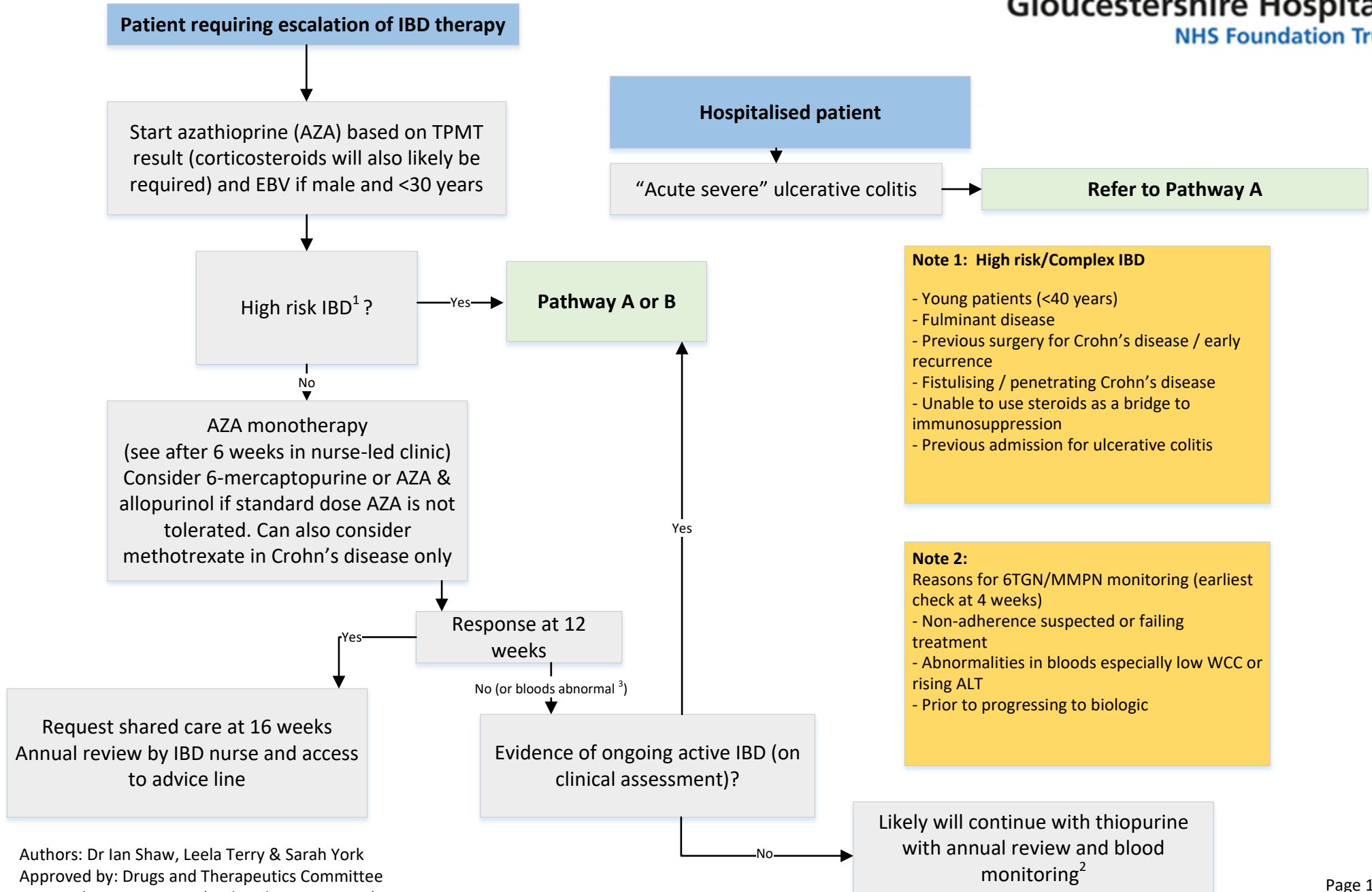


# Inflammatory Bowel Disease Biologic Pathway

## Immunosuppressant to Biologic



**Note 1: High risk/Complex IBD**

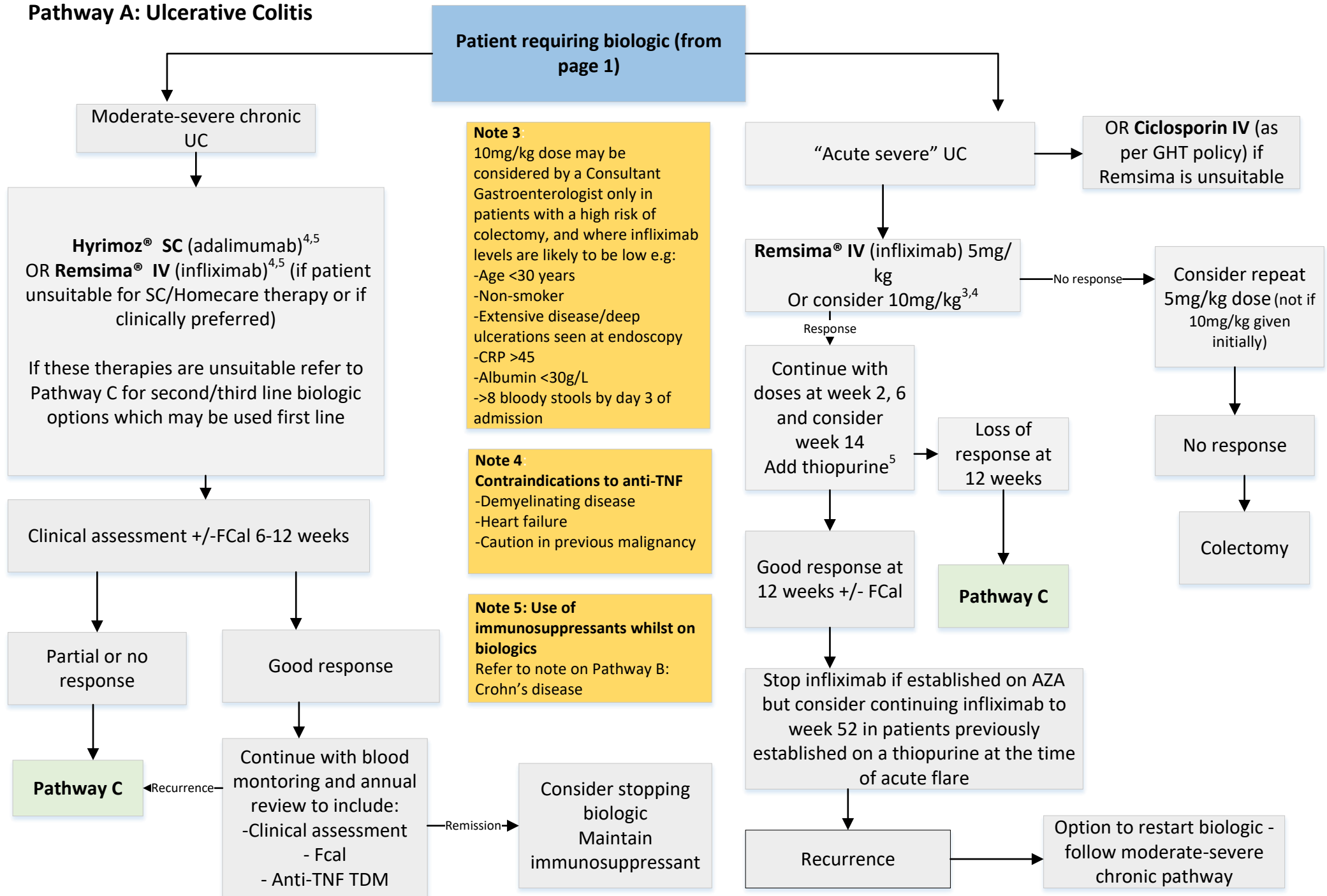
- Young patients (<40 years)
- Fulminant disease
- Previous surgery for Crohn's disease / early recurrence
- Fistulising / penetrating Crohn's disease
- Unable to use steroids as a bridge to immunosuppression
- Previous admission for ulcerative colitis

