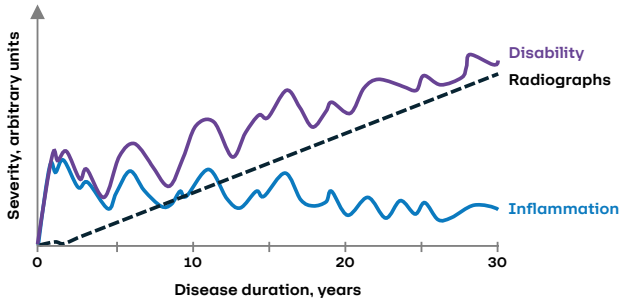
Achieving your treatment goals

Consider when a treatment switch in RA may be the right transition for your patients

Are your patients with RA achieving disease control?

Schematic of hypothetical progression in RA[1]

(Does not reflect variability that may be observed in individual patients[2])



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Consequences of uncontrolled disease
Uncontrolled disease may impact patients' physical function and quality of life[3–7]

Disease control and comorbidities
Remission or LDA can reduce risk of comorbidities (CVD, infection, etc.)[8–12]

Disease duration and remission
Longer disease duration is associated with a reduced likelihood of achieving remission[13]

Regular monitoring of disease activity is critical to timely disease control

In the absence of improvement, therapy should be reevaluated within 3 months[14]

While TNFis are the most common first choice among targeted therapies, up to **50% of patients with RA will discontinue their TNFi** within 1–4 years of initiation[15–18]

After TNFi failure, consider treatment options on a case-by-case basis:
An important consideration is a patient's type of non-response to their first TNFi[19,20]

Types of TNFi non-response[20]

Primary non-response

- Patients who do not achieve LDA or remission within 3–6 months of treatment initiation
- RA may be driven by TNF-α–independent mechanisms

Patients may have success with another MOA; they may be unlikely to achieve LDA or remission with a second TNFi

Secondary non-response

- Patients who initially achieve LDA or remission with a TNFi, but have a later loss of response

Changing to another MOA or selecting a structurally and/or functionally different TNFi may be successful in these patients

ACR RA guidelines[14]: Favors switching to a different MOA over cycling to another TNFi*

> "Switching to a bDMARD or tsDMARD of a different class is conditionally recommended over switching to a bDMARD or tsDMARD belonging to the same class for patients taking a bDMARD or tsDMARD who are not at target"

*Based on very low-certainty evidence supporting greater improvement in disease activity and drug survival among patients switching classes. The recommendation is conditional because patient and physician preferences are likely to vary based on prior experiences with specific DMARDs.

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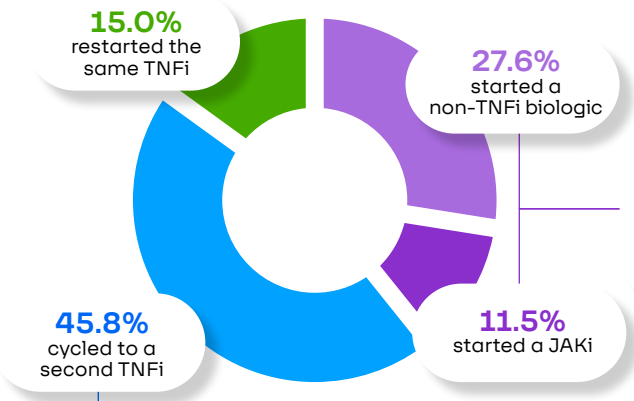
Data on treatment options after TNFi failure

Real-world treatment patterns[18]

In a retrospective study, among patients with moderate-to-severe RA who discontinued their first TNFi (N=572)*:

*A real-world, retrospective study of the American Rheumatology Network (2014–2021) reviewed treatment and care patterns in patients with RA after initiating first-line TNFis.

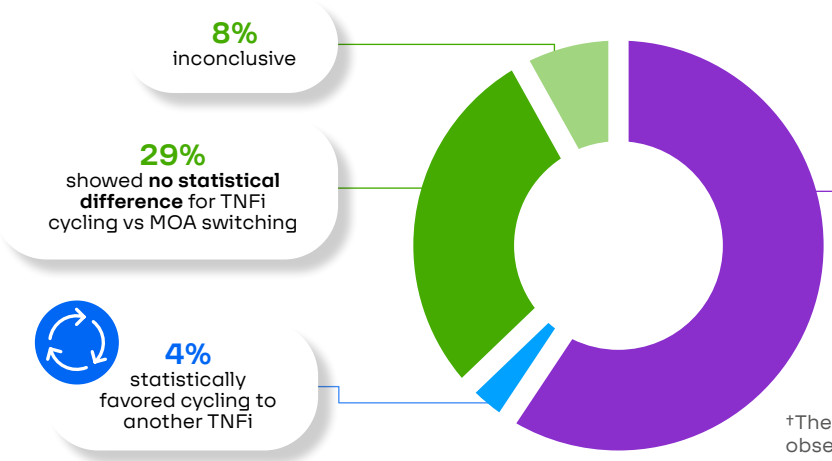


Overall **39.1%** switched to a new MOA

Among these patients, lack of efficacy was the most common reason for discontinuing their first TNFi

Outcomes in practice: a TNFi vs a new MOA after TNFi failure[21]

In a review of clinical, economic, adherence, and persistence outcomes across 68 studies (2007–2023)†:



59% statistically favored switching to a new MOA

Additionally, **longer treatment persistence** has been observed in **patients who switched MOAs** compared with patients who cycled to another TNFi[21–24]

†The studies assessed comprised prospective RCTs and observational studies, including real-world evidence (67%, n=46), meta-analyses (10%, n=7), and modeling studies (22%; n=15); most of the studies were conducted in RA (96%, n=65).

Guidelines, as well as the current body of evidence, generally support that switching MOAs after first TNFi failure is associated with improved clinical outcomes for patients with RA[14,21]

Abbreviations: ACR, American College of Rheumatology; bDMARD, biologic DMARD; CVD, cardiovascular disease; DMARD, disease-modifying antirheumatic drug; JAKi, Janus kinase inhibitor; LDA, low disease activity; MOA, mechanism of action; RA, rheumatoid arthritis; RCT, randomized controlled trial; TNF-α, tumor necrosis factor-α; TNFi, tumor necrosis factor inhibitor; tsDMARD, targeted synthetic DMARD.

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