AB0211

SWITCHING FROM ETANERCEPT ORIGINAL TO ETANERCEPT BIOSIMILAR: LONG TERM FOLLOW UP

G. Sada¹, M. C. Laño Piñero¹, V. Aldasoro¹, J. Mendizabal¹, M. Lopez¹, S. García Perez¹, L. Garrido Courel¹, N. Del-Val¹, L. Horcada¹, R. Gutiérrez Polo¹, I. Paniagua Zudaire¹, C. Fito-Manteca¹ on behalf of Complejo Hospitalario de Navarra Servicio de Reumatología. ¹Complejo Hospitalario de Navarra, Rheumatology, Pamplona, Spain

Background: Biosimilar drugs has supposed a huge savings in our health systems and there are data that conclude that they work as original molecules when we making these switchings. There are limited studies that analyze these patients across the time (1-3).

Objectives: Long term follow up of patients after switching from original etanercept to biosimilar drug.

Methods: We reviewed 187 patients who started Etanercept original in Rheumatology department at Navarra Hospital Complex and their switch to Etanercept biosimilar with a follow-up of 18 months.

Results: The switch was performed in 176 patients with rheumatoid arthritis (RA), spondyloarthritis (SpA) and psoriatic arthritis (PsA).

At 18 months of follow-up 26,1% discontinued treatment; 13% at 6 months, 9,1% at 12 months and 4% patients at 18 months. The median time in etanercept original drug before switching was 52 months.

There were 46 withdrawal patients with etanercept biosimilar: 34 inefficacy, 3 skin reaction, 2 malignancies (lymphoma and GIST), 1 injection site reaction, 1 headache, 1 diarrhea, 1 recurrent urinary infection, 1 heart failure and 2 deaths. 25 patients returned to Etanercept original but 3 did not achieve good response; all of them in RA group.

Conclusion: In our series 50 % of withdrawal happened at 6 months of follow-up. 73,9% had a good response with etanercept biosimilar at 18 months. The main reason to stop biosimilar drug was inefficacy.

Longer-term follow-up and greater number of patients are necessary to ratify these data.

REFERENCES:

- [1] Selmi C, et al. BENEFIT: real-world effectiveness of SB4 after transition from reference etanercept in rheumatoid arthritis and axial spondyloarthritis. Clin Exp Rheumatol. 2020 Jun 30. Epub ahead of print.
- [2] Glintborg B, et al. To switch or not to switch: results of a nationwide guideline of mandatory switching from originator to biosimilar etanercept. One-year treatment outcomes in 2061 patients with inflammatory arthritis from the DANBIO registry. Ann Rheum Dis. 2019 Feb;78(2):192-200.
- [3] Tweekhuysen L, et al. Open-Label, Non-Mandatory Transitioning From Originator Etanercept to Biosimilar SB4: Six-Month Results From a Controlled Cohort Study. Arthritis Rheumatol. 2018 Sep;70(9):1408-1418.

Table 1.

	WITHDRAWAL (months)	BACK TO ENBREL (n)	CONTINUE (n)	REASON FOR WITHDRAWAL SWITCH (months)	INEFFICACY	A. event*	Cancer	Death
RA	22	11	8	53	14	5	2	1
PsA	16	6	6	53,5	15	0	0	1
SpA	8	8	8	45	5	3	0	0
TOTAL	46	25	22	52	34	8	2	2

*Infections (1), Heart failure (1), skin reaction (3), injection point reaction (1)

RA: rheumatoid arthritis; PsA: psoriatic arthritis; SpA: spondyloarthritis

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.1162

AB0212

NON-ADHERENCE IN RHEUMATOLOGIC IMMUNE-MEDIATED DISEASES

A. Rodríguez-Alarcón¹, N. Carballo¹, L. Río¹, C. Pérez², E. González-Colominas¹, X. Durán³, J. Monfort², S. Grau-Cerrato¹, O. Ferrández-Quirante¹. ¹Hospital del Mar, Pharmacy, Barcelona, Spain; ²Hospital del Mar, Rheumatology, Barcelona, Spain; ³IMIM - Hospital del Mar, Statistics, Barcelona, Spain

Background: Patient adherence is a key determinant of treatment success in rheumatologic immune-mediated diseases. Available data about adherence to biological treatments and factors associated to non-adherence is limited in Spain. Moreover, no studies compare adherence between subcutaneous and oral drugs.

Objectives: To evaluate non-adherence to prescribed subcutaneous biologicals and oral drugs in patients with rheumatologic immune-mediated diseases and to assess possible predictor factors associated to treatment non-adherence.

Methods: Retrospective observational study including all patients with oral and subcutaneous treatment for rheumatologic immune-mediated diseases from 2017 to 2019 in the outpatient pharmaceutical care area from a tertiary university hospital. Non-adherence was evaluated by reviewing all scheduled drug-dispensing visits in the computerized application. We considered non-adherent every time that a patient missed at least one drug administration.

