Measurement of Serum Antibodies to Infliximab and Adalimumab

Effective: May 1, 2018

Next Review: April 2019
Last Review: April 2018

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Anti-infliximab antibodies (ATI) and anti-adalimumab antibodies (ATA) may be found in patients undergoing treatment for irritable bowel disease or rheumatoid arthritis and is thought to be associated with a loss of treatment response.

MEDICAL POLICY CRITERIA

Measurement of antibodies to infliximab or adalimumab, in a patient receiving the treatment medication, either alone or as a combination test which includes the measurement of medication serum levels, is considered investigational.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

CROSS REFERENCES

1. Medication Policy Manual, Note: Do a find (Ctrl+F) and enter drug name in the find bar to locate the appropriate policy.

BACKGROUND

INFLIXIMAB AND ADALIMUMAB IN AUTOIMMUNE DISEASE
Therapy with monoclonal antibodies has revolutionized treatment of patients with inflammatory diseases such as inflammatory bowel disease (IBD; Crohn's disease [CD] and ulcerative colitis [UC]), rheumatoid arthritis and psoriasis. These agents are generally given to patients who fail conventional medical therapy, and they are typically highly effective for induction and maintenance of clinical remission. However, not all patients respond, and a high proportion of patients lose response over time. An estimated one-third of patients do not respond to induction therapy (primary nonresponse), and among initial responders, response wanes over time in approximately 20% to 60% of patients (secondary nonresponse). The reasons for therapeutic failures remain a matter of debate but include accelerated drug clearance (pharmacokinetics) and neutralizing agent activity (pharmacodynamics) due to antidrug antibodies (ADA).[1]

Infliximab (Remicade®, Janssen Biotech) is an intravenous tumor necrosis factor alpha (TNFα) blocking agent approved by the U.S. Food and Drug Administration (FDA) for the treatment of rheumatoid arthritis, CD, ankylosing spondylitis, psoriatic arthritis, plaque psoriasis, and ulcerative colitis (UC). Infliximab is a chimeric (mouse/human) anti-TNFα monoclonal antibody. Adalimumab (Humira® AbbVie) is a subcutaneous TNFα inhibitor that is FDA-approved for treatment of the above indications (CD and UC in adults only) plus juvenile idiopathic arthritis (JIA). Adalimumab is a fully human monoclonal antibody to TNFα.

Following primary response to infliximab and adalimumab, some patients become nonresponders (secondary nonresponse). The development of ADA is considered to be a cause of secondary nonresponse. ADA are also associated with injection site reactions (adalimumab), and acute infusion reactions and delayed hypersensitivity reactions (infliximab). As a fully human antibody, adalimumab is considered less immunogenic than chimeric antibodies, such as infliximab.

DETECTION OF ANTIDRUG ANTIBODIES

The detection and quantitative measurement of ADA has been fraught with difficulty owing to drug interference and identifying when antibodies are likely to have a neutralizing effect. First-generation assays, (i.e., enzyme-linked immunosorbent assays [ELISA]) can measure only ADA in the absence of detectable drug levels, due to interference of the drug with the assay. Other techniques available for measuring antibodies include the radioimmunoassay (RIA) method, and more recently, the homogenous mobility shift assay (HMSA) using high-performance liquid chromatography. Disadvantages of the RIA method are associated with the complexity of the test and prolonged incubation time, and safety concerns related to the handling of radioactive material. The HMSA has the advantage of being able to measure ADA when infliximab is present in the serum. A reporter-gene assay (RGA) is also available, which allows for the measurement of ADAs capable of neutralizing drug activity.[2] Cell-based assays typically have difficulty in standardization, take up to two days to complete, and with effects from the serum matrix. However, the RGA can quantify the antidrug neutralizing antibody independent of matrix effects within two hours. Application of the RGA has recently been assessed for use in a clinical laboratory setting, and found to be a precise and high-throughput robust platform for detection of ADA.[3] Large randomized studies are still necessary to establish relevant clinical cut-off levels. Studies evaluating the validation of results among different assays are lacking, making inter-study comparisons difficult. One retrospective study in 63 patients demonstrated comparable diagnostic accuracy between two different ELISA methods in patients with IBD (i.e, double antigen ELISA and antihuman lambda chain-based ELISA).[4] This study did not include an objective clinical and endoscopic scoring system for
validation of results. A review by Seow and Panaccione, noted that the variability and lack of standardization in current assay tests has important implications for subsequent studies which report associations between antibodies-to-infliximab (ATIs) and infliximab levels and utilize these assays to predict treatment response. These findings highlight the need for a validated gold standard test and established diagnostic parameters with which to measure levels of infliximab and ATIs.

TREATMENT OPTIONS FOR PATIENTS WITH SECONDARY LOSS OF RESPONSE TO ANTI-TNF THERAPY

A diminished or suboptimal response to infliximab or adalimumab can be managed in several ways: shortening the interval between doses, increasing the dose, switching to a different anti-TNF agent (in patients who continue to have loss of response after receiving the increased dose), or switching to a non-anti-TNF agent.

REGULATORY STATUS

Prometheus® Laboratories Inc., a College of American Pathologists–accredited lab under CLIA, offers non-radiolabeled fluid-phase HMSA tests called the Anser™IFX test for infliximab and Anser™ADA for adalimumab. Neither of these tests are ELISA-based and both can measure antidrug antibodies in the presence of detectable drug levels, improving upon a major limitation of the ELISA method. Both tests measure serum concentrations and antidrug antibodies.

These tests were developed and their performance characteristics determined by Prometheus Laboratories Inc. Neither has been cleared or approved by the U.S. Food and Drug Administration (FDA).

EVIDENCE SUMMARY

Validation of the clinical use of any diagnostic test focuses on analytic validity, diagnostic validity, and clinical utility. Analytic validity demonstrates technical feasibility as compared to a gold standard, including assessment of test reproducibility and precision. For comparison among studies, a common standardized protocol is necessary. Diagnostic utility is evaluated by the ability of a test to accurately predict the clinical outcome in appropriate populations of patients. For accurate interpretation of study results, sensitivities, specificities, and positive and negative predictive values compared to a gold standard must be known. Clinical utility is established when the evidence demonstrates that the diagnostic information obtained from a test can be used to benefit patient management and improve health outcomes.

