



South East London Inflammatory Bowel Disease treatment pathways - September 2026

Developed by: The Inflammatory Bowel Disease sub-group of the South East London Integrated Medicines Optimisation Committee

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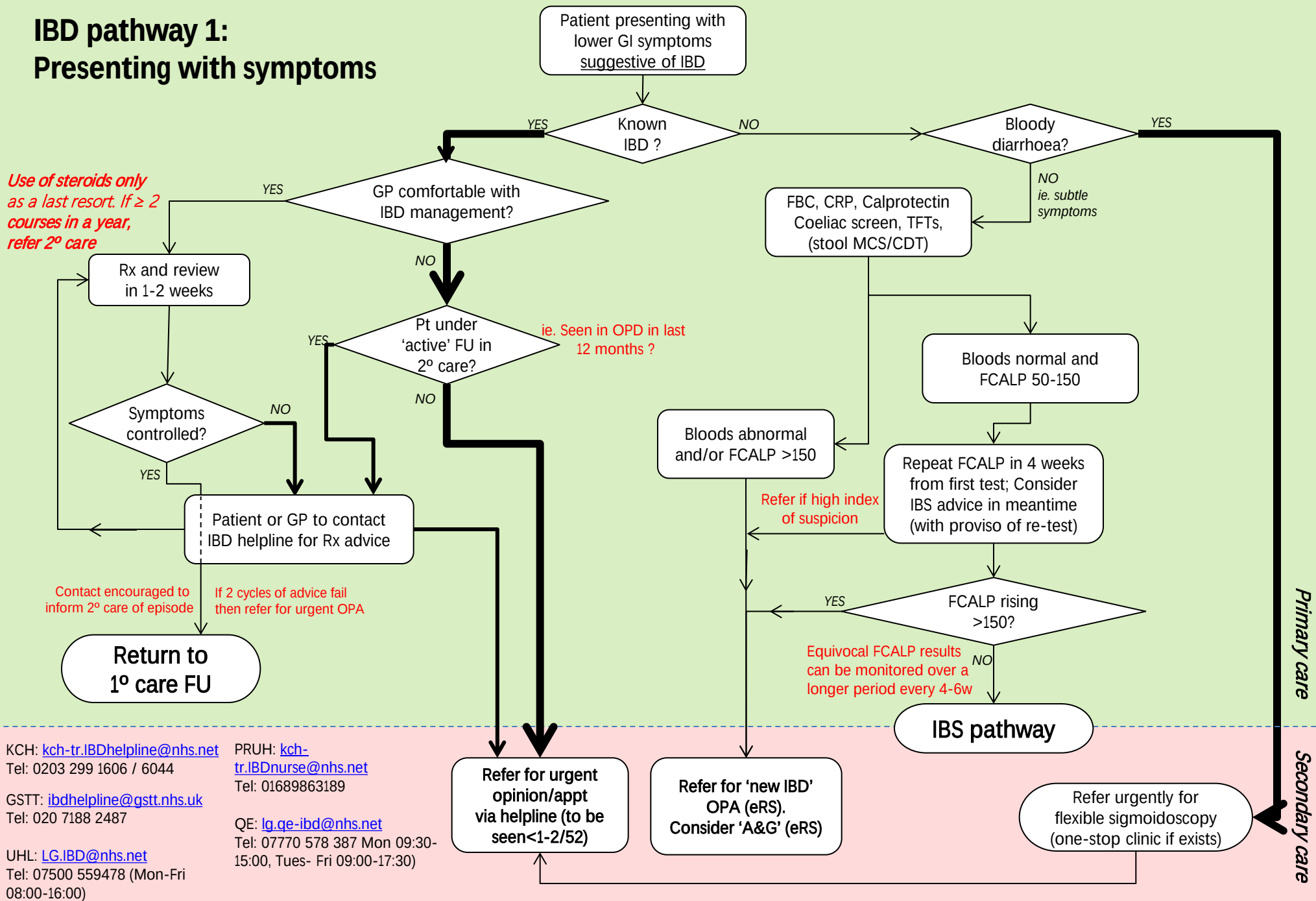
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Last reviewed and approved: September 2026 **Next review date:** September 2027 or sooner if evidence/practice changes

This pathway is correct at the time of publication. NICE Technology Appraisals (TAs) relating to Crohn's disease or ulcerative colitis in adults which are published after the approval date of this guideline will be commissioned 3 months (one month for fast track TAs) from publication and in line with the TA recommendations.