**Note 2:**

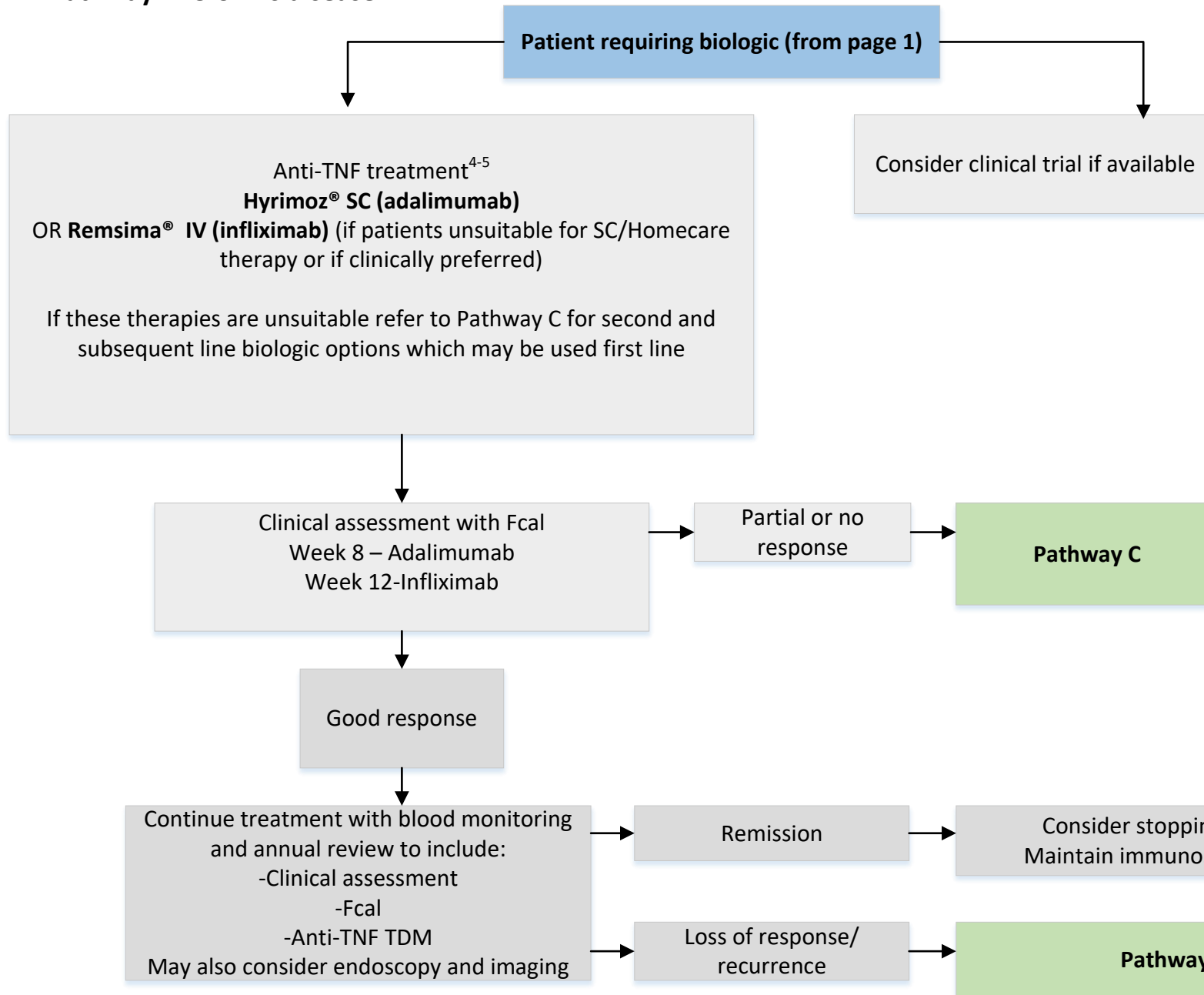
Reasons for 6TGN/MMPN monitoring (earliest check at 4 weeks)