Most studies evaluating antibodies to infliximab or to adalimumab report serum drug together with antidrug antibodies (ADA) levels, and correlate levels to disease response. Serum drug levels and disease response will not be addressed in this section and therefore the data reported on ADA will be highlighted from the identified studies. Most evidence concerning testing for ADA is derived from the data available for patients with inflammatory bowel disease (IBD) and rheumatoid arthritis (RA). Less literature exists concerning other diseases comprising psoriasis and spondyloarthropathies (SpA; i.e., ankylosing spondylitis, psoriatic arthritis, IBD-associated arthritis, reactive arthritis, and undifferentiated and juvenile SpA).

ANALYTIC VALIDITY

Measurement of Antibodies to Infliximab
In 2014, Steenholdt published a post hoc comparison of different antibodies-to-infliximab (ATI) assays.[6] Blood samples were collected from 66 (96%) of 69 patients enrolled in a randomized controlled trial (RCT) (discussed next) that assessed algorithmic treatment for Crohn’s disease (CD) relapse during infliximab therapy.[7] Samples were analyzed by three binding assays (radioimmunoassay [RIA], enzyme-linked immunosorbent assays [ELISA], homogenous mobility shift assay [HMSA]) and by RGA. ATI were detected in 18 patients (27%) by RIA, in 6 patients (9%) by ELISA, and in 22 patients (33%) by HMSA. The reporter gene assay detected anti-infliximab activity, most likely due to ATI, in seven patients (11%). As observed by the authors, this suggests that ATI detected by RIA and HMSA are not necessarily functionally active or neutralizing. Five patients (8%) were ATI-positive and 43 patients (65%) were ATI-negative by all four assays. Correlations were statistically significant (p<0.001) in all pairwise comparisons (r² range, 0.77 to 0.96). However, statistical agreement between assays could not be estimated accurately (i.e., using the intraclass correlation coefficient) because different assays reported values on different arbitrary scales. Regardless of the assay used, most patients (74% to 88%) had therapeutic serum infliximab levels and undetectable ATI, suggesting nonpharmacologic reasons for relapse or for symptoms mimicking relapse.

In 2012, Wang developed and validated a non-radiolabeled homogeneous mobility shift assay (HMSA) to measure the ATI and infliximab levels in serum samples.[8] Full method validation was performed on both the ATI- and infliximab-HMSA, and the clinical sample test results were compared with those obtained from a bridging ELISA method to evaluate the difference in performance between the two assays. Intra- and inter-assay precision rates (as indicated by the coefficient of variation [CV]) for the ATI- and infliximab-HMSA were <4% and <15%, respectively, and <6% and <15%, respectively, considered to be robust. Sera from 100 healthy subjects (obtained from blood bank donors) were tested to determine the cut points of the assay, defined to have an upper negative limit of approximately 97.5%. Using receiver operating characteristic analysis, a cut point of 1.19 μg/mL was calculated for ATI; the false positive rate with this cut point was 3%. For serum infliximab levels, a cut point of 0.98 μg/mL was calculated; the false positive rate with this cut point was 5%. One hundred serum samples that previously had tested positive with ELISA were reanalyzed by the new method. There was a high correlation between the two methods for ATI levels (p<0.001). The new method identified five false-positive samples from the bridging ELISA method, thought to be due to a higher rate of nonspecific binding in the ELISA method. Hernandez-Breijo described the use of the HMSA protocol in measuring ATI in 50 infliximab-treated Crohn disease (CD) patients, using methods similar to Wang (2012).[9]

In 2012, Kopylou analyzed test results from 63 serum samples, comparing a double-agent (DA) ELISA testing method to an alternative antihuman lambda chain (AHLC) antibody ELISA test.[4] All samples were tested using both testing methods and 22/63 and ATIs were demonstrated in 22/63 (34.9%) and 18/63 (28.5%) of patients by AHLC and DA assay, respectively (p = 0.6). Lower serum infliximab and ATIs were detected in four patients by the AHLC method but not the DA method, supporting the theory that DA ELISA testing is ineffective when any treatment is present, limiting the times when this type of testing can be performed.

Also in 2012, Vande Casteele compared three (A, B, C) different European assays using both serum and spiked control samples of 62 inflammatory bowel patients.[10] Authors concluded that all ATI assays showed good linear correlation (Pearson’s r = 0.91 for A vs. B, 0.83 for A vs. C and 0.73 for B vs. C). However, one assay detected false positive infliximab levels in nearly a fifth of the samples.
Measurement of Antibodies to Adalimumab

In 2013, Wang developed and validated a non-radiolabeled HMSA to measure antibodies-to-adalimumab (ATA) and adalimumab levels in serum samples.[11] Analytic validation of performance characteristics (calibration standards, assay limits, intra- and interassay precision, linearity of dilution, and substance interference) was performed for both the ATA- and adalimumab-HMSA. Because the elimination half-life of adalimumab (10-20 days) overlaps the dosing interval (every two weeks), ATA-positive sera to provide calibration standards were difficult to collect from human patients (i.e., the drug-free interval for antibody formation is small). Therefore, antisera from rabbits immunized with adalimumab were pooled to form calibration standards. Serial dilutions of these ATA calibration standards then generated a standard curve against which test samples were compared. Over 29 experimental runs, intra-assay precision and accuracy for the adalimumab-HMSA (as indicated by the coefficient of variation [CV]) were less than 20% and 3%, respectively; interassay (run-to-run, analyst-to-analyst and instrument-to-instrument) precision and accuracy were less than 12% and 22%, respectively. For the ATA-HMSA, CVs for intra-assay precision and accuracy were less than 3% and 13%, respectively; CVs for interassay precision and accuracy were less than 9% and 18%, respectively. ELISA could not be used as a standard comparator due to competition from circulating drug. Without a comparison to an alternative method of antibody detection, the analytic validity of the ATA test remains uncertain.

