

# EULAR Rheumatoid Arthritis Treatment Recommendations<sup>1</sup>

The 2019 EULAR recommendations provide consensus on the most recent evidence for optimal management of patients with RA.

## Overarching principles

Five general principles serve as the foundation upon which the recommendations are based.



Aim for the best care, based on shared decision-making



Rheumatologists should primarily care for RA patients



When managing RA, consider the high individual, medical, and societal costs



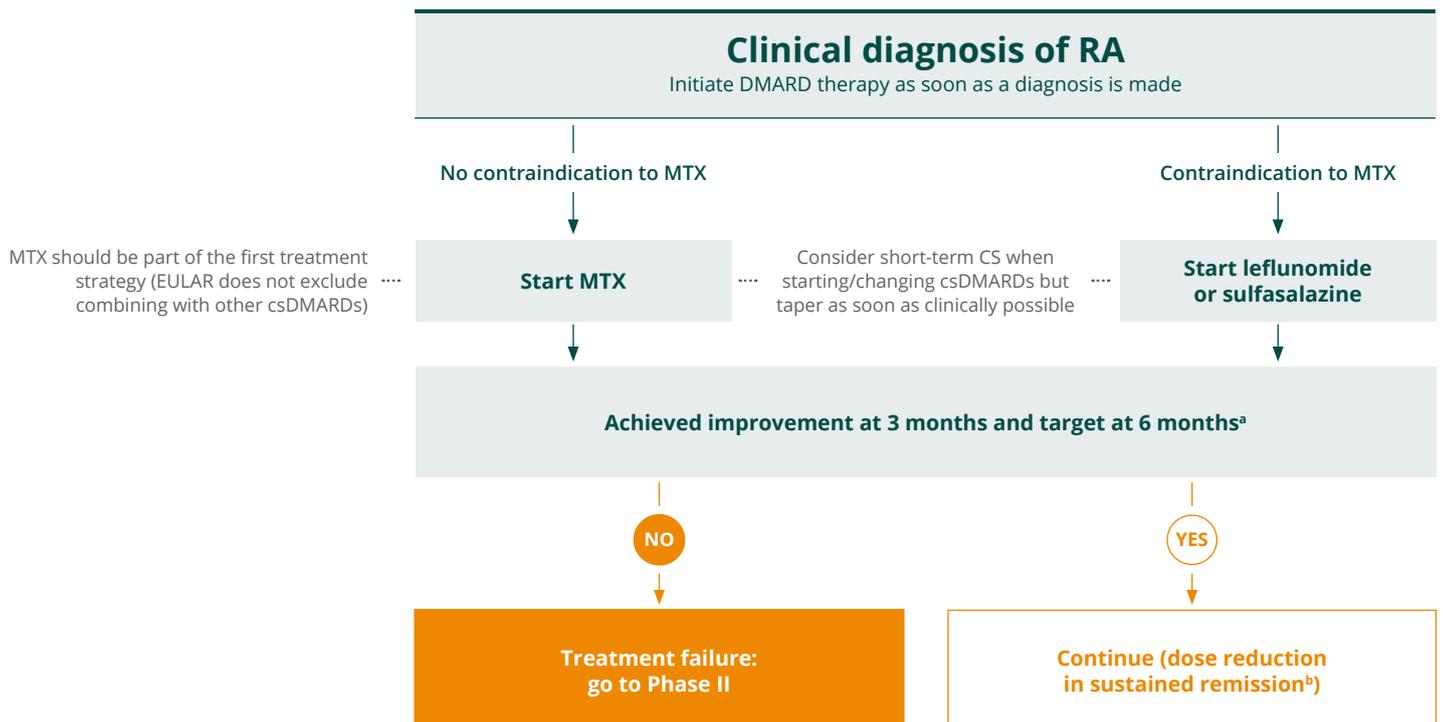
Heterogeneity of RA may require drugs with different MOAs; thus patients may require access to multiple therapies throughout life



Base treatment decisions on disease activity, safety issues, and other patient factors (eg, comorbidities, progression of structural damage)

