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STRIDE Forward – Personalizing Treat-To-Target in IBD Management: Update of the ACG 2025 Guidelines

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Disclosure

I do not have a vested interest in or affiliation with a corporate offering financial support or grant monies for this continuing education activity or any affiliation with an organization whose philosophy could potentially bias my presentation

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Presentation Objectives

Summarize	key updates in the 2025 American College of Gastroenterology (ACG) Management of Crohn's Disease (CD) and Ulcerative Colitis (UC) guidelines
Review	evidence-based pharmacologic recommendations
Apply	the guidelines to case-based scenarios
Explain	the role of pharmacists and pharmacy technicians in improving access to advanced therapies for inflammatory bowel disease

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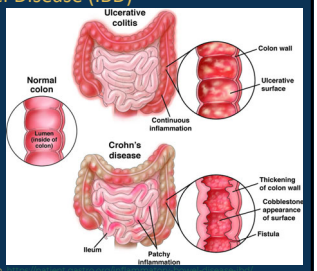
Inflammatory Bowel Disease (IBD)

- Crohn's disease (CD)
  - Can affect any part of the GI tract (mouth to anus or "gums to bum"), most commonly the ileum and cecum
  - Areas of inflammation mixed in between healthy tissue (skip lesions)
  - Can affect multiple layers of the intestine
- Ulcerative colitis (UC)
  - Can affect some or all of the colon
  - Continuous inflammation seen in the large intestine

Both may cause abdominal pain, diarrhea, urgency, bloody stool, anemia, weight loss, fatigue, joint pain



E Torres. Inflammatory Bowel Disease. American Gastroenterological Association. https://patient.gastro.org/inflammatory-bowel-disease-ibd/. Accessed 5/7/26

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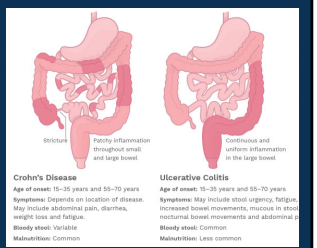
Causes

- Several factors may contribute to IBD development:
  - Abnormal immune response
  - Genetics
  - Microbiome
  - Environmental factors



Crohn's & Colitis Foundation. Image retrieved from https://www.crohnscolitisfoundation.org/patientsandcaregivers/what-is-ulcerative-colitis/overview. Accessed 5/17/26.

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Complications

- Colon cancer
- Skin, eye, and joint inflammation (Extraintestinal manifestations or EIMs)
- Blood clots
- Dehydration
- Primary sclerosing cholangitis
- Medicine side effects – e.g. corticosteroid overuse
- Intestinal surgeries
- Hospitalizations

In CD
- Stricturing disease -> bowel obstruction
- Malnutrition
- Fistulas
- Anal fissures

In UC
- Toxic megacolon
- Perforated colon

Inflammatory Bowel Disease. Mayo Clinic. Available at https://www.mayoclinic.org/diseases-conditions/inflammatory-bowel-disease/symptoms-causes/syc-20353326. Accessed 5/7/26.

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ACG 2025 GUIDELINE – CROHN'S DISEASE MANAGEMENT HIGHLIGHTS IN ADULTS

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Management of Crohn's Disease in Adults

- Diagnosis:
  - Consider clinical presentation as well as endoscopic, radiologic, histologic, and pathologic findings
  - Fecal calprotectin to differentiate inflammatory vs noninflammatory
    - Cutoff > 50-100 ug/g
  - Routine endoscopic surveillance for colorectal cancer is recommended for colonic CD

Am J Gastroenterol. 2025 Jun 3;120(6):1225-1264

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Medical Management of Crohn's Disease in Adults

- Fistulizing Crohn's Disease
  - Anti-TNF: Infliximab, Adalimumab
  - Vedolizumab
  - Ustekinumab
  - Upadacitinib
  - Antibiotics

Am J Gastroenterol. 2025 Jun 3;120(6):1225-1264

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Medical Management of Crohn's Disease in Adults

- Post Op Risk:
  - Low: Observe
  - High: Anti-TNF, Vedolizumab
- What makes a patient HIGH risk?
  - Tobacco smoker, active
  - Penetrating disease
  - Prior CD resections