Following evaluation of analytic validity of the non-radio-labeled HMSA assay, the investigators tested sera from 100 healthy subjects (obtained from blood bank donors) to determine the cut points of the assay, defined as the threshold above which samples were deemed to be positive with an upper limit of approximately 99%. The calculated cut point for serum adalimumab levels was 0.68 μg/mL, which yielded a false-positive rate of 3%. For ATA, the calculated cut point was 0.55 U/mL, which yielded a false-positive rate of 1%. Analysis of 100 serum samples from patients who were losing response to adalimumab showed that 44% were above the cut point for ATA, and 26% were below the cut point for serum adalimumab level. In samples below the adalimumab cut point (0.68 μg/mL), 68% were ATA-positive; in samples with adalimumab levels greater than 20 μg/mL, 18% were ATA-positive.

Section Summary

To date, ELISA is the most commonly studied testing assay for the detection of ATIs, although a large variety of assay tests are available. Drug interference limits the reliability of the ELISA test and it is no longer available from the manufacturer, having been replaced by the Anser IFX™ test. There are no peer reviewed publications regarding the Anser IFX™ test. No other ATI assay has been validated as the new gold standard for detecting antibodies to infliximab treatment. The pharmacokinetic properties of adalimumab (long half-life relative to dosing interval) prevented use of ELISA as a standard comparator in tests of analytic validity of ATA. Lack of comparison to an alternative method of antibody detection raises uncertainty about the analytic validity of the ATA test. The commercial Prometheus® HMSA assays do not suffer from many of the technical performance limitations of older assays; however, the HMSA assays do not distinguish neutralizing and non-neutralizing antibodies.[12]

There are significant limitations of the analytic validity of the ATI and ADA tests. Therefore, conclusions reached in subsequent studies analyzed within this policy must be considered within this context.

CLINICAL VALIDITY
There is a substantial body of evidence examining associations of ADA with nonresponse and injection or infusion site reactions; numerous systematic reviews and meta-analyses have been published. Accordingly, the review of evidence concerning clinical validity focuses on the most current systematic reviews (see Tables 3 through 5) and studies published subsequent to the search dates of those reviews,[13] as well as relevant studies not included in identified reviews (e.g., those focusing on adverse reactions and ADA).

**Systematic Reviews**

Six systematic reviews published from 2012 through 2017 were identified.[12,14-17] The number of studies included ranged from 11[16] to 68,[17] varying according to review objectives and conditions of interest. Although not detailed here, there was considerable overlap in included studies across reviews.

A systematic review and meta-analysis by Pecoraro (2017) selected 34 studies (total N=4273 patients), including RCTs (n=4), prospective observational (n=22), retrospective observational (n=6), and cross-sectional (n=2).[18] Studies evaluated RA (n=18), ulcerative colitis (n=2), CD (n=5), psoriatic arthritis (n=4), ankylosing spondylitis (n=5), plaque psoriasis (n=4), spondyloarthritis (n=1). Most of the patients (45%) received infliximab, 35% received adalimumab, and 21% received etanercept. None received golimumab or certolizumab. Reviewers identified studies published through August 2016 and rated study quality as good (n=17), fair (n=16), and poor (n=1). The effect of ADA was evaluated in 19 studies, showing a significant (p<0.05) reduction of response (RR=0.43; 95% CI, 0.3 to 0.63) in ADA-positive patients relative to ADA-negative patients, with adalimumab therapy demonstrating a greater reduction (RR=0.40; 95% CI, 0.25 to 0.65; p<0.001) than infliximab (RR=0.37; 95% CI, 0.2 to 0.7; p<0.001). Measures of heterogeneity were 84%, 57%, and 79%, respectively. Fourteen studies reported on the effect of ADA on clinical response (see Table 1). Eleven studies found the risk of developing ADA to be significantly (p=0.03) lower in patients treated with concomitant methotrexate therapy relative to treated those without methotrexate (RR=0.65; 95% CI, 0.47 to 0.9). Studies comparing treatment response with nonresponse (n=15) found responders to have a significantly (p<0.001) lower risk of developing ADA relative to nonresponders (RR=0.31; 95% CI, 0.18 to 0.52). The presence of ADA was associated with a significant reduction of anti-tumor necrosis factor α (TNF-α) serum concentration (see Table 2).

Of the 20 studies (n>2800 patients) reporting data on adverse events, 31% (n=2 studies) developed infections, 18% (n=12 studies) developed injection-site reactions, 8% (n=11 studies) discontinued treatment due to adverse events, and 5% (n=1 study) developed serious adverse events (5%). Although ADA significantly reduced TNF-α response, the results should be viewed cautiously due to reported study limitations, including small numbers of studies included and considerable heterogeneity.

A systematic review and meta-analysis by Thomas (2015) included 68 studies (14,651 patients) in patients with RA (n=8766), SpA (n=1534), and IBD (n=4351) and examined the immunogenicity of infliximab (39 comparisons), adalimumab (15), etanercept (5), golimumab (14), and certolizumab (8).[17] The review identified studies published through December 2013 and included 38 RCTs and 30 observational studies (study quality rated as good [n=32], moderate [n=26], or poor [n=10]). The pooled prevalence of ADA varied with disease and drug (see Table 3, highest with infliximab: 25.3%). Duration of exposure (reported in 60 studies) was examined for its potential effect on the development of ADA and most studies employed ELISA assays. The presence of ADA was associated with lower odds of response across most drugs and diseases (see Table 4). An exception was in studies of IBD (similar to that reported
by Lee in 2012). The use of immunosuppressive agents substantially decreased the risk of ADA (odds ratio [OR], 0.26; 95% CI, 0.21 to 0.32). Finally, infusion reactions and injection site reactions were more common (see Table 5) when ADA were detectable (OR=3.25; 95% CI, 2.35 to 4.51). Evaluation of potential publication bias or overall assessment (e.g., GRADE or similar) for the body of evidence was not reported. Additionally, no measures of heterogeneity were reported.