- Non-adherence suspected or failing treatment
- Abnormalities in bloods especially low WCC or rising ALT
- Prior to progressing to biologic

# Pathway A: Ulcerative Colitis



## Pathway B: Crohn's disease



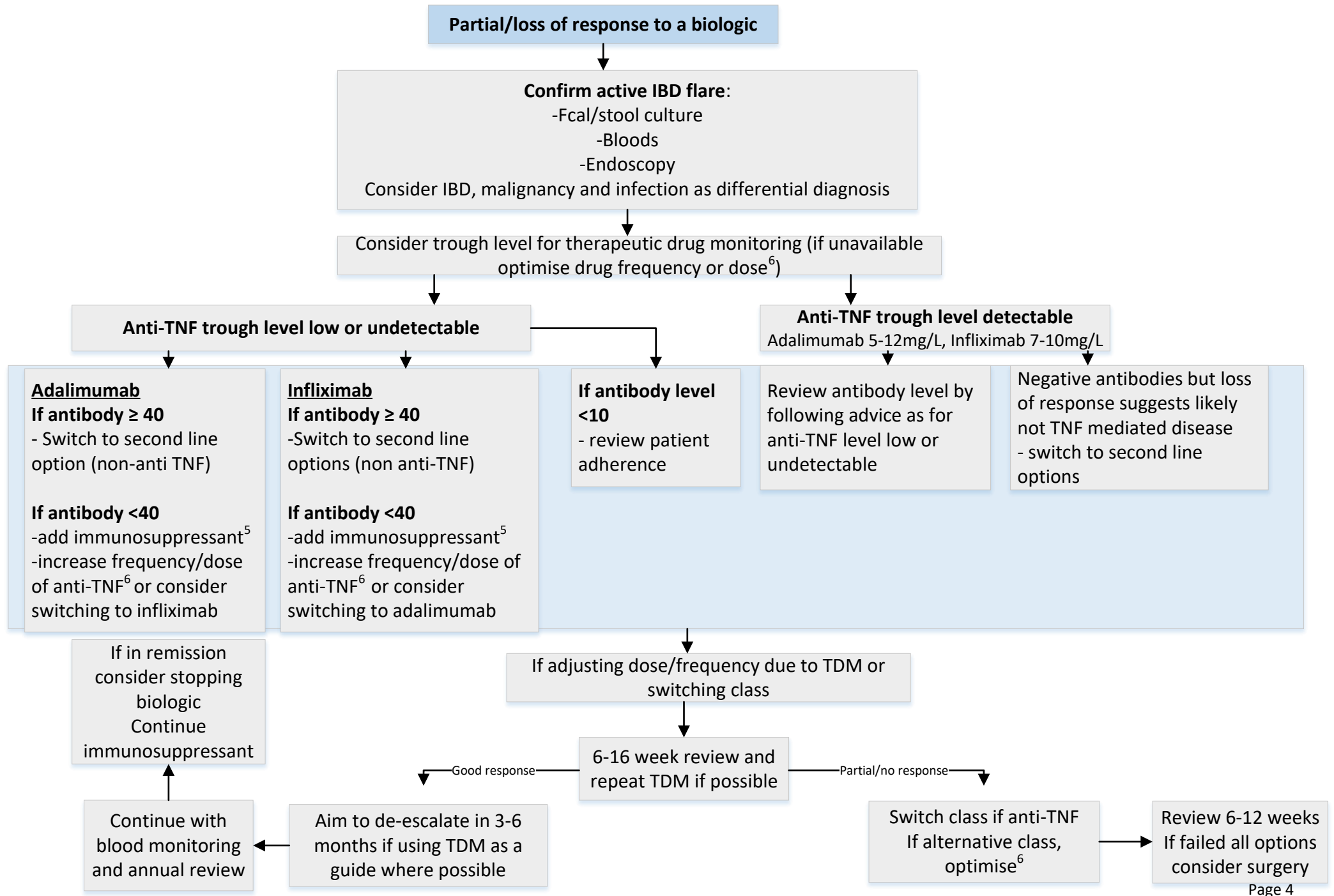
**Note 4:**  
**Contraindications to anti-TNF**  
 -Demyelinating disease  
 -Heart failure  
 -Caution in previous cancer