- When to refer to surgery:
  - Intra-abdominal abscess > 2 cm - treat with drainage and antibiotics
  - Symptomatic fibrostenotic strictures or abdominal abscesses
- Surgical and Postoperative Crohn's Disease:
  - Recommend 6-12 months post-op colonoscopy to assess for early recurrent CD
  - CD patients at high-risk for post-op recurrence
  - **Consider starting advanced therapy shortly after resection**

Am J Gastroenterol. 2025 Jun 3;120(6):1225-1264

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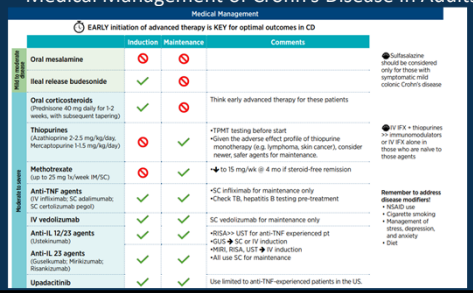
Medical Management of Crohn's Disease in Adults



Am J Gastroenterol. 2025 Jun 3;120(6):1225-1264; ACG CD Highlights https://mediacdn.gi.org/journal-cdn/wp-content/uploads/2018/04/ACG_CrohnsHighlights2025.pdf

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ACG 2025 GUIDELINE – ULCERATIVE COLITIS MANAGEMENT HIGHLIGHTS IN ADULTS

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Medical Management of Ulcerative Colitis in Adults

- Diagnosis, Assessment, Monitoring, and Prognosis
  - Stool testing to rule out *c. difficile*
  - Do not use serologic antibody testing to establish, rule out, or determine UC prognosis
- Goals:
  - Utilize treat-to-target with a goal of endoscopic improvement (Mayo Score 0 to 1)
    - Increase steroid-free remission, prevent hospitalization, surgery
  - Use Non-invasive markers (fecal calprotectin and/or intestinal ultrasound) to assess clinical response

Am J Gastroenterol. 2025 Jun 3;120(6):1187-1224.

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Mild to Moderate UC

Mild to Moderate UC	Location	Induction	Maintenance
Proctitis	within 18 cm of anal verge, distal to rectosigmoid junction	Rectal 5-ASA therapies (1 g/day) • Intolerant or nonresponsive? Tacrolimus suppository or topical steroid (suppository, budesonide foam)	Proctitis • Rectal 5-ASA therapies (1 g/day) Left Sided Colitis/Extensive Colitis • Oral 5-ASA therapy (at least 1.5 g/day) -Low-dose (2-2.4 g) of 5-ASA should be used, as compared to the higher dose (4.8 g) - No difference in remission rate - Dose based on patient preference
Left-sided Colitis	sigmoid to splenic flexure	• Rectal 5-ASA enemas (at least 1 g/day) + oral 5-ASA (2 g-4.8 g/day) compared to oral 5-ASA alone • Intolerant or nonresponsive? Oral budesonide MMX 9 mg/day for induction • Rectal 5-ASA enemas (at least 1 g/day) preferred over rectal steroids	
Extensive colitis	beyond splenic flexure, includes those with pancolitis or involvement of entire colorectum	•Oral 5-ASA (at least 2 g/day) is recommended - Fail to respond? Oral systemic steroids - In those who fail to reach remission with 5-ASA, pursue alternative therapies rather than alternating 5-ASA class.	

Am J Gastroenterol. 2025 Jun 3;120(6):1187-1224.

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Moderate to Severe UC

Induction	Maintenance
Moderate UC: • Oral budesonide MMX is recommended **Moderate to Severe UC:** • Oral systemic steroids • S1P receptor modulators (ozanimod, etrasimod) • IL-12/23 p40 antibody (ustekinumab) • IL-23 p19 inhibitor (guselkumab, mirikizumab, risankizumab) • Anti-integrin (vedolizumab) • Anti-TNF (infliximab, adalimumab, golimumab) • JAK inhibitor (tofacitinib, upadacitinib) **Positioning Considerations** • Loss of response to anti-TNF? Measure serum drug levels and anti-drug antibodies to assess • Vedolizumab >> adalimumab for induction and maintenance • Infliximab is the preferred anti-TNF therapy for patients with moderately to severely active UC. If infliximab is used in induction, recommend combo therapy with a thiopurine AVOID: • Monotherapy with thiopurines or methotrexate • Adding 5-ASA for clinical efficacy if previously failed 5-ASA and now on advanced therapies	Thiopurines for maintenance of remission >> no treatment or steroid If induction was achieved using the same therapy, can continue the following: • Oral systemic steroids (typically as a bridge until advanced therapy begins to work) • S1P receptor modulators (ozanimod, etrasimod) • IL-12/23 p40 antibody (ustekinumab) • IL-23 p19 inhibitor (guselkumab, mirikizumab, risankizumab) • Anti-integrin (vedolizumab) • Anti-TNF (infliximab, adalimumab, golimumab) • JAK inhibitor (tofacitinib, upadacitinib) Recommend against systemic, budesonide MMX, or topical steroids for maintenance Recommend against use of methotrexate alone for maintenance