A systematic review by Meroni (2015) searched PubMed through March 2013 and included 57 studies of infliximab (n=34), adalimumab (n=18), and etanercept (n=5). Studies included primarily patients with IBD and RA, but also SpA and psoriasis. Most studies were prospective cohort designs (n=42) and a formal assessment of study quality (bias) was not reported. The authors noted considerable variability in the time from drug administration to ADA and drug bioavailability testing across studies. Varied antibody testing assay methods were used and included solid-phases RIA, traditional ELISA, fluid-phase RIA, and bridging ELISA; cutoffs for positive test results were also inconsistently reported. The ranges of patients with detectable ADA varied substantially (see Table 3) but were consistent with other reviews. Qualitatively, the presence of ATI was associated with lower levels of infliximab and lower risk of disease control or remission. The presence of ATI also increased the risk of infusion reactions. When ascertained, the time to development of ATI varied from as little as 16 weeks to over a year. The time to ATA positivity varied – fifty percent of patients with detectable ATA at 28 weeks to a median time of 1 year. Finally, for both infliximab and adalimumab, immunosuppression was associated with less ADA positivity. The authors concluded that “…the lack of homogeneity in study design and methodologies used in the studies analyzed limited the opportunity to establish the time-course and clinical consequences of anti-drug antibody development....”

Although qualitative, the authors included many studies, and provided a detailed review of each study not reported by the other meta-analyses. The author’s conclusions are consistent with the meta-analyses but with emphasis on important aspects of heterogeneity across studies.

Nanda (2013) conducted a meta-analysis of studies that reported on clinical outcomes according to the presence or absence of ATI in patients with IBD.[16] MEDLINE, Web of Science, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Scopus databases were searched to February 2012, EMBASE to August 2012; 11 studies involving 707 patients were included. Six of these studies (2 RCTs, 1 prospective cohort study, 3 retrospective cohort studies) were included in the meta-analysis by Lee (outlined below). In at least one quality domain (study eligibility criteria, measurement of exposure and outcome, control for confounders, completeness of follow-up), all the included studies had high risk of bias. The prevalence of detectable ATI in the included studies ranged from 22.4% to 46% (see Table 3). The outcome of interest was loss of response to infliximab, defined as “relapse of clinical symptoms in patients who were in clinical remission from, or had responded to, infliximab.” Measures of loss of response varied across studies and included clinician assessment, standardized scales (Crohn’s Disease Activity Index [CDAI], Harvey-Bradshaw Index, Simple Clinical Colitis Activity Index), and requirement for surgery or presence of nonhealing fistula. Patients with ATIs had a 3-fold greater risk of loss of response than those without ATIs (RR=3.2; 95% CI, 2.0 to 5.0) (shown in Table 3 as the RR of clinical response in treated vs. untreated patients to allow comparison with other meta-analyses). This result was influenced primarily by 532 patients with CD (RR=3.2; 95% CI, 1.9 to 5.5); pooled results for 86 patients with ulcerative colitis (UC) were not statistically significant (pooled RR=2.2; 95% CI, 0.5 to 9.0]). (Eighty-nine patients with unspecified IBD also were included in the meta-analysis.) In addition to potential bias in included studies and heterogeneity in outcome...
assessment, the meta-analysis is limited by variability in the method of ATI detection (double-antigen ELISA, antihuman lambda chain-based ELISA, fluid-phase RIA). Study investigators stated, "[t]he true incidence of ATI in IBD patients treated with infliximab remains unknown due to the different administration schedules, timing of ATI measurements, methods used in ATI detection, and the presence of serum infliximab." Finally, although the authors noted that the funnel plot "suggested the presence of publication bias," the small number of studies and plot appearance (only 2 of 11 studies suggesting asymmetry) preclude conclusions.

Garces (2013) performed a meta-analysis of studies of infliximab and adalimumab used to treat RA, IBD, SpA, and psoriasis.\footnote{14} Databases were searched to August 2012, and 12 prospective cohort studies included involving 860 patients (540 with RA, 132 with SpA, 130 with IBD, 58 with psoriasis). The outcome of interest was response, assessed by using standard assessment scales for rheumatologic diseases (e.g., European League Against Rheumatism criteria for RA; Assessment in Ankylosing Spondylitis 20% response criteria, or ASDAS for spondyloarthritis; Psoriasis Area and Severity Index for psoriasis) and clinician assessment for IBD. Overall, detectable ADA were associated with a 68% reduction in drug response (pooled RR=0.32; 95% CI, 0.22 to 0.48). Significant heterogeneity was introduced by varying use of immunosuppressant therapy (e.g., methotrexate) across studies. To assess ADA, most studies used RIA, which is less susceptible than ELISA to drug interference and may be more accurate.

Lee (2012) conducted a meta-analysis of patients with IBD receiving infliximab to estimate the prevalence of ATI, effect of ATI on the prevalence of infusion reactions, and the effect of ATI on disease remission rates.\footnote{15} Databases were searched through October 2011, and 18 studies involving 3326 patients were included. Studies included 9 RCTs, 5 prospective cohort studies, and 4 retrospective cohort studies. The prevalence of ATI was 45.8% when episodic infusions of infliximab were given and 12.4% when maintenance infliximab was given. Patients with ATI were less likely to be in clinical remission (Table 4), but this was not statistically significant (relative risk [RR], 0.90; 95% CI, 0.79 to 1.02; p=0.10). The rates of infusion reactions were significantly higher in patients with ATI (RR=2.07 [see Table 5]; 95% CI, 1.61 to 2.67). Immunosuppressants resulted in a 50% reduction in the risk of developing ATI (p<0.001). The meta-analysis concluded that patients with IBD who test positive for ATIs are at an increased risk of infusion reactions, but have similar rates of remission compared with patients who test negative for ATIs.

<table>
<thead>
<tr>
<th>Outcome Measures</th>
<th>No. Studies</th>
<th>MD</th>
<th>95% Confidence Interval</th>
<th>$I^2$, %</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease Activity Score 28</td>
<td>9</td>
<td>0.93</td>
<td>0.41 to 1.44</td>
<td>84</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>BASDAI</td>
<td>2</td>
<td>-0.62</td>
<td>-1.51 to 0.27</td>
<td>0</td>
<td>0.17</td>
</tr>
<tr>
<td>ASDAS</td>
<td>2</td>
<td>0.96</td>
<td>-0.27 to 2.2</td>
<td>0</td>
<td>0.13</td>
</tr>
<tr>
<td>Psoriasis Area Severity Index</td>
<td>1</td>
<td>4.7</td>
<td>-1.15 to 9.25</td>
<td>NR</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Adapted from Pecoraro (2017).\footnote{18} ASDAS: Ankylosing Spondylitis Disease Activity Score; BASDAI: Bath Ankylosing Spondylitis Disease Activity Index; $I^2$: heterogeneity measure; MD: mean difference; NR: not reported.

