RA Treatment Decisions Following First TNFi Failure



Switch to an alternative Mon Not all patients achieve disease targets with TNFis: up to 50% of patients will discontinue treatment within 2-4 years1-3



in RA patients following first **TNFi** failure

In several studies,

patients who cycled

TNFi non-response

after secondary

up to 60% of

Switching has been observed to increase the likelihood of response, compared to cycling, including achieving LDA and

TNFis have an established efficacy and safety profile based on more than 20 years of data^{7,8}

ACR GUIDELINE:

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Conditional recommendation to switch¹²

Based on very low-certainty* evidence supporting better disease outcomes and treatment persistence with MOA switching

Who may be appropriate to switch?¹



Patients who are primary non-responders, whose disease may be driven by TNF-a-independent mechanisms

It is unlikely these patients will reach treatment targets with a second TNFi, and may have success with another MOA

Who may be appropriate to cycle?¹



Patients who initially had a good TNFi response, but had a later secondary loss of response

Selecting a structurally and/or functionally different TNFi may be successful in these patients

Cycle to a second muri achieved ACR209-11

An individual patient's preferences, lifestyle, comorbidities, and concomitant medications are also important to consider when selecting a treatment⁹

Consider your patient's reason for first TNFi failure when deciding to switch vs. cycle

ACR, American College of Rheumatology; ACR20, improvement of ≥20% in ACR core criteria; LDA, low disease activity; MOA, mechanism of action; RA, rheumatoid arthritis; TNF, tumor necrosis factor; TNFi, TNF inhibitor. *Very low-certainty evidence supporting greater improvement in disease activity and drug survival among patients switching classes, as determined following a systematic literature search.

1. Johnson KJ et al. Clin Rheumatol. 2019;38(11):2967-2976; 2. Souto A et al. Rheumatology (Oxford). 2016;55(3):523-534; 3. Strand V et al. Rheumatol Ther. 2017;4(2):489-502; 4. Gottenberg JE et al. JAMA. 2016;316(11):1172–1180; 5. Bogas P et al. Ther Adv Musculoskelet Dis. 2021;13:1759720X211060910; 6. Wei W et al. Adv Ther. 2017;34(8):1936–1952; 7. Monaco C et al. Int Immunol. 2015; 27(1):55-62; 8. Aaltonen KJ et al. PLoS One. 2012;7(1):e30275; 9. Taylor PC et al. Ther Adv Musculoskelet Dis. 2022;14:1759720X221114101; 10. Smolen JS et al. Lancet. 2016; 388:2763–2774; 11. Smolen JS et al. Ann Rheum Dis. 2012;71:1671–1679.12. Fraenkel L et al. Arthritis Care Res (Hoboken). 2021;73(7):924–939



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