Am J Gastroenterol. 2025 Jun 3;120(6):1187-1224.; ACG UC and CD Guideline Highlights 2025. https://webfiles.gi.org/GuidelineHighlights/UC-highlights-

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Management of Hospitalized Patient with Acute Severe UC

- Test for *C. difficile*
- DVT Prophylaxis
- For Induction:
  - IV Corticosteroids:
    - Methylprednisolone 60 mg/day OR
    - Hydrocortisone 100 mg 3-4 times per day
  - Medical Rescue
    - If failing to respond to IVCS by day 3, recommend infliximab or cyclosporine
  - Avoid:
    - Routine broad-spectrum antibiotics
    - TPN for purpose of bowel rest
- For Maintenance:
  - Remission with infliximab
    - Continue with infliximab
  - Remission with cyclosporine IV
    - Suggest maintenance with thiopurines or vedolizumab

Am J Gastroenterol. 2025 Jun 3;120(6):1187-1224.

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GOALS OF IBD MANAGEMENT

References:

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Goals of IBD Therapy

Gastroenterology. 2021 Apr;160(5):1570-1583. doi: 10.1053/j.gastro.2020.12.031. Epub 2021 Feb 19. PMID: 33359090.

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Treat-to-Target with STRIDE-II Recommendations

The Selecting Therapeutic Targets in Inflammatory Bowel Disease (STRIDE-II) group, has updated the 2015 STRIDE recommendations for treating to target in patients with CD and UC

- Select a therapy according to patient's disease risk of progression
- Measure objective markers of inflammation (e.g. CRP/fecal calprotectin) plus patient reported outcomes (PRO)
- Monitor these objective parameters at defined intervals
- Optimize treatment as needed to achieve and sustain remission and other treatment goals

Provides time-dependent clinically-useful goals in order to facilitate IBD treatment and improve long term disease outcomes

- Adapted to individual patients and local resources available

Gastroenterology. 2021 Apr;160(5):1570-1583. doi: 10.1053/j.gastro.2020.12.031. Epub 2021 Feb 19. PMID: 33359090.

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What is new in STRIDE-II?

- The STRIDE group, under the auspices of the IOIBD, has updated the 2015 first reported STRIDE recommendations and has developed 13 updated and new recommendations for treating to target in CD and UC (STRIDE-II recommendations).
- Time to expected response, remission, and endoscopic healing with the different treatments have been introduced for incorporating the treatment targets.
- STRIDE-II added clinical response and remission as well as normalization of CRP as immediate and short-term targets.
- Reduction of FC to an acceptable range has been added as a formal intermediate treatment target.
- Pediatric targets, reflected by different measuring scales and the addition of restoration of normal growth as a formal treatment target have been added.
- Restoration of QoL and absence of disability have been added to EH as long-term targets.
- Transmural healing in CD and histological healing in UC have been newly recognized as important adjunctive measures but were not endorsed as formal new treatment targets.

- Ultimately, symptom control alone is insufficient for management

Gastroenterology. 2021 Apr;160(5):1570-1583. doi: 10.1053/j.gastro.2020.12.031. Epub 2021 Feb 19. PMID: 33359090.

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Treatment Targets in CD and UC

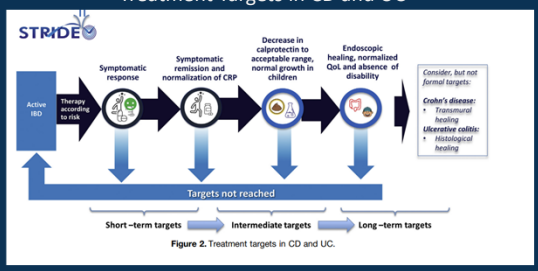

Figure 2. Treatment targets in CD and UC.

Gastroenterology. 2021 Apr;160(5):1570-1583. doi: 10.1053/j.gastro.2020.12.031. Epub 2021 Feb 19. PMID: 33359090.

