North Central London
Joint Formulary Committee

Ulcerative Colitis Prescribing Pathway

Document control

Date	Version	Amendments
Nov 2023	3.0	Pathway developed in accordance with NCL 'Principles for Commissioning High-Cost Drug Pathways for ICB Commissioned Indications' and includes relevant published NICE TAs.

Groups / Individuals who have overseen the development of this guidance:	UCLH Lead Pharmacist, Formulary & Clinical Trials, UCLH Specialised Commissioning Lead Pharmacist, NCL ICB Medicines Management Team, NCL Joint Formulary Principal Pharmacist, NCL Specialist Clinicians
Groups which were consulted and have given approval:	NCL wide consultation (NCL ICB, NCL Formulary Pharmacists, NCL Specialist Clinicians), NCL Joint Formulary Committee (Nov 2023), NCL Integrated Medicines Optimisation Board (Nov 2023)
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Ulcerative Colitis (UC) Prescribing Pathway

Green: preferred best value **Amber**: not preferred (use where green not suitable) **Red**: not preferred (least cost-effective, use where green and amber not suitable)

Criteria to start treatment for Moderately to Severely Active disease:
Patients with moderately to severely active UC, with inadequate response, intolerance or contraindication to conventional therapy (including corticosteroids or mercaptopurine/azathioprine[1])
Moderate-to-severe disease corresponds with Mayo score ≥ 6, or partial Mayo score ≥ 5, , or SCCAI ≥ 6, or where clinical scores is not a relevant indicator of disease severity, alternative objective measures of disease severity may be used (e.g. endoscopy or radiology results, faecal calprotectin).

Criteria to start treatment for acute exacerbation of severe active disease: Inpatient with severe UC flare who has a contraindication or inadequate response to corticosteroids[2] (inc. IV) for 72hrs

1ST LINE TREATMENT OPTIONS

Adalimumab SC OR **Infliximab SC/IV** biosimilars [TA329] Golimumab also available but not preferred[3] (TA329).	Filgotinib (TA792), upadacitinib (TA856), tofacitinib (TA547), vedolizumab (TA342), ustekinumab (TA633), ozanimod (TA828), and mikikizumab (TA925) also available but only if TNF inhibitors are contraindicated.

1ST LINE TREATMENT OPTION

Infliximab IV biosimilar; 3 doses [TA163]

2ND LINE ONWARDS TREATMENT OPTIONS

Alternative TNF inhibitor if secondary loss of response to 1st line TNF inhibitor – **Adalimumab SC** OR **Infliximab IV/SC** biosimilars [TA329] Golimumab also available but not preferred[3] (TA329).	**Filgotinib** OR **Upadacitinib** (JAK inhibitor) [TA792 / TA856] NB. MHRA update Filgotinib preferred for most patients, upadacitinib preferred for patients with high risk of severe disease and colectomy e.g. extensive disease, steroid refractory, diagnosis in childhood, extraintestinal manifestations or recent admission. Tofacitinib (TA547) also available but not preferred[4]. Primary non-responders to filgotinib or tofacitinib can try upadacitinib[5].	**Vedolizumab IV loading, then SC** [TA342]	**Ustekinumab** (IL12 & IL23 inhibitor) [TA633]	**Ozanimod** [TA828]	**Mirikizumab** (IL23 inhibitor) [TA925]

If more than one treatment is suitable, the least expensive treatment should be used (see RAG rating below)

Drug	Price	Usual maintenance	Dose escalation
Adalimumab	£	40mg SC every 2 weeks	40mg every week (depending on drug levels, anti-drug antibodies, and response)
Infliximab	£	120mg SC once every 2 weeks 5mg/kg IV every 8 week	10mg/kg IV every 8 week or 5mg/kg IV every 4-6 weeks (depending on drug levels, anti-drug antibodies, and response)
Filgotinib		Usually: 200mg oral daily Increased risk of VTE, MACE or malignancy: 100mg oral daily	Usually: Not available Increased risk of VTE, MACE or malignancy: 200mg oral daily
Ozanimod	££	0.92 mg oral	Not available
Upadacitinib	££	15 to 30mg oral daily	Not available
Vedolizumab	££	108mg SC every 2 weeks 300mg IV every 8 weeks	300mg IV every 4 weeks (depending on drug levels; not included in TA342 economic assessment, clinically approved by NCL JFC provided Trusts have identified a mechanism to offset the budget impact)
Ustekinumab	£££	90 mg SC every 12 weeks	90 mg SC every 8 weeks (depending on response, or can be used off-label post IV induction if patient has failed prior biologic)
Mirikizumab	£££	200mg SC every 4 weeks	Not available

Golimumab (not preferred)[3]	£££	<80Kg: 50mg SC every 4 weeks ≥80Kg: 100mg SC every 4 weeks	Not available
Tofacitinib[4] (not preferred)	££	5mg oral twice daily	Only if not at increased risk of VTE, MACE or malignancy: 10mg oral twice daily for the shortest duration possible

Assessment of response - Assess initial induction and/or dose escalation response in 12- 22 weeks based on clinical symptoms and biological markers +/- endoscopy and imaging. If partial response, consider dose escalation. If no response, stop biologic and consider initiating alternative drug, surgery, or a clinical trial.

Continuation of Biologic Treatment - 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 or continued dose escalation. 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 have the option to start treatment again.

Adverse drug reactions (ADRs) – For patients who experience an immediate ADR [within 1 month] or have responded to treatment but experience an ADR within 6 months of treatment initiation, another treatment option within the same mechanism of action (if available and appropriate) can be accessed. Where the ADR is likely to be a drug class effect, an alternative mechanism of action is preferable.

Dual biologic therapy for the same disease is not routinely commissioned; for individual cases, please consider RMOC advisory statement, discuss at MDT and contact Trust formulary teams for advice re IFR submission. **Concurrent biologic treatment for different co-morbidities,** is permissible provided NICE eligibility criteria for both treatments are met and there is MDT agreement across both specialities that dual therapy is appropriate and a single drug which is active against both co-morbidities is not available.

Footnote

[1] The requirement for pre-treatment corticosteroids *or (rather than and)* azathioprine/6-mercaptopurine brings eligibility criteria consistency between TNF inhibitors (TA329) and other NICE TA'd medicines. Further, it brings consistency with Crohn's disease pathway [JFC Nov 2023].

[2] Whilst TA163 described that infliximab is recommended in patients in whom ciclosporin is contraindicated or clinically inappropriate, clinical practice has changed since 2008 and ciclosporin is not routinely offered because of adverse effect profile (inc. renal dysfunction and risk of serious infection), and the significant reduction in cost of infliximab given availability of biosimilars [JFC Nov 2023].

[3] Golimumab is the only treatment option recommended in TA329 which is not available as a biosimilar. By inference, it is not as cost-effective as adalimumab and infliximab. As routine commissioning is for 'Up to one drug per mechanism of action, plus a second biosimilar TNF inhibitor', requests for golimumab should be via IFR and reserved for immunogenic loss of response to adalimumab and infliximab.

[4] Tofacitinib is more expensive and similarly effective as filgotinib (TA792, Paragraph 3.8), therefore not preferred.

[5] Upadacitinib may be offered to patients with primary non-response to filgotinib or tofacitinib, assessed as partial or no response at the 12-16 week assessment [JFC Nov 2023].

References

British Society of Gastroenterology consensus guidelines on the management of inflammatory bowel disease in adults 2019

European Crohn´s and Colitis Organisation Guidelines on Therapeutics in Ulcerative Colitis: Medical Treatment