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Improving health and care in Bristol, North Somerset and South Gloucestershire

Moderate to Severe Plaque Psoriasis after systemic treatments have failed

BNSSG Recommended Commissioning Pathway

The choice of treatment should be made on an individual basis, between the patient and clinician. Individual patient characteristics and risk factors should be taken into account. If treatments are found to be equally suitable for the patient the drug with the lowest overall costs should be used. This is reflected in this pathway document.

1st Line Treatment options	**Adalimumab (TA146), Infliximab (Only if PASI>20 and DLQI>18) (TA134), Etanercept (TA103)**
2nd Line Treatment options	**Ustekinumab (TA 180)**
3rd Line Treatment options	**Tildrakizumab (TA575), Certolizumab (TA574), Risankizumab (TA596), Guselkumab (TA521), Brodalumab (TA511), Ixekizumab (TA442), Secukinumab (TA350), Bimekizumab (TA723)**
Non-biological options	**Apremilast (TA419) , Dimethyl fumarate (TA45), Deucravacitinib (TA907)**

If a person has both psoriasis and psoriatic arthritis, take into account both conditions before initiating or making changes to biological therapy and manage their treatment in consultation with a rheumatologist. See also NICE's recommendations on choice of biological therapy for psoriatic arthritis for managing peripheral spondyloarthritis in adults.

Consider changing to an alternative biological drug in adults if:

The psoriasis does not respond adequately to a first biological drug as defined in NICE technology appraisals (at 10 weeks after starting treatment for infliximab, 12 weeks for etanercept, ixekizumab and secukinumab, and 16 weeks for adalimumab and ustekinumab [primary failure]) or
the psoriasis initially responds adequately but subsequently loses this response (secondary failure) or
the first biological drug cannot be tolerated or becomes contraindicated.
For adults in whom there is an inadequate response to a second biological drug, seek supra-specialist advice from a clinician with expertise in biological therapy.

UHBW Dermatology/ICB Medicines Optimisation. Approved BNSSG APMOC Aug 2023/Updated Feb 2025/Review Aug 2026

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Severe Psoriasis at localised, high impact sites not meeting NICE criteria after systemic treatments have failed

Treatment with biologics or apremilast (but not dimethyl fumarate) may be considered in people with psoriasis where the PASI <10 if **all** the following criteria are fully met:

- The psoriasis is severe at localised, high impact and difficult to treat sites such as the face, scalp, palms, soles, flexures and genitals
- It cannot be controlled with topical therapy or optimised standard systemic therapy
- It has significant impact on physical, psychological or social wellbeing
- Associated with significant functional impairment and/or high levels of distress

1. Measures or severe scalp disease must be confirmed by documenting ≥30% of scalp surface area affected and a PGA of severe. A Psoriasis Scalp Severity Index (PSSI) score of ≥20 (0-72 scale) may also be used although it is recognised that this is not currently widely used in clinical practice.
2. Measure of severe palm/sole disease or other high impact sites may utilise an adjusted PASI score to assist with assessing response from baseline. A NAPSI score may be used for severe nail disease or a ppPASI >20 for palmoplantar pustulosis.
3. Optimised standard systemic therapy includes ciclosporin and subcutaneous methotrexate to recommended doses as tolerated for at least 3 months. Consider acitretin in the context of palmoplantar disease.
4. Significant impact as measured by a DLQI >10 and or/depression attributable to psoriasis

The BNSSG psoriasis biologic pathway should be used to guide choice of treatment for patients with severe psoriasis at localised high impact sites. The most cost-effective product suitable for the individual should be used, including use of biosimilars where available.

Use of biologics and apremilast for severe psoriasis at localised high impact sites should only continue in patients where a successful response is seen, defined as a 50% improvement in an appropriate disease score outlined by clinician.

Blueteq forms will be used to monitor outcomes and usage.

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