## EULAR guidelines for the management of RA

### Phase I



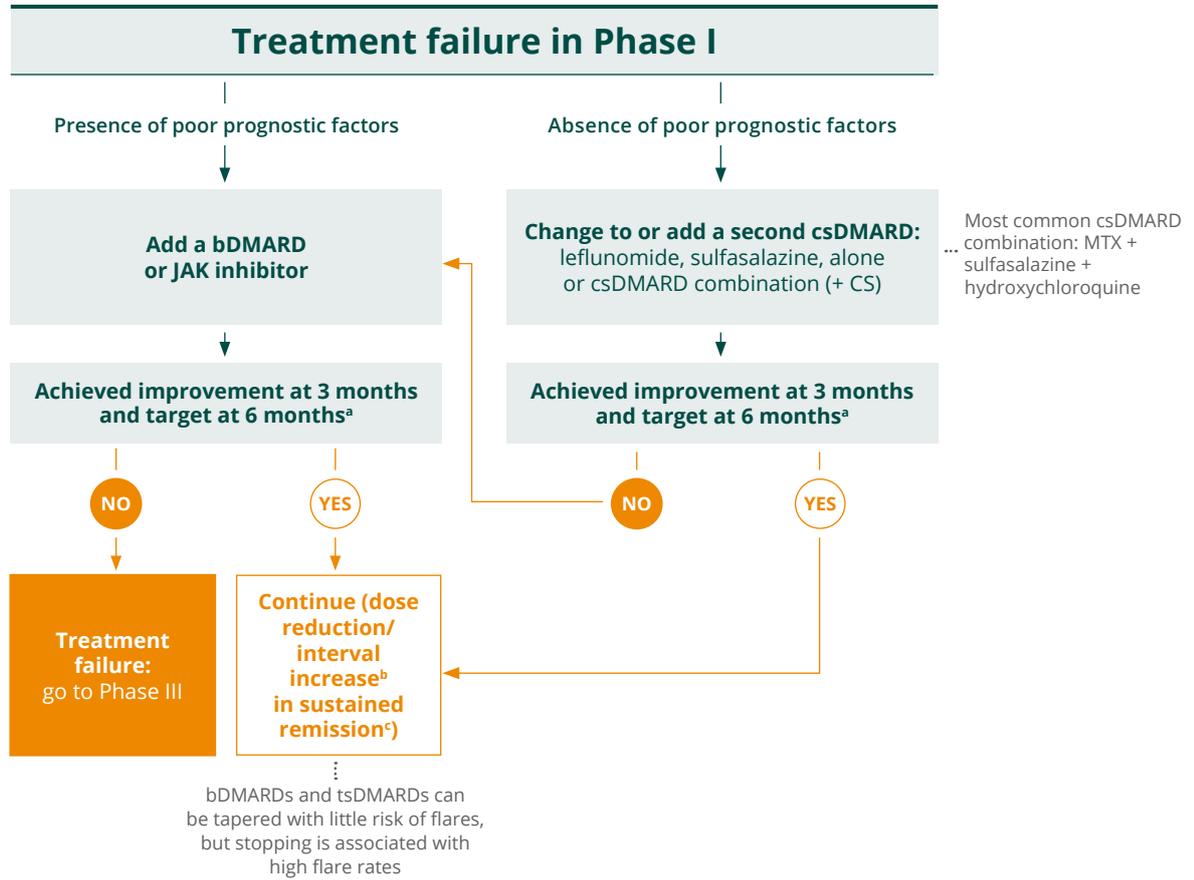
<sup>a</sup> Treatment target is clinical remission, or LDA if remission is unlikely. Monitoring should be frequent in active disease (every 1-3 months).

<sup>b</sup> Defined as  $\geq 6$  months ACR/EULAR index- or Boolean-based remission.

## Phase II

eg, RF/ACPA, high disease activity, early joint damage, failure of  $\geq 2$  csDMARDs

Should be combined with a csDMARD; in patients who cannot receive csDMARDs, IL-6 and JAK inhibitors may be preferred

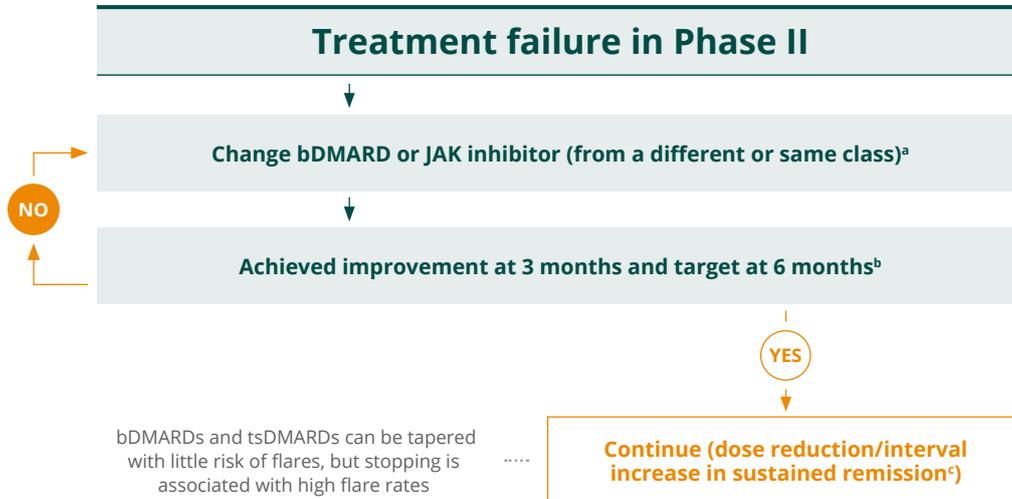


<sup>a</sup> Treatment target is clinical remission, or LDA if remission is unlikely. Monitoring should be frequent in active disease (every 1-3 months).

<sup>b</sup> Use interval increase strategy only for the treatment pathway with poor prognostic factors.

<sup>c</sup> Defined as  $\geq 6$  months ACR/EULAR index- or Boolean-based remission.

## Phase III



<sup>a</sup> Efficacy and safety have not been established for bDMARDs or subsequent JAK inhibitors after JAK inhibitor failure or for subsequent IL-6 inhibitors after IL-6 inhibitor failure.

<sup>b</sup> Treatment target is clinical remission, or LDA if remission is unlikely. Monitoring should be frequent in active disease (every 1-3 months).

<sup>c</sup> Defined as  $\geq 6$  months ACR/EULAR index- or Boolean-based remission.



• If a patient is in persistent remission after tapering CS, consider tapering bDMARDs or tsDMARDs, especially if treatment is combined with a csDMARD

• If a patient continues in persistent remission, consider also tapering the csDMARD

## Galápagos

ACPA, anticitrullinated protein antibody; ACR, American College of Rheumatology; bDMARD, biologic disease-modifying antirheumatic drug; CS, corticosteroid; csDMARD, conventional synthetic disease-modifying antirheumatic drug; DMARD, disease-modifying antirheumatic drug; EULAR, European Alliance of Associations for Rheumatology; IL-6, interleukin-6; JAK, Janus kinase; LDA, low disease activity; MOA, mechanism of action; MTX, methotrexate; RA, rheumatoid arthritis; RF, rheumatoid factor; tsDMARD, targeted synthetic disease-modifying antirheumatic drug.

**Reference:** 1. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. *Ann Rheum Dis.* 2020;79(1):685-699.

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