOG-03 (Overarching policy on switching between biosimilars).

The most appropriate treatment should be chosen after discussing the advantages and disadvantages of the treatments available with the person having treatment. If patients and clinicians consider more than one treatment to be suitable, the least expensive treatment should be used (taking into account drug administration costs, dose needed and frequency, and product price per dose). The lowest cost treatments for agents with the same mode of action are highlighted in table 2 and comparative cost indicators are provided in table 3.

According to a Regional Medicines Optimisation Committee (RMOC) Advisory Statement on the sequential use of biologic medicines (May 2020), when a treatment fails, guidance from specialist bodies suggests switching to a biologic with a new mechanism of action is more effective than switching within class. The exception to this is secondary failure of anti-TNF treatment due to formation of anti-drug antibodies, in which case switching within class may be a valid treatment option. In situations where the appropriateness of further treatment options is undecided, a peer multidisciplinary team discussion may be helpful.

Any new high-cost drug which receives a positive TA recommendation from NICE between document iterations will be approved through local ICB processes and will be included in future pathway updates.

Figure 1. High-cost drug pathway for psoriatic arthritis

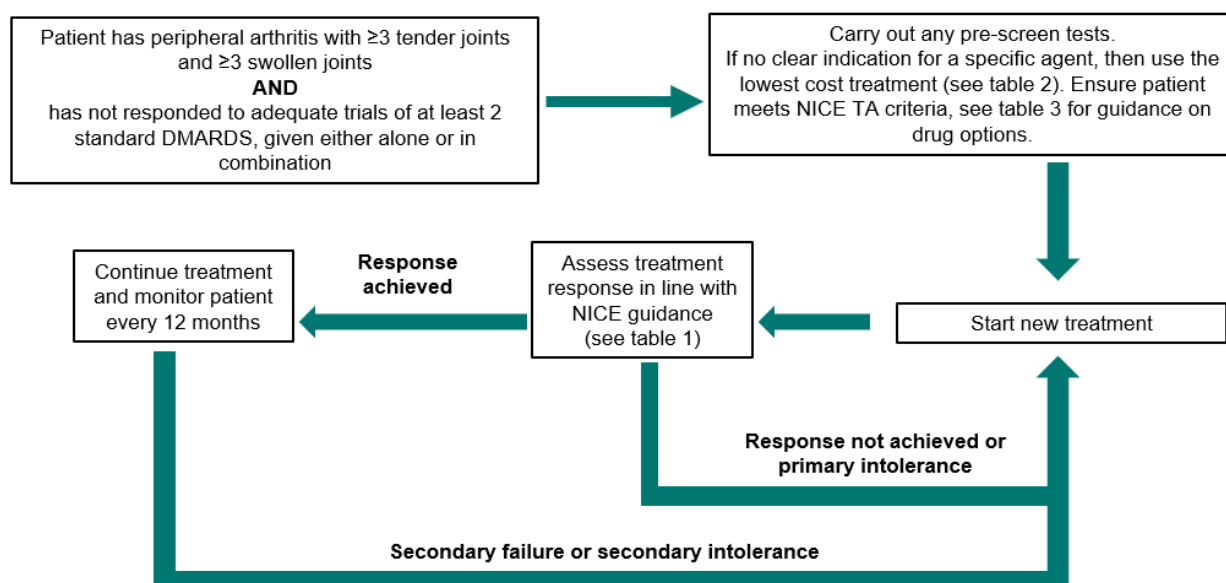


Table 1. Pathway definitions and actions

Description	Definition	Action
Response achieved	An adequate response using the Psoriatic Arthritis Response Criteria (improvement in at least 2 of the 4 criteria [1 of which has to be joint tenderness or swelling score] with no worsening in any of the 4 criteria) for that treatment at the time interval defined in the NICE TA (see table 3).	Remain on treatment. Review at 12 monthly intervals or in line with SmPC guidance.
Response not achieved	The response criteria (as above) is not fully met when assessed at the time interval defined within the NICE TA.	Move to the next treatment. Consider using an alternative mode of action (if one is available).
Primary intolerance	An occurrence that causes discontinuation of treatment, due to inability to tolerate side-effects of that treatment that occurs during the initial time period defined by the NICE TA.	Move to the next treatment. Consider another option from the same mode of action (if one is available).
Secondary intolerance	An occurrence that causes discontinuation of treatment, due to inability to tolerate side effects of that treatment that occurs after the initial time period defined by the NICE TA.	Move to the next treatment.
Secondary failure	Occurs when the response to treatment (as defined above) is no longer met after the initial time period defined by the NICE TA.	Move to the next treatment. Consider using an alternative mode of action ¹ (if one is available).

