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



(FOR SPECIALIST INITITATION 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 Ciclosporin, Methotrexate, Apremilast, Acitretin, Fumaric acid esters.

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 ciclosporin, methotrexate, apremilast, acitretin, fumaric acid esters.
- 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)

Very Severe Psoriasis (PASI>20 and DLQI>18)

1st LINE

(Including patients with PsA)

Anti-TNF:

Adalimumab*

Review at Week 16
If suboptimal response, increase to weekly dosing for 4 months before switching

If demyelination/TB risk

IL - 17 inhibitor:

Bimekizumab*, Ixekizumab*, or Brodalumab OR

IL-23 inhibitor:

Guselkumab*
(*Licensed in PsA)

Infliximab (Biosimilar)/ Ciclosporin

If unstable disease and rapid control required

Review at week 10 for infliximab

2nd LINE

If initial Biologic discontinued for criteria listed below*

- IL-23 inhibitor: Risankizumab
- IL-17 inhibitor: Bimekizumab, Brodalumab
- Co-existing PsA: IL-17 inhibitor Ixekizumab or IL-23 inhibitor Guselkumab

Alternatives

Consider IL-17 inhibitor

Bimekizumab*

Brodalumab

Ixekizumab*

Secukinumab*

(*Licensed in PsA)

3rd and 4th line

If 2nd line Biologic discontinued, choose the next appropriate agent depending on initial response, contraindications or adverse effects.

- IL-17: Bimekizumab, Brodalumab, Ixekizumab
- IL- 23: Guselkumab, Risankizumab or Tildrakizumab
- Co-existing PsA: IL-17 Ixekizumab, Secukinumab, or IL-12/23 Ustekinumab

CRITERIA FOR DISCONTINUATION:

- Discontinue if biologic is not tolerated or becomes contraindicated.
- Discontinue if 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.

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Prescribing Notes:

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.
- Etanercept not routinely recommended for psoriasis as less effective than the other biologics.

IL-17 Inhibitors:

- Caution with IL-17 inhibitors in the presence of inflammatory bowel disease/recurrent candida.
- IL-17 inhibitors as a class are considered to have a relatively fast onset of action compared to other agents.

Current list of biologics licensed for PsA:

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Anti-TNF	Adalimumab	
	Infliximab	
	Certolizumab	
	Etanercept	
IL-17 inhibitor	Ixekizumab	
	Secukinumab	
	Bimekizumab	
IL-23	Risankizumab	
	Guselkumab	
IL-12/23	Ustekinumab	
Brodalumab (IL-17) and Tildrakizumab (IL-		
23) are NOT currently licensed in PsA.		

Vaccinations:

- Annual flu/Covid vaccines recommended.
- 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.

Pre-screening Checks

- Complete pre-screening checklist with patient.
- Screen for TB, viral hepatitis, HIV and VZV serology prior to commencing biologic.
- Baseline U&Es, LFTs, FBC should be checked and then 6 monthly.
- CXR/BBV screen/QF Gold to be repeated if switching and >1 year since last screened.

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.

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Drug regimens:

Drug	Target	Adult Dosing regimen (all SC administration unless stated otherwise)	
Adalimumab	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	IL-17A/F	Loading: 320 mg - Week 0, 4, 8, 12, 16	
		Maintenance: 320mg – every 8 weeks	
Guselkumab	IL-23	Loading: 100mg - Week 0, 4	
		Maintenance: 100mg – every 8 weeks	
Brodalumab	IL-17	Loading: 210mg - Week 0, 1, 2	
		Maintenance: 210mg – every 2 weeks	
Ixekizumab	IL-17	Loading: 160mg - Week 0 THEN 80mg – week 2, 4, 6, 8, 10, 12	
		Maintenance: 80mg – every 4 weeks	
Infliximab	Anti-TNF	5mg/kg week 0, 2, 6 then every 8 weeks	
		Given IV for severe/unstable disease requiring rapid control	
Risankizumab	IL-23	Loading: 150mg - Week 0, 4	
		Maintenance: 150mg – every 12 weeks	
Secukinumab	IL-17	Loading: 300mg - Week 0, 1, 2, 3, 4	
		Maintenance: 300mg – every 4 weeks	
Ustekinumab	IL -12/23	Loading: 45mg - Week 0, 4	
		Maintenance: 45mg – every 12 weeks	
		(If weight >100kg, increase dose to 90mg)	
Tildrakizumab	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	Anti-TNF	Loading: 400mg - Week 0, 2, 4	
		Maintenance: 200mg – every 2 weeks	
		(Can be increased to 400mg if suboptimal response. Safe in pregnancy)	

Note: Biologics should be prescribed by Brand.

Abbreviations:

PASI – Psoriasis Area Severity Index, DLQI – Dermatology Life Quality Index, PsA – psoriatic arthritis.

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Appendices

1. Governance information for Guidance document

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Distribution	
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