SARAA POSITION STATEMENT: BIOSIMILAR DMARDS (bsDMARDs)

Executive Summary

Biologic therapies have provided discernible benefits in the outcomes of people living with systemic rheumatic diseases. There is substantial and growing evidence to support the role of biologics in reducing disease activity, thus limiting damage and disability in many of the rheumatic diseases. The high costs of biologics, however, limit access to these treatments. Because biologic drugs are large and highly complex molecules, an exact copy of a drug, such as a generic of a chemical drug is not possible.

A biosimilar is a biological DMARD that is a highly similar version of an already approved original biological DMARD (reference product) that is intended to be used in the treatment of the same diseases as the reference product. For a biosimilar to be approved, it must undergo a rigorous development process to ensure that it is “similar”, i.e. demonstrate no clinically meaningful differences in terms of structure and function, efficacy, safety, and immunogenicity, to the reference product. After approval, biosimilars must comply with the same pharmacological practices for biological drugs.

The conceivable benefit of these biosimilar DMARDs (bsDMARDs) is the potential for cost savings, enabling wider and earlier access to biologic therapies. At the same time, concerns of limited head-to-head clinical trial data, doubt surrounding the utilization of extrapolation (the use of bsDMARDs between indications based on a comparable biologic effect), limited albeit growing real-world evidence in terms of safety data, and the concern for lack of efficacy and treatment failure due to the “nocebo effect”, has led to prescriber hesitancy.

Several biosimilar disease-modifying antirheumatic drugs (bsDMARDs) have been approved for use in patients with systemic rheumatic diseases. These include the tumour necrosis factor inhibitors (TNF-i) adalimumab, etanercept and infliximab, as well as rituximab. The bsDMARDs currently available in South Africa include infliximab (Remsima), adalimumab (Amgevita) and rituximab (Blitsima).

SARAA supports the use of cost-effective therapies in the treatment of patients with systemic rheumatic diseases, on the provisor that these treatments are clinically-proven to be safe and efficacious. Biologic therapies are expensive, and patient-rheumatologist treatment decisions should consider the expectant cost implications for the patient.
With regards to biosimilar use:-

- Biologic-naïve patients:

  In any patient starting a biologic treatment, one should chose the most appropriate therapy for that patient based on: mechanism of action and efficacy, its safety profile and the route of administration. Thereafter, the rheumatologist should select the most cost effective option, whether it be a biosimilar or originator biologic. Biosimilars are safe and effective, and appropriate as first-line biologic agents. If however, an originator biologic is deemed to be the most appropriate therapy for the patient by the treating rheumatologist, other stakeholders (i.e. medical funders, pharmacists) should not prohibit prescribing based on cost.

- Patients already on a biologic DMARD:

  The decision to switch a patient to a bsDMARD is based on the same principles as any other switch between different biologics. There is substantial data to inform a switch between a biologic and biosimilar of the same drug without the usual problem of inadequate response or adverse events, a non-medical switch. Several studies have shown that this can be done without adverse events or loss of efficacy. However, data from many large international registries, have described loss of efficacy on switching, particularly with “mandated non-medical switching”. This has been thought to be largely due to the “nocebo effect” - a negative outcome or failure of therapy resulting from a patient’s negative expectations toward a new therapy or a change in therapy. Patient education is essential to avoid this noteworthy problem.

  For this reason, the decision to switch should be an informed and shared-decision between the patient and the rheumatologist. The medical funder or health

administrator should not automatically switch without prior approval from the prescribing rheumatologist.

- Additional considerations:
  Prescriptions should state the brand name (e.g. Remsima or Amgevita) and not the international non-propriety name (e.g. infliximab or adalimumab) to prevent confusion and ensure the correct therapy is provided to the patient.
- Dispensing pharmacists should not substitute a originator product with a biosimilar without the permission of the prescribing rheumatologist.

It is important to ensure ongoing pharmacovigilance with regards to the use of new therapies, including bsDMARDs. The SARAA biologics registry is an important tool to assist with monitoring the safety and efficacy of the biosimilars. We encourage all members to submit to the registry, so as to inform ongoing appropriate use and safe practice.