CARRA
Childhood Arthritis and Rheumatology Research Alliance

Polyarticular Juvenile Idiopathic Arthritis Consensus Treatment Plan
Option 1: STEP-UP

VISIT 1 (BASELINE)

- Physician Global Assessment (PGA)*
- Begin conventional synthetic disease-modifying antirheumatic drug (csDMARD)** treatment
- Optional prednisone: Use lowest possible dose and taper quickly (see tapering algorithms)
- Optional intra-articular steroid injection(s) (IAS)

Option for unscheduled visit earlier than 3 months if patient has no response or is worsened at 1-2 months to proceed to increased therapy.

VISIT 2 AT THREE MONTHS

Should be off prednisone if possible.

Patient much better, off prednisone, AND PGA ≤2***

- Continue visit 1 treatment

Patient not much better, PGA ≥2, and/or still on prednisone

- Increase csDMARD if not at max
- Consider optional IAS
- Consider adding biologic DMARD treatment (bDMARD)******

VISIT 3 AT SIX MONTHS

Patient much better, off prednisone, AND PGA ≤2

- Continue visit 2 treatment

Patient not much better, PGA ≥2, and/or still on prednisone

- Increase csDMARD if not at max
- Consider optional IAS
- Begin or change bDMARD

Optional reassessment at 9 months if treatment change at visit 3.

VISIT 4 AT TWELVE MONTHS

Patient much better, off prednisone, AND PGA ≤2

- Continue visit 3 treatment or consider tapering csDMARD

Patient not much better, PGA ≥2, and/or still on prednisone

- Increase csDMARD if not at max or change + optional IAS
- Begin or change bDMARD

* PGA is based on a visual analog scale of 0-10 assessing JIA disease activity.
** Conventional synthetic DMARD: Methotrexate, sulfasalazine, or leflunomide.
*** This CTP was adapted to use the Juvenile Arthritis Disease Activity Score (cJADAS10) for the STOP-JIA CTP study. cJADAS10 <=2 was used in the STOP-JIA CTP study as a target.
**** Biologic choices: Any inhibitor of TNF, T cell costimulation, IL6, or B cells.

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