<table>
<thead>
<tr>
<th>Outcome Measures</th>
<th>No. Studies</th>
<th>MD, mg/L</th>
<th>95% Confidence Interval</th>
<th>$I^2$, %</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA-positive vs ADA-negative</td>
<td>8</td>
<td>-7.07</td>
<td>-8.9 to -5.25</td>
<td>98</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Outcome Measures</td>
<td>No. Studies</td>
<td>MD, mg/L</td>
<td>95% Confidence Interval</td>
<td>I², %</td>
<td>p</td>
</tr>
<tr>
<td>----------------------------------------</td>
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<td>-------------------------</td>
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<td>-----</td>
</tr>
<tr>
<td>Responders vs no responders</td>
<td>13</td>
<td>2.77</td>
<td>1.97 to 3.58</td>
<td>82</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Adalimumab therapy</td>
<td>6</td>
<td>5.07</td>
<td>3.77 to 6.36</td>
<td>62</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Infliximab</td>
<td>4</td>
<td>2.74</td>
<td>0.59 to 4.89</td>
<td>62</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Etanercept</td>
<td>3</td>
<td>0.85</td>
<td>0.41 to 1.13</td>
<td>82</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>DAS28 change from baseline</td>
<td>8</td>
<td>-2.18</td>
<td>-2.91 to -1.44</td>
<td>97</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Adapted from Pecoraro (2017). [18]

ADA: antidrug antibodies; DAS28: Disease Activity Score in 28 joints; I²: heterogeneity measure; MD: mean difference; TNF: tumor necrosis factor.

### Table 3. Estimated Prevalence of Antidrug Antibodies from Meta-Analyses [19]

<table>
<thead>
<tr>
<th>Author</th>
<th>Included Studies</th>
<th>Drugs</th>
<th>Disease</th>
<th>Prevalence of ADA</th>
<th>Pooled (95% CI)</th>
<th>Range in Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lee (2012)</td>
<td>18</td>
<td>IFX</td>
<td>IBD</td>
<td>20.8% (19.2 to 22.5)</td>
<td>12.4% (10.8 to 14.1)</td>
<td>22.4%-46%</td>
</tr>
<tr>
<td>Episodic</td>
<td>5</td>
<td>ADL</td>
<td>RA</td>
<td>45.8% (41.7 to 50.0)</td>
<td>12.4% (10.8 to 14.1)</td>
<td>22.4%-46%</td>
</tr>
<tr>
<td>Maintenance</td>
<td>10</td>
<td>Other</td>
<td>SpA</td>
<td>12.4% (10.8 to 14.1)</td>
<td>12.4% (10.8 to 14.1)</td>
<td>22.4%-46%</td>
</tr>
<tr>
<td>Nanda (2013)</td>
<td>11</td>
<td></td>
<td></td>
<td>12.4% (10.8 to 14.1)</td>
<td>12.4% (10.8 to 14.1)</td>
<td>22.4%-46%</td>
</tr>
<tr>
<td>Thomas (2015)</td>
<td>39</td>
<td>IFX</td>
<td>IBD</td>
<td>25.3% (19.5 to 32.3)</td>
<td>12.1% (8.1 to 17.6)</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>ADL</td>
<td>RA</td>
<td>6.9% (3.4 to 13.5)</td>
<td>8.9% (3.8 to 19.2)</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td></td>
<td>SpA</td>
<td>15.8% (9.6 to 24.7)</td>
<td>12.1% (8.1 to 17.6)</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>44</td>
<td>IFX</td>
<td>IBD</td>
<td>25.3% (19.5 to 32.3)</td>
<td>12.1% (8.1 to 17.6)</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>ADL</td>
<td>RA</td>
<td>6.9% (3.4 to 13.5)</td>
<td>8.9% (3.8 to 19.2)</td>
<td>15%</td>
</tr>
<tr>
<td>Meroni (2015)</td>
<td>14</td>
<td>IFX</td>
<td>IBD</td>
<td>19% (17% to 22%)</td>
<td>8.9% (3.8 to 19.2)</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>ADL</td>
<td>RA</td>
<td>15% (13% to 18%)</td>
<td>8.9% (3.8 to 19.2)</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td></td>
<td>SpA</td>
<td>26% (20% to 33%)</td>
<td>8.9% (3.8 to 19.2)</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>IFX</td>
<td>IBD</td>
<td>26% (20% to 33%)</td>
<td>8.9% (3.8 to 19.2)</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>ADL</td>
<td>RA</td>
<td>5% (0% to 14%)</td>
<td>8.9% (3.8 to 19.2)</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
<td>SpA</td>
<td>9% (0% to 17%)</td>
<td>8.9% (3.8 to 19.2)</td>
<td>15%</td>
</tr>
</tbody>
</table>

ADL: adalimumab; CI: confidence interval; IBD: inflammatory bowel disease; IFX: infliximab; RA: rheumatoid arthritis; SpA: spondyloarthropathy.

a Includes etanercept, golimumab, certolizumab.
b Includes 3 studies including both maintenance and episodic therapy
c Number of comparisons in table; did not report studies for pooled prevalence.
d Also psoriasis.

### Table 4. Results from Meta-Analyses of Antidrug Antibodies and Clinical Response [19]

<table>
<thead>
<tr>
<th>Author</th>
<th>Included Studies</th>
<th>Drugs</th>
<th>Disease</th>
<th>Clinical Response: ADA vs None</th>
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</thead>
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<tr>
<td>Lee (2012)</td>
<td>18</td>
<td>IFX</td>
<td>IBD</td>
<td>0.90 (0.79 to 1.02)</td>
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<td>Nanda (2013)</td>
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<td>RA</td>
<td>0.33 (0.20 to 0.40)</td>
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<td>Garces (2013)</td>
<td>12</td>
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<td>SpA</td>
<td>0.32 (0.22 to 0.48)</td>
</tr>
<tr>
<td>Thomas (2015)</td>
<td>4</td>
<td>IFX</td>
<td>IBD</td>
<td>1.16 (0.66 to 2.03)</td>
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<tr>
<td></td>
<td>13</td>
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<td>RA</td>
<td>0.27 (0.20 to 0.36)</td>
</tr>
<tr>
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<td>SpA</td>
<td>0.18 (0.09 to 0.37)</td>
</tr>
<tr>
<td></td>
<td>9</td>
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<td>RA</td>
<td>0.42 (0.30 to 0.58)</td>
</tr>
</tbody>
</table>