**Note 5: Use of immunosuppressants whilst on biologics**  
**Anti-TNF:** Continue/start a thiopurine or consider methotrexate (only for CD) if thiopurines are contraindicated

This is due to evidence showing that outcomes with anti-TNF plus thiopurines are improved compared to anti-TNF monotherapy. This effect can also be assumed with methotrexate due to reduced risk of immunogenicity.

**Ustekinumab/risankizumab/mirikizumab/vedolizumab/JAK inhibitors/ozanimod:**  
 There is currently no evidence that continuing immunosuppressants is beneficial whilst on these medications

## Pathway C: Partial response/Loss of response to anti-TNF



## Pathway C: Second and subsequent line options

### Second and subsequent choices following anti-TNF failure or contraindications

In UC: Switch to either **Jyseleca® PO** (filgotinib) or **Entyvio® SC** (vedolizumab, IV is also available for patients in whom SC is unsuitable)

#### Further options in order of preference are:

-**Omvo® SC** (mirikizumab) 4 weekly or **Rinvoq® PO** (upadacitinib)

-**Zeposia® PO** (ozanimod), **Xeljanz® PO** (tofacitinib) or **Stelara® SC** (ustekinumab) 8 weekly (aim to reduce to 12 weekly dosing if possible)

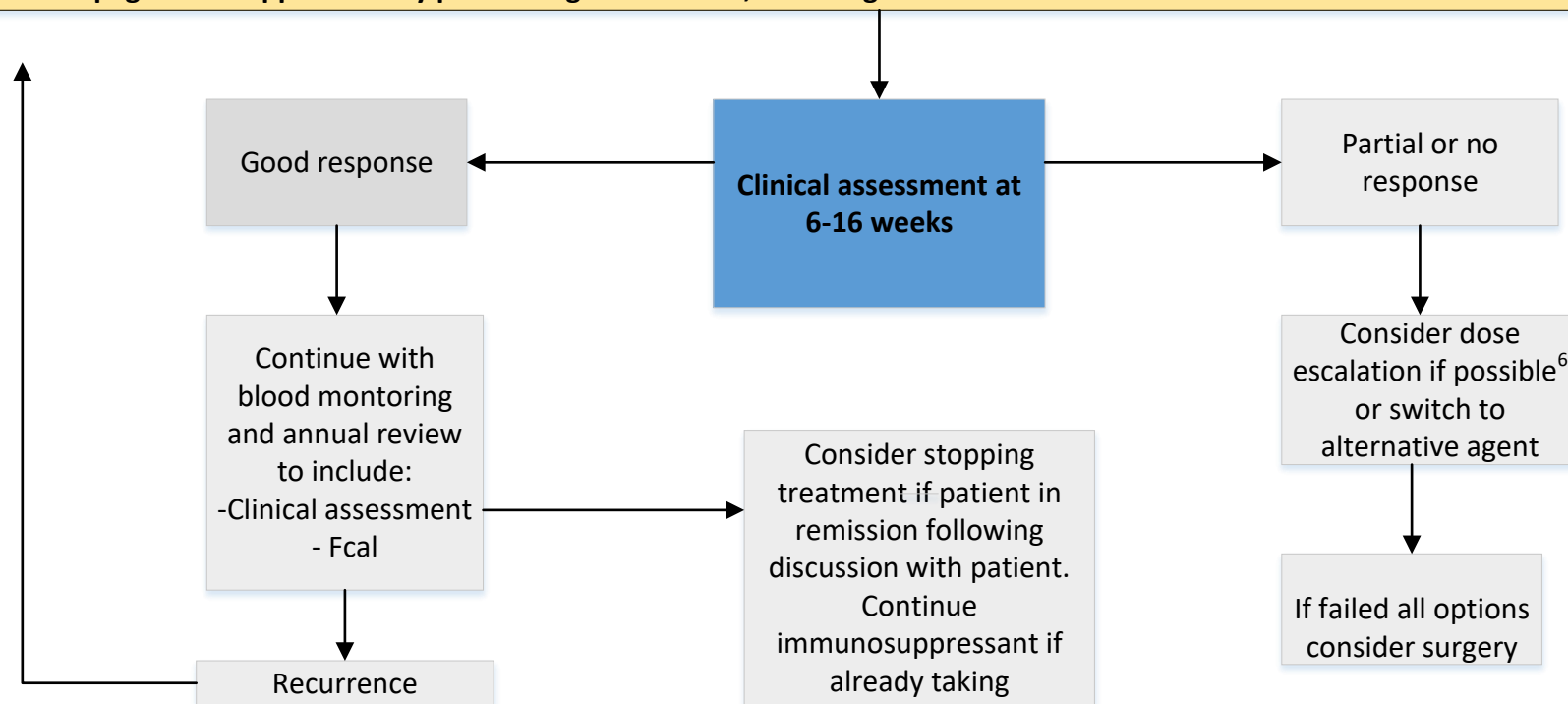
In Crohn's disease: Switch to **Rinvoq® PO** (upadacitinib)