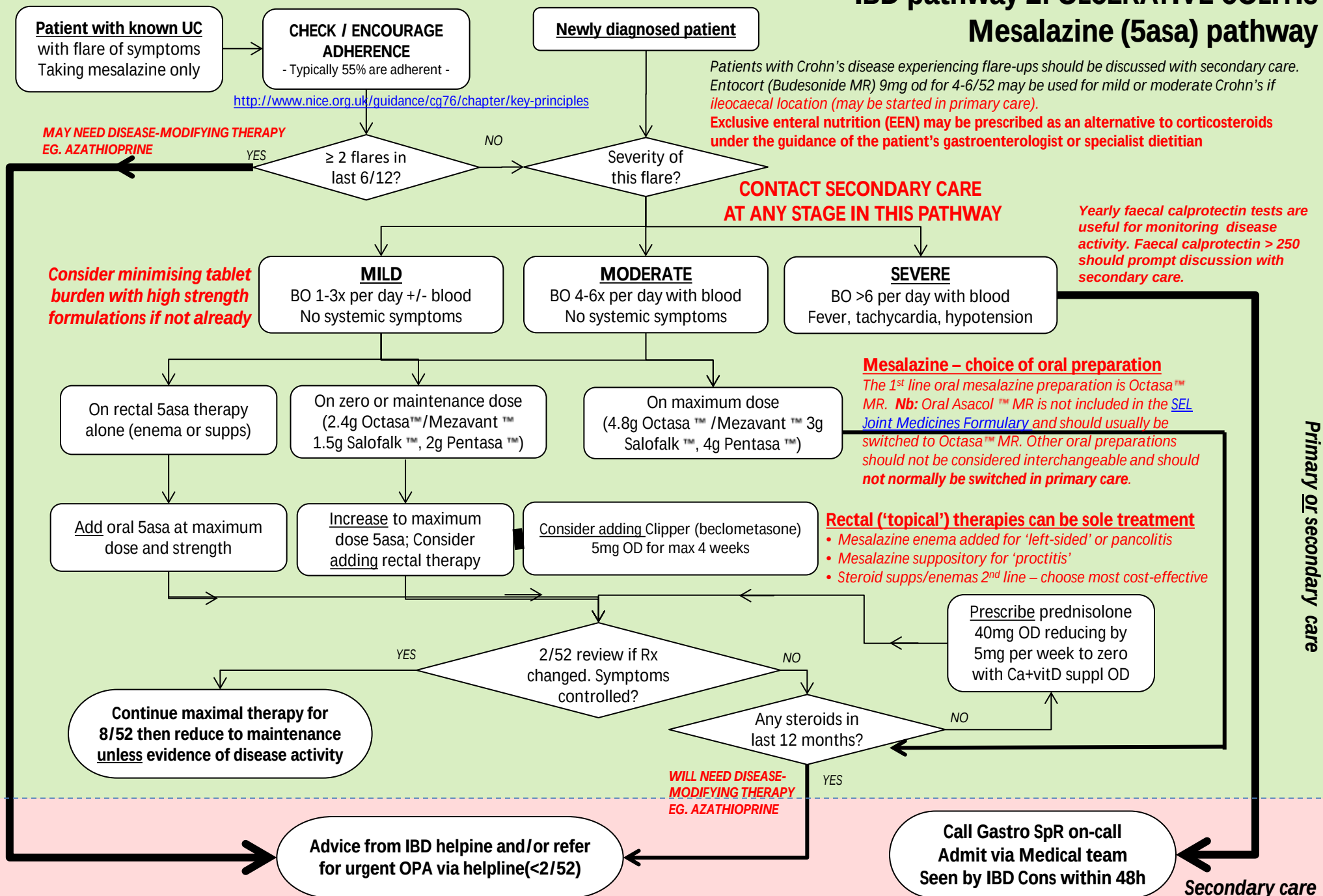
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IBD pathway 1: Presenting with symptoms