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IBD Pharmacotherapy

- Choice of therapy based on:
  - Disease severity
  - Extent of inflammation
  - Prognostic factors
  - Patient preference (lifestyle, route of administration)
  - Insurance coverage
- Shared decision making between provider and patient is key

Drug Therapies	Examples
Corticosteroids (CS)	Prednisone, Budesonide, Methylprednisolone, Hydrocortisone
Symptom support	Antidiarrheals, bile acid sequestrants, low dose tricyclic antidepressants, non-opioid pain interventions
Antibiotics	e.g. Metronidazole, Ciprofloxacin, Levofloxacin
Aminosalicylates (5-ASAs)	Mesalamine, Sulfasalazine, Balsalazide
Immunomodulators	Thiopurines (azathioprine/6MP), Methotrexate
Advanced Therapies - for moderate to severe IBD	Biologics: Anti-TNFs, Anti-integrins, IL12/23 and IL23 inhibitors Small Molecules: S1P modulators, JAK inhibitors

Lichtenstein GR, Loftus EV, Afzali A, Long MD, Barnes EL, Isaacs KL, Ha CY. ACG Clinical Guideline Management of Crohn's Disease in Adults. Am J Gastroenterol. 2025 Jun 3;120(6):1225-1264. doi: 10.14309/ajg.0000000000003445. PMID: 40701562. Rubin DT, Ananthakrishnan AN, Siegel CA, Barnes EL, Long MD. ACG Clinical Guideline Update: Ulcerative Colitis in Adults. Am J Gastroenterol. 2025 Jun 3;120(6):1187-1224. doi: 10.14309/ajg.0000000000003443. PMID: 40701156.

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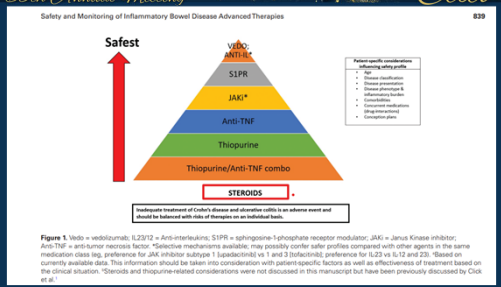

Figure 1. Vedo = vedolizumab; IL23/12 = Anti-interleukins; S1PR = sphingosine-1-phosphate receptor modulator; JAKi = Janus Kinase inhibitor; Anti-TNF = anti-tumor necrosis factor. *Selective mechanisms available; may possibly confer safer profiles compared with other agents in the same medication class (eg, preference for JAK inhibitor subtype 1 [upadacitinib] vs 1 and 3 [tofacitinib]; preference for IL23 vs IL12 and 23). †Based on currently available data. This information should be taken into consideration with patient-specific factors as well as effectiveness of treatment based on the clinical situation. ‡Steroids and thiopurine-related considerations were not discussed in this manuscript but have been previously discussed by Click et al.[1]

. Inflamm Bowel Dis. 2024 May 2;30(5):829-843. doi: 10.1093/ibd/izad120. PMID: 37450619.

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ADVANCED THERAPIES FOR MODERATE TO SEVERE IBD IN ADULTS

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BIOLOGICS (IV, SC)

IV – intravenous; SC - subcutaneous

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Anti-TNF agents

	Adult Standard Dosage
Infliximab (IV) -biosimilars	UC/CD: 5 mg/kg IV at week 0, 2, 6 followed by every 8 week dosing
Infliximab-dyyb (SC)	120 mg SC every 2 weeks starting at week 10 - When switching from IFX IV, administer 1st SC dose in place of next scheduled IV infusion

Infliximab: And Infliximab-dyyb. In: Micromedex database (electronic version). Merative; 2025. Accessed 5/17/26. https://www.micromedexsolutions.com

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Anti-TNF agents

	Adult Standard Dosage
Adalimumab (SC) - biosimilars	UC/CD: Day 1: 160 mg SC Day 15: 80 mg SC Day 29: 40 mg then every other week thereafter

Adalimumab. In: Micromedex database (electronic version). Merative; 2025. Accessed 5/17/26. https://www.micromedexsolutions.com

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Anti-TNF agents

	Adult Standard Dosage
Certolizumab	CD: 400 mg SC (as 2 injections of 200 mg) at week 0, 2, 4 followed by 400 mg every 4 weeks
Golimumab	UC: 200 mg SC at week 0, then 100 mg at week 2 and every 4 weeks thereafter