ADL: adalimumab; CI: confidence interval; IBD: inflammatory bowel disease; IFX: infliximab; NR: not reported; OR: odds ratio; RA: rheumatoid arthritis; RR: relative risk; SpA: spondyloarthropathy.
a Includes etanercept, golimumab, certolizumab.
b Also psoriasis.
Table 5. Increased Risk of Adverse Reaction Associated With the Presence of Antidrug Antibodies\[19\]

<table>
<thead>
<tr>
<th>Author</th>
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<th>Drugs</th>
<th>Disease</th>
<th>Adverse Reactions: ADA vs None</th>
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<td>Others*</td>
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<td>●</td>
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<td>●</td>
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<tr>
<td>Thomas (2015)</td>
<td>NR</td>
<td>●</td>
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<td>●</td>
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</table>

ADL: adalimumab; CI: confidence interval; IBD: inflammatory bowel disease; IFX: infliximab; NR: not reported; OR: odds ratio; RA: rheumatoid arthritis; RR: relative risk; SpA: spondyloarthropathy.

* Infusion reaction.

Nonrandomized Studies

Recent publications not included in the systematic reviews above are included, below.

Cludts (2017) conducted a single-center retrospective cohort analysis of patients with RA (n=18), psoriatic arthritis (n=9), or ankylosing spondylitis (n=12) in Italy.\[20\] Serum samples were taken prior to adalimumab therapy and after 12 and 24 weeks of treatment. Psoriatic arthritis and ankylosing spondylitis patients were grouped together (SpA) due to axial involvement in all psoriatic arthritis patients. Although adalimumab levels varied among patients (0 to 30 μg/mL), median levels were significantly lower at 12 and 24 weeks in ATA-positive samples, and antibody formation was associated with decreasing levels of circulating adalimumab. A reporter gene assay detected neutralizing antibodies against TNF antagonists in ATA-positive, therapeutic-negative patients; however, neutralization could not be confirmed in all ATA-positive samples due to adalimumab interference. There was a negative correlation between ATA levels and adalimumab in all groups, with 43.6% and 41% of the adalimumab-treated patients developing antibodies at 12 and 24 weeks, respectively. These percentages increased to 48.7% and 46% after subjecting the samples to acid treatment. There was a negative correlation between adalimumab trough levels and DAS28 and Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) scores (p<0.001). There were no significant differences between BASDAI in ATA-positive compared with ATA-negative patients at 12 or 24 weeks. The study is consistent with others suggesting that adalimumab levels can serve as an indicator of ATA; however, limitations included small sample size, retrospective research design, and failure to confirm neutralization in all ATA-positive samples.

Using an observational, cross-sectional study design, Ara-Martin (2017) analyzed the impact of immunogenicity on response to anti-TNF therapy in 137 adults with moderate-to-severe plaque psoriasis at 35 centers in Spain between 2012 and 2014.\[21\] All patients experienced secondary nonresponse to adalimumab (n=65), etanercept (n=47), and infliximab (n=19) after 6 or more months of treatment. Serum ADA was identified in 48%, 0%, and 42% of patients of patients treated with adalimumab, etanercept, and infliximab, respectively. Loss of efficacy was assessed using the Psoriasis Area and Severity Index (PASI; >5), 75% improvement in PASI score from baseline (PASI75), and/or the Physician Global Assessment (PGA, >2). PGA values for ADA-positive vs ADA-negative patients were significantly worse in the adalimumab group (3.7 vs 3.2; p=0.02) but not in the infliximab group. There was a significant negative linear correlation between serum drug concentrations and ADA in both the adalimumab group (p=0.001) and among the 3 groups combined (p=0.001), and a significant (p=0.019) correlation between serum ADA titer and body surface area. Unlike the other studies, in this study, the use of concomitant antirheumatic drugs was not associated with anti-TNF immunogenicity in any of the groups. This study provided evidence of antibody development against adalimumab.
and infliximab (not against etanercept) in patients with psoriasis, with ADA formation accounting for half of the secondary nonresponse associated with these therapies. However, conclusions were limited due to the cross-sectional study design, use of ELISA to detect ADAs due to drug interference, the potential presence of neutralizing antibodies as confounding factors, and limited information about patients' health status prior to the study period.

A case-control, longitudinal study by Lombardi (2016) excludes possible confounding factors by analyzing adalimumab treatment for psoriasis in five distinct groups, including individuals who received: biologic therapies after switching from adalimumab (n=20); ongoing adalimumab therapy (n=30); novel adalimumab therapy (n=30); biologic therapies other than adalimumab (n=15); and no treatment with immunosuppressants or biologics (n=15), serving as a quasi-control.[22] The clinical severity of psoriasis was scored using the PASI. At 12-month follow-up, ADA was highest (87%) in patients who received biologic therapies after switching from adalimumab. The false-positive rate was 23% for adalimumab detection and 22% for antiadalimumab antibodies in individuals who were never treated with adalimumab. There was no significant difference in median PASI score between the anti-adalimumab antibody-negative patients (1.1) and the anti-adalimumab antibody-positive patients (4.0). There was no association between PASI score or TNF-α concentration and the presence of anti-adalimumab antibodies in patients receiving adalimumab. Additionally, there were no significant differences in TNF-α and C-reactive protein concentrations. Study limitations included its observational design, small sample size, use of ELISA to measure ADA, and high variability of results. The authors concluded that the assay has limited clinical utility.

While many studies have evaluated clinical validity using single ADA measurements, at least one study assessed their persistence over time. Vande Casteele (2013) analyzed infliximab trough and ATI levels using an HMSA assay with banked serum obtained from 90 IBD patients treated between May 1999 and August 2011.[23] ATI levels had been previously assayed using an ELISA-based test. A total of 1232 samples were evaluated (mean 14 per patient). Treatment decisions were made solely on clinical evaluation and C-reactive protein levels. ATI were detected in 53 of 90 (59%) of patients but subsequently were nondetectable in 15 of the 53 (28%). Persistent ATIs were associated with discontinuation of infliximab (RR=5.1; 95% CI, 1.4 to 19.0), but the wide confidence interval reflects considerable uncertainty. Although transience of ATI in IBD has not been carefully scrutinized, if replicated, these results suggest interpreting a single ATI result cautiously.