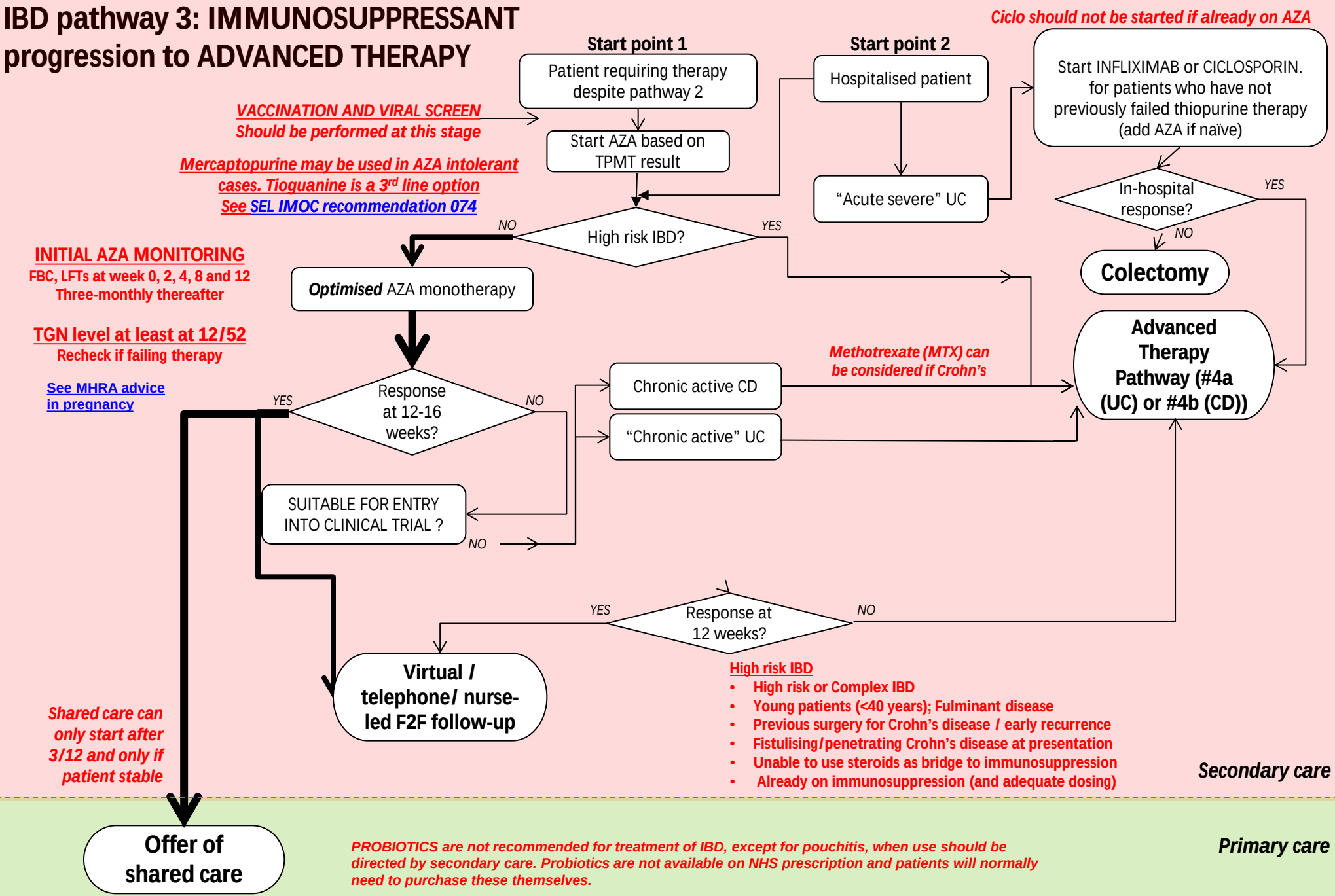


IBD pathway 2: ULCERATIVE COLITIS

Mesalazine (5asa) pathway



IBD pathway 3: IMMUNOSUPPRESSANT progression to ADVANCED THERAPY



IBD pathway 4a: ADVANCED THERAPY for UC

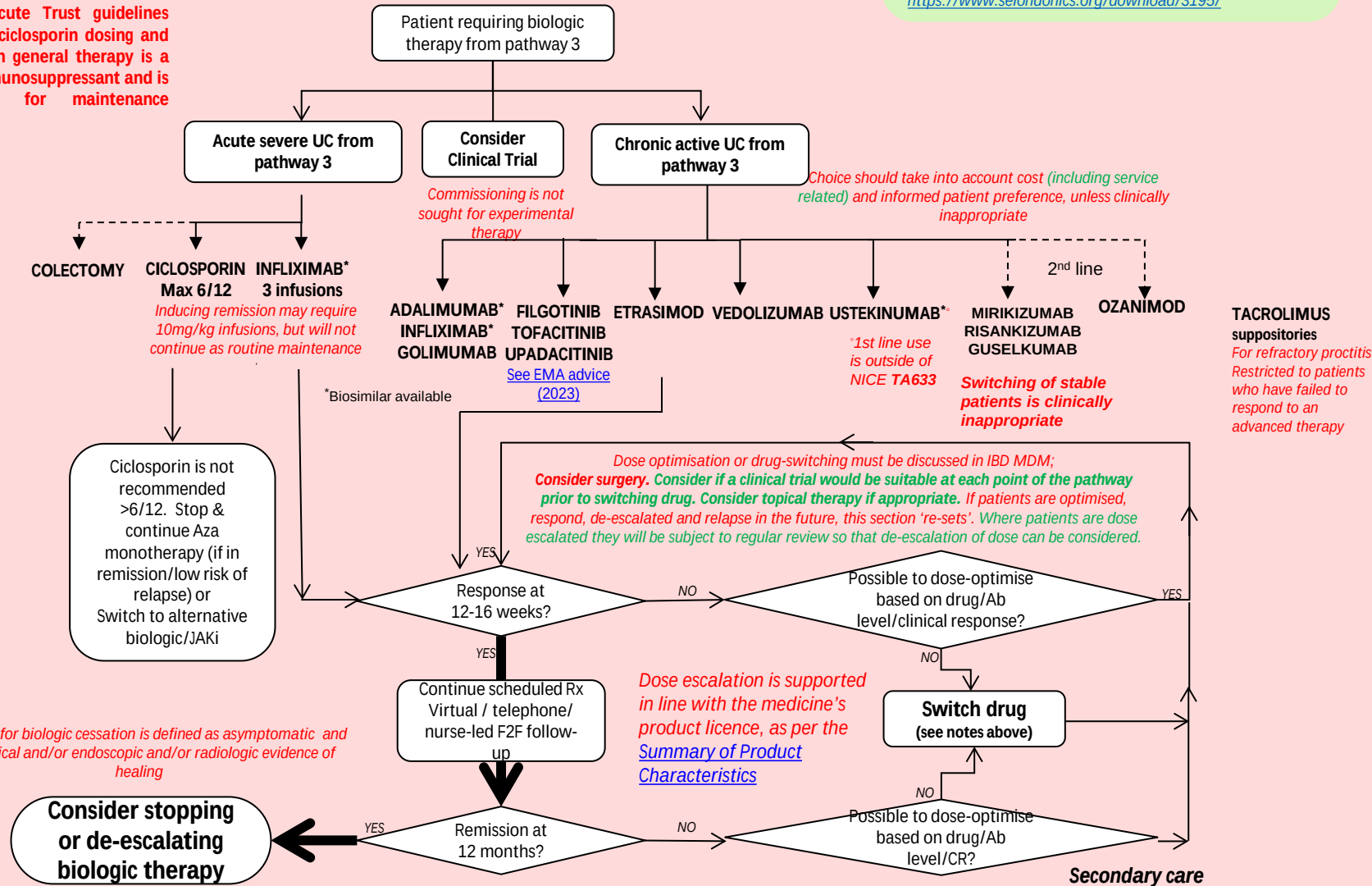
As part of the medicines reconciliation process, it is important that GP practices accurately record hospital prescribed and supplied medicines for their patients on their practice system but **do not** inadvertently issue a prescription for them. This includes biologic medicines and advanced medicines used in IBD. Local guidance on reconciling hospital only medicines in GP practice electronic record systems can be found at: <https://www.selondonics.org/download/3195/>