Certolizumab. In: Micromedex database (electronic version). Merative; 2025. Accessed 5/17/26. https://www.micromedexsolutions.com
Golimumab. In: Micromedex database (electronic version). Merative; 2025. Accessed 5/17/26. https://www.micromedexsolutions.com

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Anti-TNF agents - class

Baseline Monitoring	Ongoing Monitoring	Contraindications/ Warnings	Side effects
• TB • Hepatitis panel • CBC	• CBC every 3-6 months • Hepatic panel every 3-6 months • Viral hepatitis panel + TB annually (if high risk, for insurance considerations) • Signs and symptoms of infection • Annual skin exam	• New York Heart Association Class III or IV • Preexisting demyelinating disease • Live vaccines during treatment	Infections (TB, hepatitis B, fungal), infusion/ injection site reactions, lymphoma, melanoma, hepatosplenic T-cell lymphoma, hepatotoxicity, demyelinating disease, lupus-like syndrome, paradoxical psoriasiform, immunogenicity

. Inflamm Bowel Dis. 2024 May 2;30(5):829-843. doi: 10.1093/ibd/izad120. PMID: 37450619.

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Anti-Integrin

	Dosing	Baseline Monitoring	Ongoing Monitoring	Contraindications/ Warnings	Side effects
Vedolizumab - Gut selective	UC/CD: 300 mg IV at week 0, 2, 6 followed by every 8 weeks thereafter Option to switch IV to SC: 108 mg SC at week 6 then every 2 weeks	• TB • Hepatitis panel • Hepatic panel • CBC	• Hepatic panel and CBC every 3-6 months	Live vaccines	infections (upper respiratory infections), headache, arthralgia; not associated with same risk of progressive multifocal leukocencephalopathy (PML) as natalizumab

Vedolizumab. In: Micromedex database (electronic version). Merative; 2025. Accessed 5/17/26. https://www.micromedexsolutions.com
Inflamm Bowel Dis. 2024 May 2;30(5):829-843. doi: 10.1093/ibd/izad120. PMID: 37450619.

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IL-12/23 inhibitor

	Standard Adult Dosing	Baseline Monitoring	Ongoing Monitoring	Contraindications/ Warnings	Side effects
Ustekinumab	UC/CD: Induction (IV x 1): ≤ 55 kg: 260 mg 55 to 85 kg: 390 mg ≥ 85 kg: 520 mg Maintenance: 90 mg SC every 8 weeks	• TB • Hepatitis panel • Hepatic panel • CBC	• Hepatic panel and CBC every 3-6 months	Live vaccines	nasopharyngitis, upper respiratory tract infection, headache, fatigue, back pain, and dizziness

Ustekinumab. In: Micromedex database (electronic version). Merative; 2025. Accessed 5/17/26. https://www.micromedexsolutions.com
Inflamm Bowel Dis. 2024 May 2;30(5):829-843. doi: 10.1093/ibd/izad120. PMID: 37450619.

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IL-23 inhibitors

	Guselkumab	Mirikizumab	Risankizumab
Adult Standard Dosing	UC/CD: Induction: 200 mg IV at week 0, 4, and 8 OR 400 mg SC (administered as 2 consecutive injections) at week 0, 4, and 8 Maintenance: 100 mg SC at week 16 and every 8 weeks thereafter OR 200 mg SC at week 12 and every 4 weeks thereafter	CD: Induction: 900 mg IV at week 0, 4, 8 Maintenance: 300 mg SC (given as 2 injections of 100 mg and 200 mg in any order) at week 12, and every 4 weeks thereafter UC: Induction: 300 mg IV at week 0, 4, 8 Maintenance: 200 mg SC (given as 1 injection of 200 mg or 2 injections of 100 mg) at week 12, and every 4 weeks thereafter	CD: Induction: 600 mg IV at week 0, 4, 8 Maintenance: 180 mg or 360 mg SC at week 12 and every 8 weeks thereafter UC: Induction: 1200 mg IV at week 0, 4, 8 Maintenance: 180 mg or 360 mg at week 12 and every 8 weeks thereafter

Guselkumab and Mirikizumab and Risankizumab. In: Micromedex database (electronic version). Merative; 2025. Accessed 5/17/26. https://www.micromedexsolutions.com
Inflamm Bowel Dis. 2024 May 2;30(5):829-843. doi: 10.1093/ibd/izad120. PMID: 37450619.

