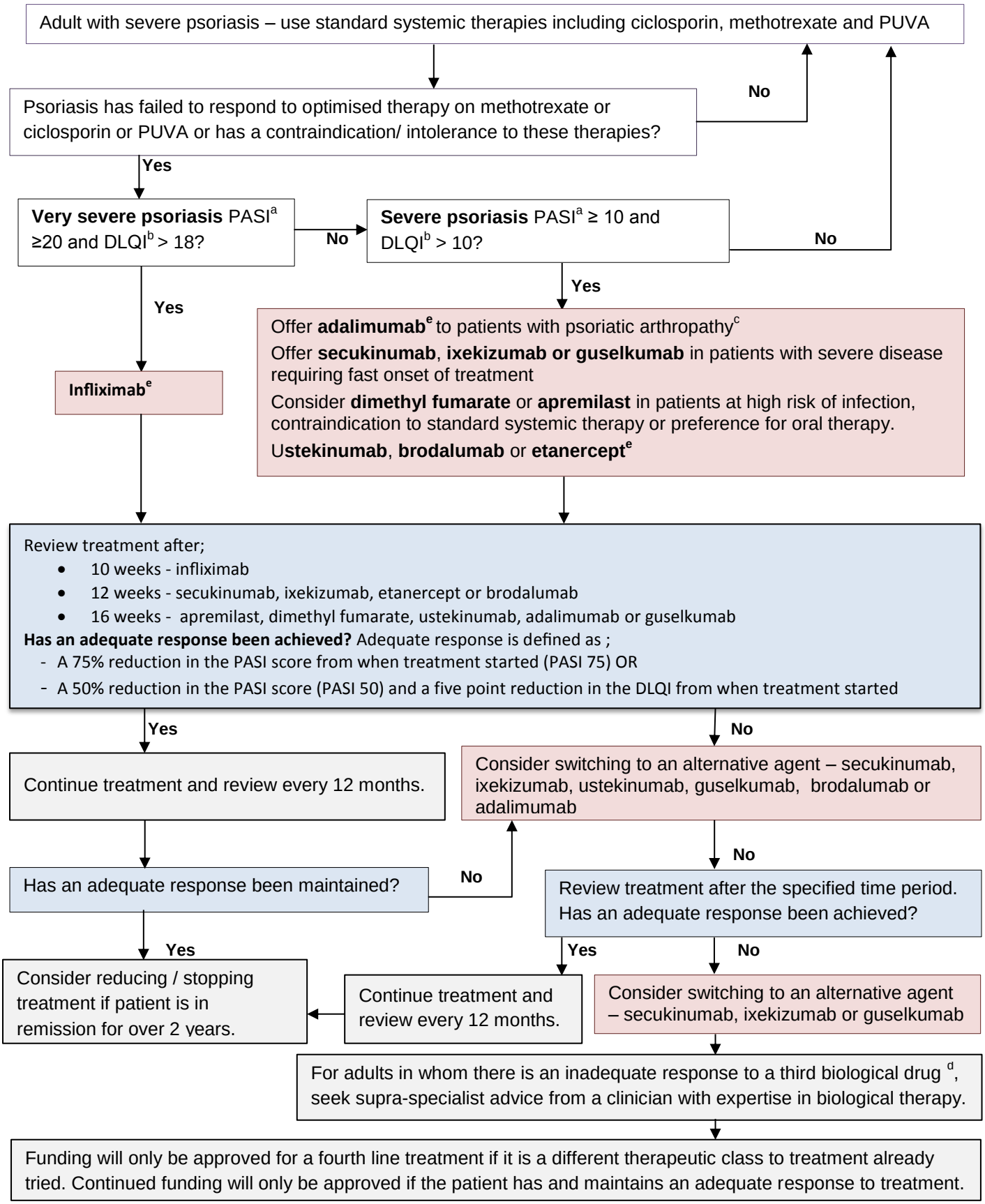
NHS
MID ESSEX LOCALITY

Commissioning pathway for PbR excluded drugs for Psoriasis



a. When using the PASI, healthcare professionals should take into account skin colour and how this could affect the PASI score, and make the clinical adjustments they consider appropriate.
b. When using the DLQI, healthcare professionals should take into account any physical, psychological, sensory or learning disabilities, or communication difficulties, that could affect the responses to the DLQI and make any adjustments they consider appropriate.
c. Treatment should be managed in consultation with a rheumatologist.
d. NICE guidance allows for treating with two biological drugs, after which supra- specialist advice should be sought. This pathway supports the use of three lines of biological drugs.
e. Where 2 or more products are available and in line with product licence, mid Essex CCG expect the product with the lowest acquisition to be prescribed, this is usually the biosimilar product.

Assessing appropriateness for treatment with a systemic biologic therapy, apremilast or dimethyl fumarate

Treatment should be initiated and supervised by a specialist experienced in the diagnosis and treatment of psoriasis. Treatment should only be considered in patients who meet the following criteria:

- Disease is severe as defined by a total Psoriasis Area Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10.

and

- The psoriasis has not responded to **optimal** conventional systemic therapies including methotrexate, ciclosporin and PUVA (psoralen and long-wave ultraviolet radiation); **or** the person is intolerant of, **or** has a contraindication to, these treatments.
  - Treatment with methotrexate can be optimised by;
    - Adjusting folic acid dose/frequency/formulation to improve tolerance of oral methotrexate[1]
    - Consider subcutaneous methotrexate to increase bioavailability as well as tolerance or poor compliance[2]

For patients who are intolerant of or have a contraindication to conventional DMARDs and or PUVA offer treatments such as;

- **Apremilast -** less effective than systemic biologic therapies, however can be considered as a treatment option for patients with significant comorbidities who are at a higher risk of developing adverse effects **or** when laboratory parameters preclude conventional systemic therapies (methotrexate or ciclosporin). Apremilast can be considered as an alternative for patients with either psoriasis alone or psoriasis in combination with psoriatic arthropathy. There is an increased risk that some patients may experience psychiatric symptoms with apremilast, including depression and suicidal thoughts. Stop treatment if patients have new psychiatric symptoms or if existing symptoms worsen (see summary of product characteristics (SmPC).
- **Dimethyl Fumarate (Skilarence)** - less effective than systemic biologic therapies (when compared indirectly) but it is also less costly. To be considered in patients with a significant risk of infection or significant comorbidities, such as demyelination, or when laboratory parameters may preclude other therapies. Dimethyl fumarate can be considered as an alternative for patients with moderate to severe psoriasis in the absence of psoriatic arthritis. Three monthly blood monitoring is required for patients on dimethyl fumarate (see SmPC)

If a systemic biological therapy is considered more appropriate, in the absence of any specific clinical circumstance choose the least expensive treatment, taking into account administration cost and patient access schemes. Patient specific factors that may suggest specific treatment options:

- **High infection risk** – etanercept due to its low immunogenicity[3]
- **High body weight** – ustekinumab due to its weight based dosing
- **Patients planning for pregnancy** - adalimumab or etanercept[4,5,6]
- **Co-morbidites such as inflammatory bowel disease, psoriatic arthropathy and uveitis** – adalimumab as it is licensed for these indications
- **Needle phobia** - apremilast or dimethyl fumarate because these are oral preparations or ustekinumab as it is a three monthly injection
- **Cancer in the last 10 years or interstitial lung disease** – IL-7A inhibitors (secukinumab or brodalumab)
- **Severe disease requiring fast onset of treatment** – ixekizumab[7] or secukinumab[8]

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