#### Further options in order of preference are:

- **Skyrizi® SC** (risankizumab) or **Entyvio® SC** (vedolizumab, IV is also available for patients in whom SC is unsuitable)

- **Stelara® SC** (ustekinumab) 8 weekly (aim to reduce to 12 weekly dosing if possible)

Refer to page 6 for supplementary prescribing information, including dose escalation



## Supplementary information

### Note 6: Dose escalation

**Adalimumab:** Increase to 40mg weekly

**Infliximab IV:** If levels low increase IV dose to 10mg/kg 8 weekly. If dose wearing off too soon, consider 5mg/kg 6 weekly

**Vedolizumab:** Can use 300mg IV dose at week 10 in Crohn's disease and also 4 weekly maintenance dosing in both Crohn's disease and UC when using the IV preparation. If loss of response on SC preparation consider switching to 4 weekly IV as evidence suggests levels higher on this regime

**Mirikizumab:** Patients who do not achieve adequate therapeutic benefit at week 12 can receive additional IV loading doses at weeks 12,16 and 20 before commencing SC at week 24. If no benefit is seen by week 24 treatment should be discontinued. Patients who lose response during the maintenance treatment may receive re induction with 3 IV doses given every 3 weeks for 4 doses.

**Upadacitinib:** Continue 45mg induction dose for an additional 8 weeks in UC only. Dose can also be increased to 30mg if initiated on 15mg daily as a maintenance dose

**Tofacitinib:** Continue 10mg BD induction phase for an additional 8 weeks, can use 10mg BD as maintenance but VTE risk assessment must be re-checked

**In patients with risk factors for VTE on JAK inhibitors, use lower doses where possible**

**Janus kinase (JAK) inhibitors: measures to reduce the risks of major cardiovascular events, malignancy, venous thromboembolism, serious infections and increased mortality:**

JAK inhibitors (**filgotinib, upadacitinib and tofacitinib**) should not be used in patients with the following risk factors unless there are no other suitable alternatives:

- Age 65 or over
- Current or past long-time smoking
- Other risk factors for cardiovascular disease or malignancy

Use caution when prescribing in patients with other risk factors for VTE and prescribe lower doses where possible  
Carry out periodic skin examinations on all patients to check for skin malignancy (*MHRA April 2023*)

Patients should not receive maintenance treatment with tofacitinib 10mg twice daily if they have risk factors for VTE unless there are no other suitable options