¹ The exception to this is secondary failure of TNF alpha inhibitor treatment due to formation of anti-drug antibodies, in which case switching within class may be a valid treatment option.

Table 2. Regionally approved drug treatment options. Individual agents within class listed in order of cost² (lowest acquisition cost option highlighted).

Mode of action		Treatment	Method of administration
TNF alpha inhibitor		Adalimumab	Subcutaneous (SC) injection
		Infliximab	
		Etanercept	
		Golimumab	
		Certolizumab	
Interleukin inhibitor	12/23	Ustekinumab	SC injection
	17	Secukinumab 150mg ³	
		Bimekizumab	
		Ixekizumab	
		Secukinumab 300mg ³	
	23	Guselkumab	
		Risankizumab	
PDE4 inhibitor		Apremilast	Oral tablet
Janus Kinase (JAK) inhibitor ⁴		Tofacitinib	
		Upadacitinib	

² Based on drug acquisition cost in year 1

³ As detailed in table 3, the recommended dose of secukinumab in patients who are anti-TNF inadequate responders is 300 mg. For other patients, the recommended dose is 150 mg, based on clinical response, the dose can be increased to 300 mg.

⁴ Clinicians should consider [measures to reduce risks of major cardiovascular events \(MACE\), malignancy, venous thromboembolism \(VTE\), serious infections and increased mortality](#) when prescribing JAK inhibitors in certain patient groups with PsA

Table 3. TA recommendations and other approved licenced dosing regimens.

Treatment	TA	First line option	NICE TA indication	Initial treatment length (weeks)	Biosimilar available	Maintenance dose
Adalimumab	TA199 (2010)	Yes	The person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints AND the psoriatic arthritis has not responded to adequate trials of at least 2 standard DMARDs, administered either individually or in combination.	12	✓	<ul style="list-style-type: none"> • 40mg SC injection every other week
Infliximab		Yes		12	IV – ✓ SC - x	<ul style="list-style-type: none"> • 5mg/kg IV every 8 weeks • 120mg SC injection every 2 weeks
Etanercept	TA199 (2010)	Yes	The person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints AND the psoriatic arthritis has not responded to adequate trials of at least 2 standard DMARDs, administered either individually or in combination.	12	✓	<ul style="list-style-type: none"> • 25mg SC injection twice weekly • 50mg SC injection once weekly
Golimumab	TA220 (2011)	Yes	The person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints AND the psoriatic arthritis has not responded to adequate trials of at least 2 standard DMARDs, administered either individually or in combination.	12	✓	<ul style="list-style-type: none"> • 50mg SC once a month • 100mg SC once a month if the person has a body mass >100kg and does not show a response after 3 or 4 doses

Treatment	TA	First line option	NICE TA indication	Initial treatment length (weeks)	Biosimilar available	Maintenance dose
Certolizumab	TA445 (2017)	Yes	The person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints AND the psoriatic arthritis has not responded to adequate trials of at least 2 standard DMARDs, administered either individually or in combination OR the person has a TNF-alpha inhibitor but their disease has not responded within the first 12 weeks or has stopped responding after 12 weeks	12	x	<ul style="list-style-type: none"> • 200mg SC injection every 2 weeks or 400mg every 4 weeks
Ustekinumab	TA340 (2015)	No ⁵	The person has active psoriatic arthritis AND treatment with tumour necrosis factor (TNF) alpha inhibitors is contraindicated OR the person has had treatment with 1 or more TNF-alpha inhibitors	24	✓	<ul style="list-style-type: none"> • 45mg SC injection every 12 weeks • 90mg SC injection may be considered in individuals with a body mass >100kg.

