	Overarching Principles	LoE	SoR	LoA
A	Treatment of RA patients should aim at the best care and must be based on a shared decision between the patient and the rheumatologist.	n.a.	n.a.	9.7
B	Treatment decisions are based on disease activity, safety issues and other patient factors, such as comorbidities and progression of structural damage.	n.a.	n.a.	9.8
C	Rheumatologists are the specialists who should primarily care for RA patients.	n.a.	n.a.	9.9
D	Patients require access to multiple drugs with different modes of action to address the heterogeneity of RA; they may require multiple successive therapies throughout life.	n.a.	n.a.	9.9
E	RA incurs high individual, medical and societal costs, all of which should be considered in its management by the treating rheumatologist.	n.a.	n.a.	9.4
	Recommendations			
1.	Therapy with DMARDs should be started as soon as the diagnosis of RA is made.	1a	A	9.8
2.	Treatment should be aimed at reaching a target of sustained remission or low disease activity in every patient.[1]	1a	A	9.7
3.	Monitoring should be frequent in active disease (every 1–3 months); if there is no improvement by at most 3 months after the start of treatment or the target has not been reached by 6 months, therapy should be adjusted.	2b	B	9.3
4.	MTX should be part of the first treatment strategy.	1a	A	9.4
5.	In patients with a contraindication to MTX (or early intolerance), leflunomide or sulfasalazine should be considered as part of the (first) treatment strategy.	1a	A	9.0
6.	Short term glucocorticoids should be considered when initiating or changing csDMARDs, in different dose regimens and routes of administration, but should be tapered as rapidly as clinically feasible.	1a	A	8.9
7.	If the treatment target is not achieved with the first csDMARD strategy, in the absence of poor prognostic factors[1], other csDMARDs should be considered.	5	D	8.4
8.	If the treatment target is not achieved with the first csDMARD strategy and poor prognostic factors[1] are present, a bDMARD[2] or a tsDMARD[3] should be added.	1a	A	9.3
9.	bDMARDs and tsDMARDs should be combined with a csDMARD; in patients who cannot use csDMARDs as comedication, IL-6 pathway inhibitors and tsDMARDs may have some advantages compared to other bDMARDs.	1a	A	8.9
10.	If a bDMARD[2] or tsDMARD[3] has failed, treatment with another bDMARD or a tsDMARD should be considered; if one TNF inhibitor therapy has failed, patients may receive an agent with another mode of action or a second TNF inhibitor.	*1b #5	A D	8.9

11.	If a patient is in persistent remission after having tapered glucocorticoids, one can consider tapering bDMARDs or tsDMARDs, especially if this treatment is combined with a csDMARD.	1b	A	9.2
12.	If a patient is in persistent remission, tapering the csDMARD could be considered.	2b	B	9.0

Abbreviations: boDMARDs, biological originator DMARDs; bsDMARD, biosimilar DMARDs; csDMARDs, conventional synthetic DMARDs; DMARDs, disease-modifying antirheumatic drugs; EULAR, European League Against Rheumatism; Jak, Janus kinase; MTX, methotrexate; RA, rheumatoid arthritis; TNF, tumour necrosis factor; tsDMARDs, targeted synthetic DMARDs (currently Janus kinase inhibitors).

[1]For definitions of remission, low disease activity and poor prognostic factors, see Table 1.

[2]Abatacept, rituximab, sarilumab, tocilizumab, and TNF-inhibitors: adalimumab, certolizumab pegol, etanercept, golimumb, infliximab (whether boDMARDs or EMA-approved/FDA-approved bsDMARDs).

[3]Janus kinase inhibitors