**Section Summary**

A large body of evidence has evaluated the clinical validity of ADA testing. ADA has been associated with secondary nonresponse in RA, SpA, but not clearly in IBD. The presence of ADA has been consistently associated with an increased risk of infusion-site reaction related to infliximab and injection site reactions related to adalimumab. A concomitantly administered immunosuppressant agent reduces the risk of developing ADA.

**CLINICAL UTILITY**

Several algorithms have been developed for management of patients with IBD[24-26] or RA[27] who have relapsed during TNF-inhibitor therapy. These algorithms are generally based on evidence that has indicated an association between ADA, reduced serum drug levels, and relapse. None has included evidence demonstrating improved health outcomes, such as reduced time to recovery from relapse (response), using algorithmic rather than dose-escalation approaches.
Afif (2010) evaluated the clinical utility of measuring ATI (referred to as human antichimeric antibodies [HACA] in the study) and infliximab concentrations by retrospectively reviewing patient medical records. Record review from 2003 to 2008 identified 155 patients who had had ATI, had data on infliximab concentrations, and met the study inclusion criteria. A single physician ordered 72% of the initial tests. The authors retrospectively determined clinical response to infliximab. Forty-seven percent of patients were on concurrent immunosuppressive medication. The main indications for testing were loss of response to infliximab (49%), partial response after initiation of infliximab (22%), and possible autoimmune or delayed hypersensitivity reaction (10%). ATI were identified in 35 (23%) patients and therapeutic infliximab concentrations in 51 (33%) patients. Of 177 tests assessed, the results impacted treatment decisions in 73%. In ATI-positive patients, change to another anti-TNF agent was associated with a complete or partial response in 92% of patients, whereas dose escalation occurred in 17%.

The authors concluded that measurement of ATI and infliximab concentration had a clinically useful effect on patient management. The strategy of increasing infliximab dose in patients with ATI was ineffective whereas in patients with subtherapeutic infliximab concentrations this strategy was a good alternative to changing to another anti-TNF agent. Study limitations included the retrospective design and using ELISA testing for ATI. Because there was no control group, one cannot determine what changes in management would have been made absent ATI measurement. Because clinicians are likely to change management for patients who do not achieve or maintain a clinical response, it is important to understand how these management decisions differ when ATI are measured.

In 2014, Steenholdt reported results of a noninferiority trial and cost-effectiveness analysis of 69 patients with CD who relapsed (CDAI ≥220 and/or ≥1 draining perianal fistula) during infliximab therapy. Patients were randomized to infliximab dose intensification (5 mg/kg every four weeks) or algorithmic treatment based on serum infliximab level and ATI: Patients with subtherapeutic infliximab level (<0.5 μg/mL) had infliximab dose increased if ATI were undetectable or were switched to adalimumab if ATI were detectable; patients with therapeutic infliximab level underwent repeat testing of infliximab and ATI levels if ATI were detectable or diagnostic reassessment if ATI were undetectable. Serum infliximab and ATI levels were measured in all patients using RIA in single-blind fashion (patients unaware but investigators aware of test results). Randomized groups were similar at baseline; overall, 55 (80%) of 69 patients had nonfistulizing disease. Most patients (70%) had therapeutic serum infliximab levels without detectable ATI; revised diagnoses in 6 (24%) of 25 such patients in the algorithm arm included bile acid malabsorption, strictures, and IBS. In both intention-to-treat (ITT) and per-protocol analyses, similar proportions of patients in each randomized group achieved clinical response at week 12, defined as a minimum 70-point reduction from baseline CDAI for patients with nonfistulizing disease and a minimum 50% reduction in active fistulas for patients with fistulizing disease (ITT, 58% in the algorithm group vs 53% in the control group; p=0.810; per-protocol; 47% in the algorithm group vs 53% in the control group; p=0.781). Only the ITT analysis fell within the prespecified noninferiority margin of -25% for the difference between groups.

Conclusions on the noninferiority of an algorithmic approach compared with dose intensification from this trial are limited. The noninferiority margin was arguably large and was exceeded in the conservative per-protocol analysis. Dropouts were frequent and differential between groups; 17 (51%) of 33 patients in the algorithm group and 28 (78%) of 36 patients in the control group completed the 12-week trial. A large proportion of patients (24%) in the
algorithmic arm were potentially misdiagnosed (ie, CD flare was subsequently determined not to be the cause of relapse); the comparable proportion in the control arm was not reported. In most patients (80% who had nonfistulizing disease), only a subjective measure of treatment response was used (minimum 70-point reduction from baseline CDAI).

Roblin (2014) conducted a single-center, prospective observational study of 82 patients with IBD (n=45 CD, n=27 UC) with clinical relapse (CDAI >220 or Mayo Clinic >5) during treatment with adalimumab 40 mg every two weeks.\[31\] For all patients, trough adalimumab levels and ADA were measured in a blinded fashion using ELISA, and adalimumab dose was optimized to 40 mg weekly. Those who did not achieve clinical remission (CDAI <150 or Mayo score <2) within four months underwent repeat trough adalimumab and anti-adalimumab antibody testing and were switched to infliximab. Clinical and endoscopic responses after adalimumab optimization and after infliximab therapy for 6 months were compared across three groups: (1) those with a therapeutic adalimumab level (>4.9 μg/mL\[32\]), (2) those with a subtherapeutic adalimumab level and undetectable ATA; and (3) those with a subtherapeutic adalimumab level and detectable ATA. After adalimumab optimization, more group 2 patients achieved clinical remission (16 [67%] of 24 patients) than group 1 (12 [29%] of 41 patients; p<0.01 vs group 2) and group 3 (2 [12%] of 17 patients; p<0.01 vs group 2) patients. Duration of remission was longest in group 2 (mean, 15 months) compared with group 1 (mean, 5 months) and group 3 (mean, 4 months; p<0.01 for both comparisons vs group 2). At 1 year, 13 (52%) of 24 patients in group 2 maintained clinical remission compared with no patients in groups 1 or 3 (p<0.01 for both comparisons vs group 2). Results were similar when remission was defined using calprotectin levels (<250 μg/g stool) or endoscopic Mayo score (<2).

