TREATMENT PATHWAY FOR THE MANAGEMENT OF ADULTS WITH MODERATE TO SEVERE PSORIASIS IN SECONDARY CARE.

(FOR SPECIALIST INITIATION ONLY)

TARGET AUDIENCE	All clinical staff working within Dermatology in secondary care.
PATIENT GROUP	Adults with Moderate to Severe Psoriasis AND inadequate response to or contraindications to one or more standard systemic therapies including Methotrexate, ciclosporin and phototherapy

Clinical Guidelines Summary

- This guideline describes the pathway for management of adult patients with moderate to severe psoriasis with an inadequate response to or contraindications to one or more standard systemic therapies including methotrexate, ciclosporin and phototherapy.
- The pathway provides a stepwise approach to the management of psoriasis with biologic therapy
- The pathway includes drug prescribing guidance for the use of biologics in psoriasis

Moderate to Severe Psoriasis (PASI>10 and DLQI>10)

(failed to respond to standard systemic therapy including methotrexate, ciclosporin or phototherapy and/or intolerant or have contraindications to these treatments)

General Guidance:

- Choice of treatment should take into account comorbidities, including presence of psoriatic arthritis, contraindications, individual patient characteristics including needle phobia, family planning, lifestyle, patient preference for injection frequency and adherence.
- Consider the effectiveness and safety profile of each drug – refer to BAD Decision Aid for Biological Therapy for Psoriasis.
- Once the above is considered, the most suitable cost effective drug should be chosen.
- Consider escalation of treatment for those with predictors of psoriatic arthritis – scalp, nail or gluteal/perianal disease.

FIRST LINE

- **Anti-TNF**
  Adalimumab (Amgevita®) *Licensed for PsA.*
  First line unless contraindicated. Review at week 16 - can increase to weekly
  Certolizumab *Licensed for PsA.*
  Drug of choice in women planning conception.

- **IL12/23 Inhibitor**
  Ustekinumab (Pyzchiva®) *Licensed for PsA.*
  If demyelination/TB risk/Preference for less frequent injections - Review week 28

If biologic contraindicated/not appropriate/needle phobia/tablet preference/ short half-life required

- **Tyrosine kinase 2 inhibitor**
  Deucravacitinib
  Review at week 24. Not licensed for PsA.
- **PDE4 inhibitor**
  Apremilast
  Review at week 24. Licensed for PsA.

SECOND LINE

- Discontinue first biologic if not tolerated, becomes contraindicated or response is not adequate at the review date or there is loss of response.
- Adequate response is defined as: 75% reduction in PASI score from when treatment started or a 50% reduction in PASI score and a 5 point reduction in DLQI.
- Subsequent choice of treatment should take into account comorbidities, contraindications, individual patient characteristics including needle phobia, family planning, lifestyle, injection frequency.
- **Where multiple agents are appropriate, consider the most cost effective choice.**

- **IL- 17 inhibitor** (**Bimekizumab, Ixekizumab, Brodalumab***)
  If demyelination/TB risk - Review at week 16.
  Avoid if history of IBD

  or

- **IL-23 inhibitor** (**Guselkumab, Rizankizumab**)
  If demyelination/TB risk/History of IBD. Review at week 16.

THIRD/FOURTH LINE

Choose an alternative mechanism of action from the first and second line choices.

- **Biologics:**
  - IL-12/23 inhibitor: **Ustekinumab**
  - IL-17 inhibitor: **Bimekizumab, Brodalumab*, Ixekizumab, Secukinumab**
  - IL- 23 inhibitor**: Guselkumab, Risankizumab or Tildrakizumab***
  - Anti- TNF: **Certolizumab, Infliximab**
- **Tyrosine Kinase 2 inhibitor:**
  - **Deucravacitinib***
- **PDE4 inhibitor:**
  - **Apremilast**

Brodalumab, Tildrakizumab and Deucravacitinib are NOT currently licensed in PsA.

Prescribing Notes:

- Consider Ciclosporin for rescue treatment if very severe disease and bridging treatment required.

Anti-TNFs:

- Avoid anti-TNF if demyelination disease/TB risk/moderate or severe heart failure.
- Certolizumab is the biologic of choice in pregnancy/breastfeeding/patient planning a pregnancy during treatment. It should only be used in pregnancy if clinically needed. It is recommended to wait a minimum of 5 months following the mother's last administration during pregnancy before administration of live/live-attenuated vaccines, unless benefit clearly outweighs the theoretical risk.
- Etanercept – not routinely recommended for psoriasis as less effective than the other biologics.

IL-17 Inhibitors:

- Contraindicated in the presence of inflammatory bowel disease
- Caution if recurrent candida.
- Most superior option in patients with axial psoriatic arthritis (morning stiffness, persistent back pain). PEST not good at identifying.