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IL-23 inhibitors – class

Baseline Monitoring	Ongoing Monitoring	Contraindications/Warnings	Side effect profile
• TB • Hepatitis panel • Hepatic panel • CBC	• Hepatic panel and CBC every 3-6 months	• Live vaccines	• Infections (upper respiratory), headaches, arthralgia, hepatotoxicity

Inflamm Bowel Dis. 2024 May 2;30(5):829-843. doi: 10.1093/ibd/izad120. PMID: 37450619.

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SMALL MOLECULES (ORAL)

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S1P Receptor Modulators

Ozanimod	Etrasimod
UC: Day 1-4: 0.23 mg po daily Day 5-7: 0.46 mg po daily Then 0.92 mg po daily thereafter	UC: 2 mg po daily

Ozanimod in: Micromedex database (electronic version). Merative; 2025. Accessed 5/17/26. https://www.micromedexsolutions.com
Etrasimod in: Micromedex database (electronic version). Merative; 2025. Accessed 5/17/26. https://www.micromedexsolutions.com

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S1P Receptor Modulators - class

Baseline monitoring	Ongoing monitoring	Contraindications/ Warnings	Side effect profile
- ECG for pre-existing cardiac abnormalities - Hepatic panel in last 6 months - Use in hepatic impairment not recommended - CBC in last 6 months - Ophthalmology evaluation in those with diabetes, uveitis, or history of retinal disease - Skin exam - Spirometry evaluation to assess pulmonary function if clinically indicated - Pregnancy test	- CBC - Stop treatment if lymphocyte count < 0.2 × 109/L; re-initiate once level reaches > 0.5 × 109/L - Hepatic panel - Blood pressure, heart rate - Signs and symptoms of infection - Medication list	- Myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III or IV heart failure (within last 6 months) - Mobitz type II second-degree or third-degree atrio- ventricular (AV) block, sick sinus syndrome, or sino-atrial block, unless functioning pacemaker present - Severe sleep apnea (ozanimod) - Pre-existing pulmonary disease (ozanimod) - Macular edema (S1PRMs) - PML and PRES have been reported with S1PRMs - Concomitant MAOI (ozanimod) - CYP2C9 poor metabolizers also using moderate to strong inhibitors of CYP2C8 or CYP3A4: Use of etrasimod is not recommended in this population	Infection (**herpes zoster**, upper respiratory tract infection), lymphocytopenia, headache, hepatotoxicity, hypertension, bradycardia

Inflamm Bowel Dis. 2024 May 2;30(5):829-843. doi: 10.1093/ibd/izad120. PMID: 37450619.
Micromedex

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Janus Kinase Inhibitors (JAKi)

Drug	Tofacitinib	Upadacitinib
Adult standard dosage Small molecule Oral	UC: - For those with inadequate response or intolerance to 1 or more anti-TNF agents -10 mg po BID x 8 weeks THEN 5 mg BID (consider 10 mg BID if experience loss or response.) -22 mg XR po daily x at least 8 weeks depending on therapeutic response, transition to maintenance therapy or continue 22 mg orally once daily for a MAX of 16 weeks; THEN 11 mg daily (consider 22 mg XR if experience loss or response during maintenance phase if benefits outweighs risks and with close monitoring)	• UC/CD: - For those with inadequate response or intolerance to 1 or more anti-TNF agents or at least 1 prior approved systemic therapy if anti-TNF agent is inadvisable UC: 45 mg po daily x 8 weeks then 15 or 30 mg daily based on individual patient presentation/disease severity CD: 45 mg po daily x 12 weeks then 15 or 30 mg daily based on individual patient presentation/disease severity

Tofacitinib in: Micromedex database (electronic version). Merative; 2025. Accessed 5/17/26. [redacted]
Product information. RINVOQ(TM) oral extended-release tablets, upadacitinib oral extended-release tablets. AbbVie Inc (per FDA), North Chicago, IL, 2022. Upadacitinib in: Micromedex database (electronic version). Merative; 2025. Accessed 5/17/26. [redacted]