Fifty-two patients (n=30 CD, n=22 UC) who failed to achieve clinical remission after adalimumab optimization were switched to infliximab. More patients in group 3 achieved clinical remission (12 [80%] of 15 patients) than in group 1 (2 [7%] of 29 patients) or group 2 (2 [25%] of 8 patients; p<0.01 for both comparisons vs group 3). Duration of response after switching to infliximab was longest in group 3 (mean, 14 months) compared with group 1 (mean, 3 months) and group 2 (mean, 5 months; p<0.01 for both comparison vs group 3). At 1 year, 8 (55%) of 15 patients in group 3 maintained clinical remission compared with no patients in groups 1 or 2 (p<0.01 for both comparisons vs group 3). Results were similar using objective measures of clinical remission (calprotectin level, endoscopic Mayo score).

These results suggested that patients with IBD who relapse on adalimumab and have subtherapeutic serum adalimumab levels may benefit from a higher adalimumab dose if ATA are undetectable or from a change to another TNF inhibitor if ATA are detectable. Relapsed patients who have therapeutic serum adalimumab levels may benefit from change to a different drug class. Strengths of the study include its use of subjective and objective measures of remission and blinded serum drug level and ATA monitoring. However, results were influenced by the small sample size, use of ELISA for antibody testing, and lack of ADA levels for decision making. Subsequent study comparing the management using the algorithm proposed with usual care is needed. Ideally, using more than one method of assaying antibodies would further assessment of analytic validity. Finally, the lead author of the study received lecture fees from the ADA test provider (Theradiag).

Section Summary

Convincing evidence for the clinical utility of ADA testing currently is lacking. Uncontrolled retrospective studies in IBD have demonstrated the impact of ADA testing on treatment...
decisions but cannot demonstrate improved patient outcomes compared with a no-testing strategy. Additional limitations of these studies include lack of clinical follow-up after treatment decisions were made (in Affif[28]) and lack of clinical assessments to guide treatment decisions (in Steenholdt[29]). Additionally, determination of a clinically relevant threshold for ADA level is complicated by the use of various assay methods. A small, nonrandomized prospective study suggested that ADA levels may be informative in relapsed patients with IBD who have low serum adalimumab levels, but this finding requires confirmation in larger, randomized trials. Methodologic flaws, including relapse misclassification, limit conclusions from the RCT in patients with relapsed IBD. Direct or indirect evidence for clinical utility in patients with RA or SpA was not identified. Finally, although ADA are associated with increased risk of infliximab infusion- and adalimumab injection-site reactions, whether testing for ADA can reduce that risk is unclear. For example, Lichtenstein (2013) conducted a systematic review of infliximab-related infusion reactions and concluded “…there is a paucity of systematic and controlled data on the risk, prevention, and management of infusion reactions to infliximab,”[26] He added that “[m]ore randomised controlled trials are needed in order to investigate the efficacy of the proposed preventive and management algorithms.”

SUMMARY OF EVIDENCE

For individuals who have rheumatoid arthritis, psoriatic arthritis, or juvenile idiopathic arthritis; inflammatory bowel disease (Crohn disease, ulcerative colitis); ankylosing spondylitis; or plaque psoriasis who receive evaluation for anti-tumor necrosis factor α inhibitor antibodies to infliximab or adalimumab, the evidence includes multiple systematic reviews, one randomized controlled trial (RCT), and observational studies. Relevant outcomes are test accuracy and validity, change in disease status, health status measures, quality of life, and treatment-related morbidity. Antibodies to infliximab (ATI) or to adalimumab (ATA) develop in a substantial proportion of treated patients and are believed to neutralize or enhance clearance of the drugs. Considerable evidence has demonstrated an association between antidrug antibodies (ADA) and secondary nonresponse as well as injection site and infusion reactions. The clinical usefulness of measuring ADA hinges on whether test results inform management changes, thereby leading to improved outcomes, compared with management directed by symptoms, clinical assessment, and standard laboratory evaluation. Limited evidence has described management changes after measuring ADA. A small RCT in patients with Crohn disease comparing ATI-informed management of relapse with standard dose escalation did not demonstrate improved outcomes with the ATI-informed approach. Additionally, many assays—some having significant limitations—have been used in studies; ADA threshold values that are informative for discriminating treatment responses have not been established. The evidence is insufficient to determine the effects of the technology on health outcomes.

PRACTICE GUIDELINE SUMMARY

In 2017, the American Gastroenterological Association published an evidence-based clinical practice guideline on therapeutic drug monitoring (TDM) in inflammatory bowel disease (IBD).[33] The guideline was developed according to the GRADE framework to evaluate certainty of evidence, and a Technical Review was published to accompany the recommendations.[34] Regarding measurement of antidrug antibodies, the Association made the following statement:
“In adults with active IBD treated with anti-TNF agents, the AGA suggests reactive therapeutic drug monitoring to guide treatment changes.” **Conditional recommendation, very low quality of evidence.**

According to the GRADE method, **very low quality** is defined as: We have very little confidence in the effect estimate. The true effect is likely to be substantially different from the estimate of effect.

The Association also stated: Of note, there may be a small subset of patients who may still respond by targeting higher target concentrations. Optimal trough concentrations for induction therapy are uncertain.

Due to insufficient evidence, the Association also stated:

“In adult patients with quiescent IBD treated with anti-TNF agents, the AGA makes no recommendation regarding the use of routine proactive therapeutic drug monitoring.” **No recommendation, knowledge gap.**

**SUMMARY**

Antibodies to infliximab (ATI) or adalimumab (ATA) are present in a substantial number of patients treated with these medications, and there may be a correlation between the level of these antibodies and clinical response. However, there is not enough research to determine whether measurement of these antidrug antibodies can be used in patient management to improve net health outcomes. In addition, the optimal timing of when to measure antibody levels and measurement cutoff levels has not been established. Therefore, the measurement of antidrug antibodies in patients receiving treatment with infliximab or adalimumab is considered investigational.

**REFERENCES**


### CODES

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*Date of Origin: January 2013*