Current list of biologics licensed for PsA:

Anti-TNF	Adalimumab
	Infliximab
	Certolizumab
	Etanercept
IL-17 inhibitor	Ixekizumab
	Secukinumab
	Bimekizumab
IL-23	Risankizumab
	Guselkumab
IL-12/23	Ustekinumab
PDE4 Inhibitor	Apremilast

Brodalumab, Tildrakizumab and Deucravacitinib are NOT currently licensed in PsA.

Vaccinations:

- Annual flu vaccine is recommended. Consider Shingles vaccine as per Public Health Scotland Guidance.
- Pneumococcal vaccination 2- 4 weeks before initiation. Only repeat after 5 years if asplenic/splenic dysfunction or Chronic Kidney Disease 4 or 5 (will also require Hep B vaccination).
- Check VZV serology prior to commencing and refer for vaccination if required.
- Consider Shingles vaccine as per Public Health Scotland Guidance.

Treatment Pathway for the Management of Adults with Psoriasis

Pre-screening Checks

- Complete pre-screening checklist with patient.
- Screen for TB, viral hepatitis, HIV and VZV serology
- Baseline U&Es, LFTs, FBC should be checked and then 6-12 monthly.
- BBV screen/QF Gold to be repeated if switching and patient's lifestyle predisposes them to increased risk of infection. Treatment of positive Quantiferon Gold (i.e. latent TB) may not be essential for initiation of DMARDs/IL-17/IL-23. Refer to ID for advice.
- CXR if required (if smoker, previous smoker, lung disease)

Transfer of Information to Primary Care:

Drug name (Biosimilar or equivalent) and dosing schedule should be documented in clinic letter for GP so ECS can be updated appropriately.

Drug regimens:

Drug	Target	**Adult Dosing regimen** (all SC administration unless stated otherwise)
Adalimumab (Amgevita®)	**Anti-TNF**	Loading: 80mg - Week 0 Maintenance: 40mg – Week 1 THEN 40mg every 2 weeks If suboptimal response at 16 weeks, increase to 40mg weekly
Bimekizumab (Bimzelx®)	**IL-17A/F**	Loading: 320 mg - Week 0, 4, 8, 12, 16 Maintenance: 320mg – every 8 weeks Patients >120kg who do not achieve clear skin after week 16 can increase to 320mg every 4 weeks.
Guselkumab (Tremfya®)	**IL-23**	Loading: 100mg - Week 0, 4 Maintenance: 100mg – every 8 weeks
Brodalumab (Kyntheum®)	**IL-17**	Loading: 210mg - Week 0, 1, 2 Maintenance: 210mg – every 2 weeks
Ixekizumab (Taltz®)	**IL-17**	Loading: 160mg - Week 0 THEN 80mg – week 2, 4, 6, 8, 10, 12 Maintenance: 80mg – every 4 weeks
Infliximab (Remsima®)	**Anti-TNF**	IV infusion - 5mg/kg week 0, 2, 6 then every 8 weeks Or 5mg/kg week 0 and 2 by IV infusion, then 120mg subcutaneously every 2 weeks from week 6.
Risankizumab (Skyrizi®)	**IL-23**	Loading: 150mg - Week 0, 4 Maintenance: 150mg – every 12 weeks
Secukinumab (Cosentyx®)	**IL-17**	Loading: 300mg - Week 0, 1, 2, 3, 4 Maintenance: 300mg – every 4 weeks Patients >90kg if no response in 16 weeks, can increase to 300mg every 2 weeks.
Ustekinumab (Pyzchiva®)	**IL -12/23**	Loading: 45mg - Week 0, 4 Maintenance: 45mg – every 12 weeks (If weight >100kg, increase dose to 90mg)
Tildrakizumab (Ilumetri®)	**IL-23**	Loading: 100mg – Week 0, 4 Maintenance: 100mg – every 12 weeks Can use higher dose of 200mg for high impact disease or weight > 90kg
Certolizumab pegol (Cimzia®)	**Anti-TNF**	Loading: 400mg - Week 0, 2, 4 Maintenance: 200mg – every 2 weeks (Can be increased to 400mg if suboptimal response. Safe in pregnancy)
Deucravacitinib (Sotyktu®)	**TYK2 inhibitor**	6mg daily (oral tablet)

Apremilast (Otezla®)	**PDE4 inhibitor**	10mg daily, increasing by 10mg daily up to a maintenance dose of 30mg twice daily.

Note: Biologics should be prescribed by Brand name.

Abbreviations:

PASI – Psoriasis Area Severity Index, DLQI – Dermatology Life Quality Index, PsA – Psoriatic Arthritis.

Appendices

1. Governance information for Guidance document

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CHANGE RECORD			
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Oct 2025	Carole Martin	• Pathway updated to reflect current practice • Addition of deucravacitinib and apremilast to pathway. • Prescribing notes updated to reflect current and best practice • Brand names added under drug regimens • Table for drugs licensed in PsA updated.	2