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	<b>Overarching Principles</b>	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
	<b>Recommendations</b>			
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. <sup>1</sup>	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 <sup>1</sup> , 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 <sup>1</sup> are present, a bDMARD <sup>2</sup> or a tsDMARD <sup>3</sup> 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 <sup>2</sup> or tsDMARD <sup>3</sup> 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).

<sup>1</sup>For definitions of remission, low disease activity and poor prognostic factors, see Table 1.

<sup>2</sup>Abatacept, rituximab, sarilumab, tocilizumab, and TNF-inhibitors: adalimumab, certolizumab pegol, etanercept, golimumab, infliximab (whether boDMARDs or EMA-approved/FDA-approved bsDMARDs).

<sup>3</sup>Janus kinase inhibitors