Healthier Together

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

Ulcerative Colitis

BNSSG Recommended Biologic Commissioning Pathway

1st Line Treatment options — Adalimumab (TA 329) or Infliximab (TA 163) & (TA 329)

2nd Line Treatment option — Filgotinib (TA 792) or Tofacitinib (TA 547) or Upadacitinib (TA 856)

3rd Line Treatment option — Golimumab (TA 329) or Ustekinumab (TA 633) or Mirikizumab (TA 925)

4th Line Treatment option — Vedolizumab (TA 342)

5th Line Treatment option — Ozanimod (TA 828)

5th Line treatments are the end of the commissioned pathway

Choosing which biologic treatment

NICE does not make specific recommendations on the sequential use of biologics in UC.

The choice of treatment should be made on an individual basis, between the patient and clinician. **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.

A cost calculator is available

NICE Criteria to start treatment

Infliximab, adalimumab, golimumab, tofacitinib and vedolizumab are recommended, within their marketing authorisations, as options for treating moderately to severely active ulcerative colitis in adults whose disease has responded inadequately to conventional therapy including corticosteroids and mercaptopurine or azathioprine, or who cannot tolerate, or have medical contraindications for, such therapies.

Infliximab for acute exacerbations

Infliximab is recommended as an option for the treatment of acute exacerbations of severely active ulcerative colitis only in patients in whom ciclosporin is contraindicated or clinically inappropriate, based on a careful assessment of the risks and benefits of treatment in the individual patient.

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. 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 should have the option to start treatment again.

Use of biologics for post-surgery prophylaxis in UC is **not recommended.**

Approved by: APMOC Feb 24, Review Feb 27

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