There are Acute Trust guidelines available for ciclosporin dosing and monitoring; In general therapy is a bridge to immunosuppressant and is inappropriate for maintenance >6/12

Colectomy should be considered for all patients with ASUC, but is usually indicated for those failing at least one rescue therapy (IFX or CsA)

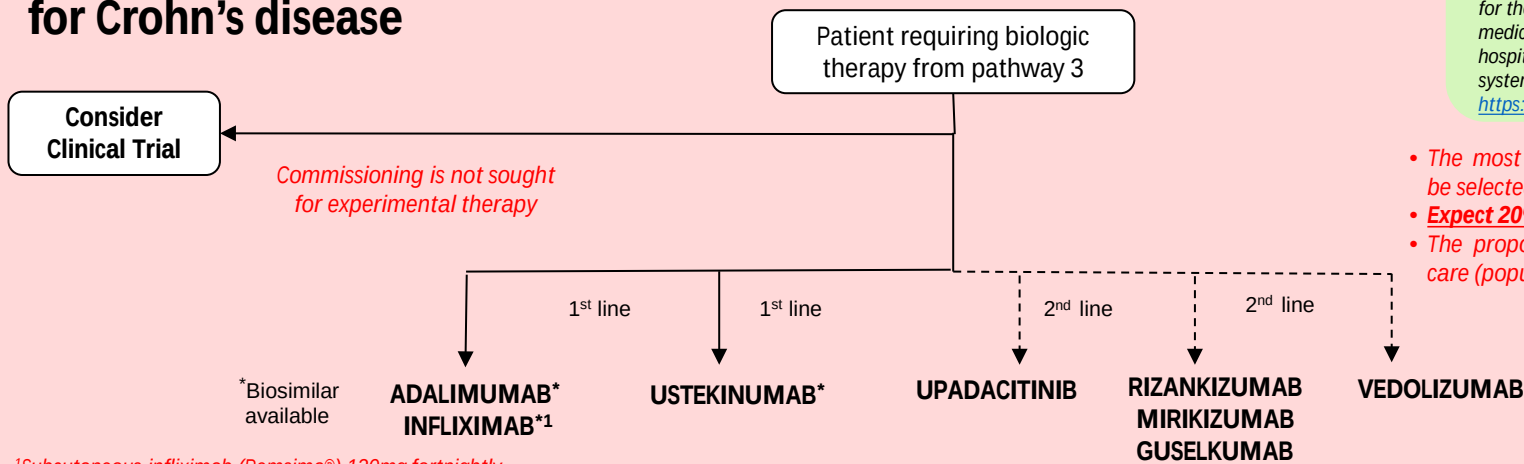
Remission for acute severe UC defined by Mayo <2 when steroid-free

Remission for biologic cessation is defined as asymptomatic and biochemical and/or endoscopic and/or radiologic evidence of healing



IBD pathway 4b: ADVANCED THERAPY for Crohn's disease

As part of the medicines reconciliation process, it is important that GP practices accurately record hospital prescribed and supplied medicines for their patients on their practice system but **do not** inadvertently issue a prescription for them. This includes biologic medicines and advanced medicines used in IBD. Local guidance on reconciling hospital only medicines in GP practice electronic record systems can be found at: <https://www.selondonics.org/download/3195/>



- The most appropriate and cost-effective biologic will be selected according to NICE guidance for CD
- **Expect 20% of local population of CD in this arm**
- The proportion of patients will be higher in tertiary care (population outside LSLBGB)

¹Subcutaneous infliximab (Remsima®) 120mg fortnightly (off label) is approved locally for maintenance therapy (after IV induction), and may be escalated to 120mg weekly dosing or 240mg fortnightly in patients with secondary loss of response to standard dosing after week 22

Choice should take into account cost (including service related) and informed patient preference, unless clinically inappropriate