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JAKi - class

Baseline Monitoring	Ongoing Monitoring	Contraindications/Warnings	Side effect profile
• TB • Hepatitis panel • Hepatic panel - Not recommended in Child-Pugh C (severe hepatic impairment) • CBC - Not recommended if absolute lymphocyte count < 500 cells/mm3, absolute neutrophil count < 1000 cells/ mm3, or hemoglobin level < 8 g/dL or decrease of more than 2 g/dL • Serum creatinine - Dose adjustment needed in severe renal impairment (eGFR 15 to < 30 mL/min/1.73m2) • - Upadacitinib not recommended in end stage renal disease (eGFR < 15 mL/min/1.73m2); tofacitinib can be administered after dialysis session • Lipid panel • Consider pregnancy test/discussion of family planning in women of childbearing potential • Assess concurrent use of medications that are strong CYP3A4 inhibitors/inducers OR moderate CYP3A4 inhibitor combined with strong CYP2C19 inhibitor. Avoid concurrent use with immunosuppressive medications (eg, azathioprine, cyclosporine) - See prescribing information for dosing recommendations	• Hepatic panel, serum creatinine and CBC at least every 3 months - Interrupt treatment if absolute neutrophil count is < 1000 cells/mm3 - Interrupt treatment if absolute lymphocyte count is < 500 cells/mm3 - Interrupt treatment if hemoglobin is < 8 g/dL • Lipid panel: - 4 to 8 weeks after start (tofacitinib) - 12 weeks (upadacitinib) - Manage hyperlipidemia per clinical guidelines • Signs & symptoms of infection	• Live vaccines • Pregnancy/Lactation • Age ≥ 50 years old • Pre-existing cardiovascular history • Malignancy • VTE	• Infections (upper respiratory tract infection, TB, **herpes zoster**), hyperlipidemia, increased blood creatinine phosphokinase, **acne**, neutropenia, hepatotoxicity, rash, MACE, VTE, malignancy • Medication residue in stool (upadacitinib)

Micromedex; Bhat S, Click B, Regueiro M. Safety and Monitoring of Inflammatory Bowel Disease Advanced Therapies. Inflamm Bowel Dis. 2024 May 2;30(5):829-843. doi: 10.1093/ibd/izad120. PMID: 37450619.

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Impact of a Clinical IBD Pharmacy Team

- Pharmacy technicians & Pharmacists:
  - Prior authorization and appeal support
    - Reduces administrative burden on GI providers
  - Medication access and insurance navigation
    - Help patients apply for copay savings programs and patient assistance programs
    - Collaborate with Field Reimbursement Managers to assist with patient access for individual patients
- Pharmacists
  - Clinical Pharmacists/Specialty Pharmacists
    - Patient education
    - Therapeutic drug monitoring
      - Treat-to-target strategies
      - Medication optimization
    - Safety monitoring
    - Health Maintenance
      - vaccination screening
      - smoking cessation
    - Drug information
    - Adherence support
    - Health system efficiency

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Helpful IBD Resources

GI organizations
- American College of Gastroenterology (ACG)
- American Gastroenterological Association (AGA)

Crohn's & Colitis Foundation
- IBD Practice Resources
- Education – IBD Pharmacist Virtual Symposium
- Health Maintenance Checklist - https://www.crohnscolitisfoundation.org/sites/default/files/2025-11/health-maintenance-checklist%20July%202025%20v2.pdf

Cornerstones Health IBD Checklist for Monitoring & Prevention
https://cornerstoneshealth.org/wp-content/uploads/2024/02/IBD-Checklist-for-Monitoring-Prevention-2024.pdf

Global Consensus on the Management of Pregnancy and Lactation in IBD
https://pianostudy.org/docs/CGH%20Global%20Consensus%20Statement.pdf

Attend a conference – e.g. AIBD pharmacy track

IBD Pharmacist Network – join on Facebook

IBD Live Weekly webcast

IBD Drive Time Podcast

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Take Home Message

As subsets of IBD, CD and UC are immune-mediated GI diseases characterized by chronic inflammation with relapsing and remitting symptoms.
- Progressive in nature and can cause significant impacts on quality of life

Using a top down, treat to target approach with timely treatment has been shown to help control symptoms, decrease use of steroids, ultimately modify disease progression and prevent serious complications of IBD

Choice of advanced therapy dependent on various factors – shared decision making between provider and patient is key

Pharmacists & pharmacy technicians can be an integral part of the multidisciplinary IBD team to assist with timely medication access and education

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Questions?

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STRIDE Forward – Personalizing Treat-To-Target in IBD Management: Update of the ACG 2025 Guidelines

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Thank you!

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