⁵ Unless TNF alpha inhibitors are contraindicated

Treatment	TA	First line option	NICE TA indication	Initial treatment length (weeks)	Biosimilar available	Maintenance dose
Secukinumab	TA445 (2017)	Yes	The person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints AND the psoriatic arthritis has not responded to adequate trials of at least 2 standard DMARDs, administered either individually or in combination OR treatment with tumour necrosis factor (TNF)-alpha inhibitors is contraindicated.	16	x	<ul style="list-style-type: none"> • 150mg SC injection every month
		No	OR the person has had a TNF-alpha inhibitor, but their disease has not responded within the first 12 weeks or has stopped responding after 12 weeks.			<ul style="list-style-type: none"> • 300mg SC injection every month
Bimekizumab	TA916 (2022)	No ⁵	The person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints AND the psoriatic arthritis has not responded to adequate trials of at least 2 standard DMARDs, administered either individually or in combination AND the person has had at least 1 biological DMARD OR treatment with tumour necrosis factor (TNF)-alpha inhibitors is contraindicated	16	x	<ul style="list-style-type: none"> • 160mg SC injection every 4 weeks
Ixekizumab	TA537 (2018)	Yes	The person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints AND the psoriatic arthritis has not responded to adequate trials of at least 2 standard DMARDs, administered either individually or in combination OR the person has a TNF-alpha inhibitor but their disease has not responded within the first 12 weeks or has stopped responding after 12 weeks OR treatment with tumour necrosis factor (TNF)-alpha inhibitors is contraindicated	16	x	<ul style="list-style-type: none"> • 80mg SC injection every 4 weeks

Treatment	TA	First line option	NICE TA indication	Initial treatment length (weeks)	Biosimilar available	Maintenance dose
Guselkumab	TA815 (2022)	No ⁵	The person has active psoriatic arthritis and they have had 2 conventional DMARDS AND at least 1 biological DMARD OR treatment with tumour necrosis factor (TNF)-alpha inhibitors is contraindicated	16-24	x	<ul style="list-style-type: none"> • 100mg SC injection every 8 weeks • For patients with a high risk of joint damage (according to clinical judgment) 100mg every 4 weeks may be considered
Risankizumab	TA803 (2022)	No	The person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints AND the person has moderate to severe psoriasis ⁶ AND the person has had 2 conventional DMARDS and at least 1 biological DMARD	16	x	<ul style="list-style-type: none"> • 150mg SC injection every 12 weeks
Apremilast	TA433 (2017)	Yes ⁷	The person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints AND the psoriatic arthritis has not responded to adequate trials of at least 2 standard DMARDS, administered either individually or in combination.	16	x	<ul style="list-style-type: none"> • 30mg tablet, twice daily

⁶ A body surface area of at least 3% affected by plaque psoriasis and a Psoriasis Area and Severity Index [PASI] score greater than 10.

⁷ [TA433](#) states that apremilast is not as clinically effective as the TNF-alpha inhibitors for treating PsA.

Treatment	TA	First line option	NICE TA indication	Initial treatment length (weeks)	Biosimilar available	Maintenance dose
Tofacitinib ⁴	TA543 (2018)	Yes	The person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints AND the psoriatic arthritis has not responded to adequate trials of at least 2 standard DMARDs, administered either individually or in combination OR the person has had a tumour necrosis factor (TNF)-alpha inhibitor but their disease has not responded within the first 12 weeks or has stopped responding after 12 weeks OR treatment with TNF-alpha inhibitors is contraindicated	12	x	<ul style="list-style-type: none"> • 5mg oral tablet twice daily
Upadacitinib ⁴	TA768 (2022)	No ⁵	The person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints AND they have had 2 conventional DMARDs AND at least 1 biological DMARD OR treatment with TNF-alpha inhibitors is contraindicated.	12	x	<ul style="list-style-type: none"> • 15mg oral tablet once daily

Version control:

Version 1.0 – Policy developed July 2025

Version 2.0 – August 2025 - Minor corrections

Version 3.0 - Updated to reflect biosimilar availability and minor updates for clarity and consistency. Circulated to ICBs for ratification 27th November 2025.

Notes:

This policy recommendation will be reviewed when new information becomes available that is likely to have a material effect on the current recommendation.

South East region ICBs will always consider appropriate individual funding requests (IFRs) through their IFR processes.