Switching of stable patients is clinically inappropriate

Further considerations for Severe Crohn's disease

- There is local agreement that anti-TNF therapy (intravenous infliximab/adalimumab) can be escalated above standard escalated doses within the [agreed criteria](#) to achieve therapeutic levels if this is thought more clinically appropriate than switching to other agents (e.g. in perianal CD, extensive stricturing disease). The agreed escalated dosing's are:
 - Intravenous infliximab: 10mg/kg every four/six weeks
 - Adalimumab 80mg weekly

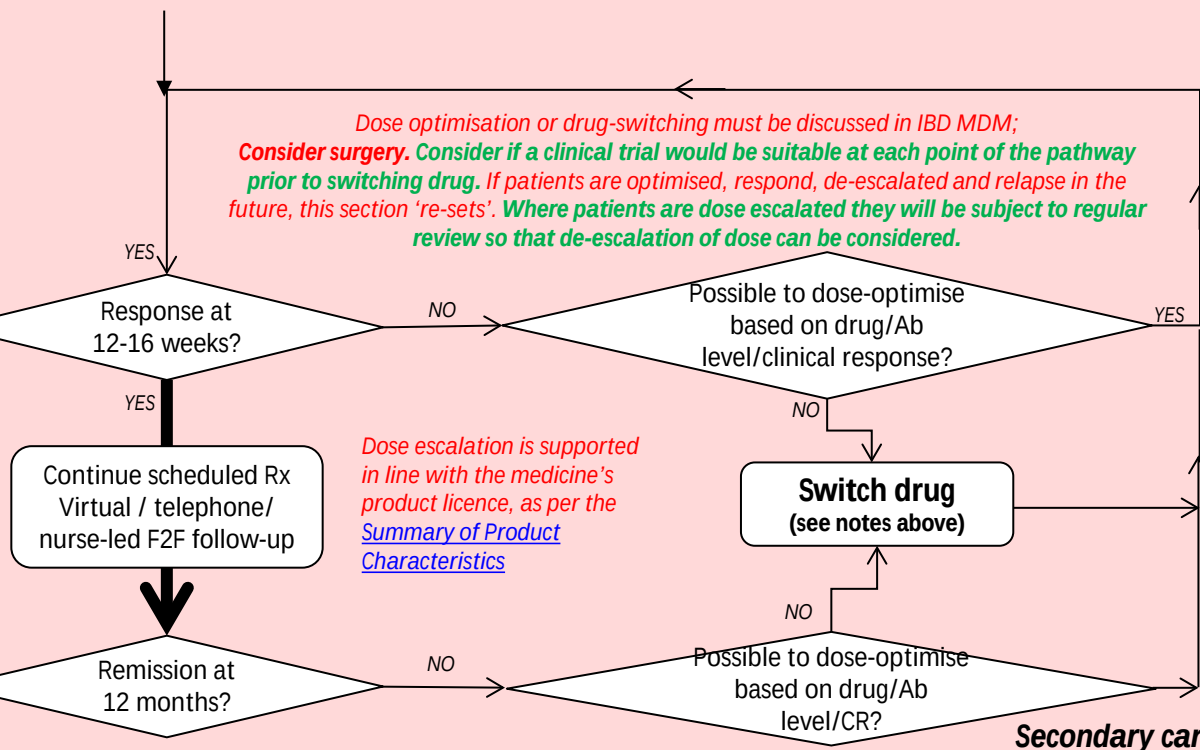
- The following dual advanced therapies may be considered within the [locally agreed criteria](#) for refractory Crohn's disease where combined mechanisms of action may be more effective:

- o Anti-TNF*/ustekinumab
- o Anti-TNF*/vedolizumab
- o Anti-TNF*/risankizumab
- o Ustekinumab/upadacitinib
- o Ustekinumab/vedolizumab

*Anti-TNF therapies: adalimumab or infliximab

Remission for biologic cessation is defined as asymptomatic and biochemical and/or endoscopic and/or radiologic evidence of healing