Data collected: demographic, total patients and patient-treatments, total dispensing visits and route of administration for drug dispensed in every visit.

We classified patients in adherent and non-adherent considering dispensing visits. Non-adherent group: number of dispensing visits, reasons for non-adherence, number of missed administrations per patient and drug and predictor factors for non-adherence.

Results: 783 patients included: 52.4(13.7) years; 427(54.5%) female; 164 (20.9%) smoker; 697 (89%) Caucasian.

A total of 79 (10.1%) of 783 patients received more than one treatment.

869 patient-treatments: 294 adalimumab (33.8%), 236 etanercept (27.2%), 78 golimumab (8.9%), 47 apremilast (5.4%), 39 certolizumab (4.5%), 34 secukinumab (3.9%), 30 tocilizumab (3.5%).

9,197 dispensing visits. Route of administration: 6,406 subcutaneous (93.2%), 374 oral (6.8%).

Non-adherence analysis: 2417 (26.3%) dispensing visits, reasons for non-adherence/ dispensing visits: 92 unjustified (97.5%), 33 infection (1.4%), 18 (surgery) 0.7%, 3 pregnancy (0.1%), 6 others (0.3%).

Number of missed administrations/patient treatment: 675 patients missed at least one administration (77.7%). Mean 2.5 (±12.9) missed administrations.

Number of missed administrations/drug: 9.9 baricitinib (±20.8), 15.8 tofacitinib (±31.2), 25.4 apremilast (±53.2).

Predictor factors for non-adherence: ethnicity (p=0.015), treatment with golimumab (p=0.006), and tocilizumab (p=0.036). Age (p=0.072).

Conclusion: - Non-adherence to the prescribed drug occurred in 77.7% of patients with rheumatologic immune-mediated diseases

- Demographic factors such as ethnicity as well as golimumab and tocilizumab treatment, despite their different frequency of administration, were predictors for non-adherence

- Route of administration did not influence non-adherence.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.1304

AB0213

SAVING GLUCOCORTICOID AFTER RITUXIMAB TREATMENT IN PATIENTS WITH RHEUMATOID ARTHRITIS. ANALYSIS OF A COMMON CLINICAL PRACTICE COHORT

G. Jurado Quijano¹, L. Fernández de la Fuente Bursón¹, B. Hernández-Cruz¹, P. Muñoz Reinoso¹, V. Merino Bohóquez², J. J. Pérez Venegas¹. ¹Hospital Universitario Virgen Macarena, UGC Reumatología, Sevilla, Spain; ²Hospital Universitario Virgen Macarena, UGC Farmacia Hospitalaria, Sevilla, Spain

Background: Rituximab (RTX) is a monoclonal antibody against the CD20 B cell antigen that has been used successfully in recent years for the treatment of rheumatoid arthritis (RA). It is an effective drug that reaches survival rates of 60% at 5 years of treatment as reflected in the British experience. However, survival in Spanish patients is unknown.

Objectives: To study the survival of RTX treatment and the characteristics of patients with RA treated with the drug since its commercialization in Spain.

Methods: Observational, retrospective and analytical study of a cohort of patients with RA treated with at least one dose of RTX. We reviewed the medical records of all patients with RA from January 2007 to June 2017. A total of 178 previous defined variables were collected, highlighting data about treatment (use of RTX, associated conventional synthetic disease modifying drugs [FAMEsc], doses of corticosteroids [GC] used) and activity indices. Descriptive statistics were performed (median and the 25th and 75th percentiles are shown). The comparative analysis was done with χ^2 and U of Mann Whitney for categorical variables and paired sign rank test or Student's t for continuous. Survival Kaplan Mayer curves were constructed. The study was carried out in accordance with the standards of our Clinical Research Ethics Committee.

Results: A total of 54 patients were analyzed. 74% (n = 40) of them were women, the age was 61.2 years (51.0 - 67.4). 74% (n = 40) presented some type of relevant comorbidity. Its RA was FR + in 96% (n = 52) and ACCP + in 78% (n = 42) of the cases, with an evolution time of 9.3 years (3.5-19, 2), and with radiographic erosions in up to 63% (n = 34). At the time of the start of the RTX, 100% of the patients (n = 54) received some FAMEsc, and 33 (61%) were treated with prednisone; the daily dose of prednisone was 9 (6-12) mg. The baseline DAS28-VSG was 5 (4.1 - 6.0). The duration of the follow-up was 56.6 (29.3-92.1) months. Patients received a mean of 5 (1-6) cycles of RTX at a dose of 1000 mg on days 0 and 15 in most cases. The final DAS28-VSG was 2.6 (2.1 - 4.0), p = 0.0001 compared to baseline. The delta between baseline and final DAS was -2.36 (-0.55 - -3.1). At the end of the RTX treatment, the EULAR response rate