Consider stopping or de-escalating biologic therapy



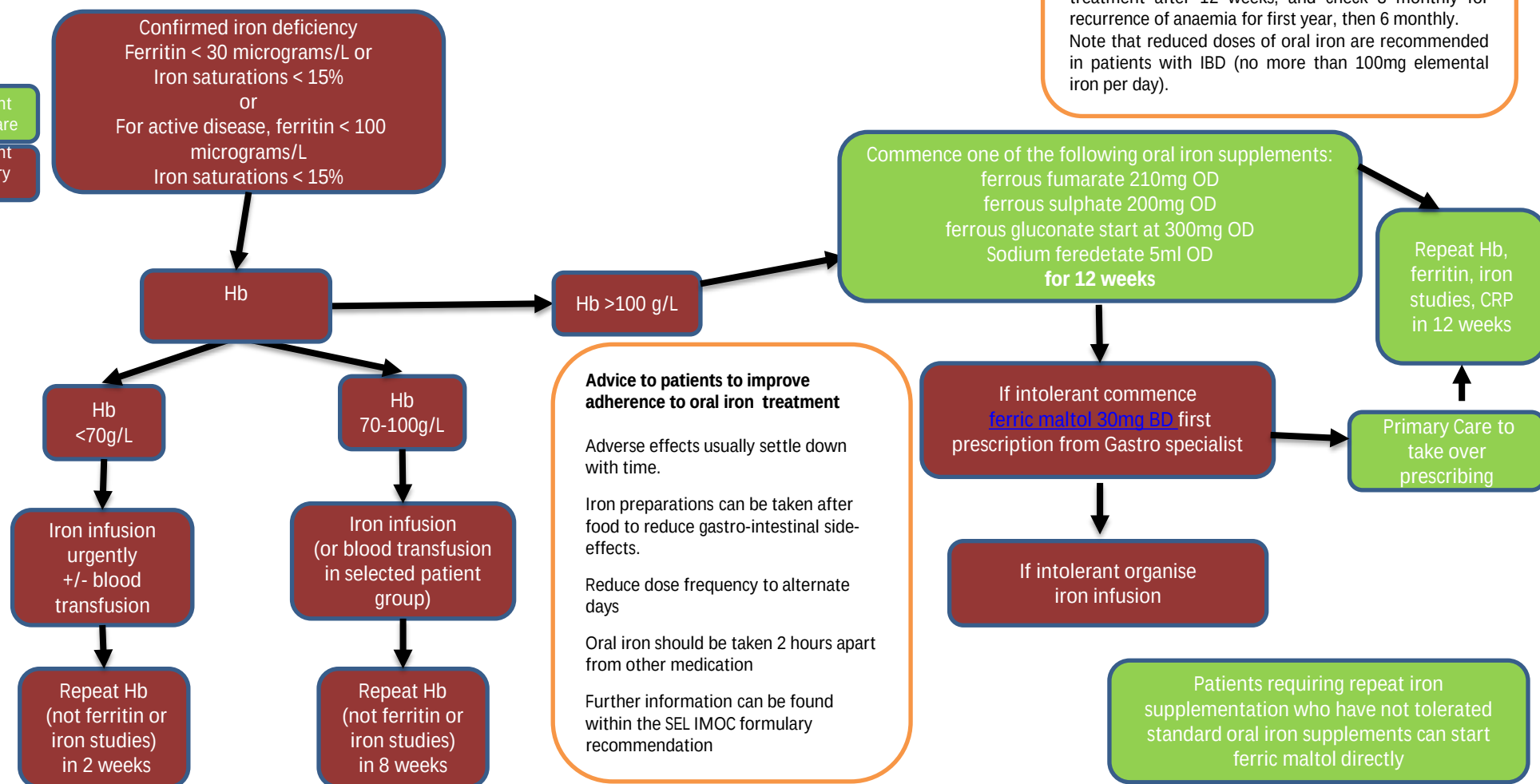
Dose escalation is supported in line with the medicine's product licence, as per the [Summary of Product Characteristics](#)

Pathway 5: Iron deficiency treatment pathway for patients with Inflammatory Bowel Disease (IBD)

Key:

Management
in Primary care

Management
in Secondary
care



Inflammatory Bowel Disease Pathway Cost profiling sheet for Advanced Therapies

Option	Drug (listed by increasing price, including infusion tariff in cost comparison)	Dosing	Cost tier	Mode of Action	Route/Form	Licensing		Intravenous (requiring day case admission)	Notes
						CD	UC		
1	Adalimumab biosimilar*	standard/escalated	£	TNF inhibitor	SC syringe/pen	✓	✓	X	
2	Ustekinumab biosimilar*	Standard	£	IL-23 & IL-12 inhibitor	SC syringe/pen	✓	✓	✓	12 weekly
3	Ustekinumab biosimilar*	Escalated	£	IL-23 & IL-12 inhibitor	SC syringe/pen	✓	✓	✓	8 weekly
4	Ozanimod	standard	£	S1P modulator	Oral capsules	X	✓	X	
5	Etrasimod	standard	£	S1P modulator	Oral tablets	X	✓	X	
6	Filgotinib	standard	£	JAK inhibitor	oral tablets	X	✓	X	
7	Adalimumab originator*	standard	£	TNF inhibitor	SC syringe/pen	✓	✓	X	
8	Infliximab biosimilar*	standard	£	TNF inhibitor	SC syringe/pen	✓	✓	✓	
9	Golimumab	standard/escalated	£	TNF inhibitor	SC syringe/pen	X	✓	X	
10	Upadacitinib	standard	££	JAK inhibitor	oral tablets	✓	✓	X	15mg daily
11	Infliximab biosimilar*	standard	££	TNF inhibitor	IV vial for infusion	✓	✓	✓	5mg/kg 8 weekly
12	Tofacitinib	standard	££	JAK inhibitor	oral tablets	X	✓	X	5mg BD
13	Vedolizumab	standard	££	α4β7 integrin inhibitor	SC syringe/pen	✓	✓	✓	
14	Guselkumab	Standard	££	IL-23 inhibitor	SC pen	✓	✓	✓ ^	100mg 8 weekly
15	Infliximab biosimilar*	escalated	££	TNF inhibitor	IV vial for infusion	✓	✓	✓	10mg/kg 8 weekly
16	Adalimumab originator*	escalated	££	TNF inhibitor	SC syringe/pen	✓	✓	X	
17	Upadacitinib	standard	£££	JAK inhibitor	oral tablets	✓	✓	X	30mg daily
18	Mirikizumab	standard	£££	IL-23 inhibitor	SC pen	X	✓	✓	200mg Q4 (UC)
19	Ustekinumab originator	standard	£££	IL-23 & IL-12 inhibitor	SC syringe	✓	✓	✓	90mg 12 weekly
20	Mirikizumab	standard	£££	IL-23 inhibitor	SC pen	✓	X	✓	300mg 4 weekly (CD)
21	Vedolizumab	standard	£££	α4β7 integrin inhibitor	IV vial for infusion	✓	✓	✓	300mg 8 weekly
22	Tofacitinib	escalated	£££	JAK inhibitor	oral tablets	X	✓	X	10mg BD
23	Risankizumab	standard	££££	IL-23 inhibitor	SC on body injector	✓	✓	✓	360mg 8 weekly (180mg maintenance dose available in UC)
24	Guselkumab	Escalated	££££	IL-23 inhibitor	SC pen	✓	✓	✓	200mg 4 weekly
25	Ustekinumab originator	escalated	££££	IL-23 & IL-12 inhibitor	SC syringe	✓	✓	✓	90mg 8 weekly
26	Vedolizumab	escalated	£££££	α4β7 integrin inhibitor	IV vial for infusion	✓	✓	✓	300mg 4 weekly

Cost profiling tool last updated: August 2026

Next update: September 2027 or sooner if indicated

Inflammatory Bowel Disease Pathway Cost profiling sheet for Advanced Therapies

SC = subcutaneous administration, IV = intravenous administration

*= no longer high cost drug as of 01/04/2026

= s/c loading option available

Cost calculations are based on annual cost of maintenance treatment for a 70kg patient (induction doses are not included in cost comparison). Cost of induction is not included in this comparison tool.

Due to patient convenience and additional costs of administration it is always preferable to use a subcutaneous or oral options.

The choice of best value biologic will be dependent upon a number of factors (for example contraindications to therapy, co-morbidities and other patient factors). Where more than one agent is suitable for the patient, the agent with the lowest acquisition cost (considering method of administration) will be chosen.

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