



JANUS KINASE INHIBITORS FOR ALOPECIA AREATA

Professional guidance supplementary to NICE TA958 and TA1178

Version 3, September 2026

In March 2024, NICE published its [technology appraisal guidance TA958](#), recommending ritlecitinib [Janus Kinase (JAK) 3 and tyrosine kinase (TEC) inhibitor] for severe alopecia areata (AA) in those aged 12 years and over:

- Ritlecitinib is recommended, within its marketing authorisation, as an option for treating severe alopecia areata in people 12 years and over. Ritlecitinib is only recommended if the company provides it according to the [commercial arrangement](#).
- Having concluded that ritlecitinib is a cost-effective use of NHS resources, the committee recommended it for routine use in the NHS, for treating severe alopecia areata in people aged 12 years and over.

In July 2026, NICE published its [technology appraisal guidance TA1178](#), recommending deuruxolitinib (JAK1/2 inhibitor) for severe AA in adults:

- Deuruxolitinib can be used, within its marketing authorization, as an option to treat severe AA in adults. Deuruxolitinib can only be used if the company provides it according to the [commercial agreement](#).
- Use the least expensive option of the suitable treatments (including deuruxolitinib and ritlecitinib), having discussed the advantages and disadvantages of the available treatments with the person with the condition. Take account of administration costs, dosages, price per dose and commercial arrangements.

Deuruxolitinib and ritlecitinib should be available routinely for people with AA through general dermatology clinics. Ritlecitinib has also been recommended by the [Scottish Medicines Consortium](#) for use in NHS Scotland and deuruxolitinib is likely to be under consideration.

Under the [NHS Constitution](#), patients have a legal right to drugs and treatments recommended by NICE in their technology appraisal (TA) and highly specialised technology appraisal guidance, provided their doctor deems it clinically appropriate. NICE guidance usually mandates funding within 90 days of publication, helping ensure equitable access across the NHS.¹

This guidance, developed by representatives of the British Hair and Nail Society (BHNS), British Association of Dermatologists' (BAD) Therapy & Guidelines sub-committee and Guideline Development Group (GDG) for managing people with AA,² and Alopecia UK, aims to supplement the above recommendations for JAK inhibitors in providing additional information that would help clinicians, commissioners and drugs formulary teams with implementation.

We do **NOT** recommend the use of these JAK inhibitors in patients whose current episode or disease duration is less than 6 months. This is in line with entry criteria in clinical trials. These patients can respond to other treatments, and a small cohort can demonstrate spontaneous regrowth.

1. SEVERITY OF AA

Severe AA is defined as having at least 50% loss of scalp hair (e.g. Severity Alopecia Tool [SALT] score of ≥ 50).

The AA severity definitions used in the BAD's AA *living* guideline² are based primarily on the extent of scalp hair loss, with **limited (mild)** hair loss representing 1-20% scalp involvement, **moderate** hair loss representing 21-49% scalp involvement and **severe** hair loss representing 50-100% scalp involvement. Unfortunately, the extent of scalp hair loss alone does not capture the wider impact of AA on an individual, particularly when psychological distress or functional impact (e.g. loss of eyelashes or nails) is prominent or when other visible body sites are involved.

'Therefore, a recent expert consensus³ has advocated adjusting the SALT-based severity rating when other additional factors are present.' Thus, people with **moderate AA (absolute SALT score 21-49)** 'may have their severity rating increased by one level to **severe** if one or more of the following are present:

- negative impact on psychological functioning resulting from AA
- noticeable involvement of eyebrows or eyelashes
- inadequate response after at least 6 months of treatment' (treatments include intralesional/oral corticosteroids or other treatments)
- 'diffuse (multifocal) positive hair pull test consistent with rapidly progressive AA.'^{2,3}

There may be other factors which could increase the severity rating.

Clinical trials have shown a lower response rate in people with a longer duration of severe disease; however, there is insufficient evidence at present to inform decision-making about access to treatment based on disease duration. Clinical experience has demonstrated hair regrowth in people with AA who would have been excluded from clinical trials due to their disease duration. Therefore, we do not recommend disease duration is included in the application for JAK inhibitors, or when assessing the patient's eligibility for treatment. This may change in the future as more evidence becomes available.

People with severe AA already established on a JAK inhibitor privately may seek prescription for ritlecitinib or deuruxolitinib via the NHS. It would be reasonable to establish an estimated absolute SALT score prior to initiating a JAK inhibitor, e.g. via images or patient description.

Key points – severity assessment

Severe disease is defined as having:

- 1) At least 50% loss of scalp hair, e.g. absolute SALT score ≥ 50
- OR
- 2) Absolute SALT score 21-49 *plus* at least one additional factor

1.1 Psychological/psychosocial assessment of people with AA

Psychological/psychosocial assessment of people with AA is recommended using appropriate scoring tools to demonstrate severity on initiation but is not required for continuation of treatment. We appreciate that the Dermatology Life Quality Index (DLQI) is used routinely for initiation of high-cost treatments in other dermatological conditions. However, DLQI does not always capture accurately the impact of hair loss.

Demonstrating psychological/psychosocial impact of AA can be supported by using mental health patient-reported outcome measures (PROMs) or screening tools (BAD AA *living* guideline 2025; Appendix O) that have psychometrically reliable cut-off points. These include:

- Patient Health Questionnaire-9 (PHQ-9)
- PHQ-9 modified for Adolescents (PHQ-A)
- General Anxiety Disorder-7 (GAD-7) or
- Mood and Feelings Questionnaire.

Key points – impact assessment

- 1) Undertake psychological/psychosocial assessment to understand the impact of AA on the patient, including suicide risk.
- 2) Significant psychological impact increases the severity of the condition.
- 3) There is no one recommended measure, with clinical experience suggesting some commonly used measures do not always capture the impact of the condition (e.g. DLQI/EQ5D). From appendix O included in the 2025 iteration of the BAD AA living guideline's supporting information document:
"Mental health patient-reported outcome measures (PROMs) questionnaires can enable healthcare professionals to assess and/or monitor the mental health of their patients. PROMs scores should never be interpreted in isolation, as they cannot be used to make a definitive mental health diagnosis."
Thus, a holistic appraisal, supported by appropriate measures as necessary, should be applied.
- 4) Currently, assessing psychological outcomes is not a recommended measure of the effectiveness of treatment with JAK inhibitors as there is insufficient evidence a) that it has an impact on patients' psychology and b) on the most appropriate tool to use. Additionally, there is poor correlation between psychological and objective AA severity outcome measures.
- 5) Provide information on relevant patient support organisations (see Appendix).

2. WHEN TO ASSESS TREATMENT RESPONSE

- At week 36, clinicians should review treatment response; the decision on continuation of treatment depends on the evidence of hair growth, recording the absolute SALT score at this point.
- Mental health PROMs scores do not need to be recorded for treatment continuation purposes, only for defining AA severity upon initiation.

3. INADEQUATE TREATMENT RESPONSE

Prior to commencing JAK inhibitors, a discussion should be had with people with AA that treatment will need to be discontinued if limited hair regrowth is achieved or if there are significant adverse effects. It is likely that any regrown hair will be lost upon discontinuation and patients should be made aware of this prior to commencing.

In both clinical trials,^{4,5} the companies used an absolute SALT score of ≤ 20 as the primary outcome. We recommend that this endpoint is also used in clinical practice.

- At week 36, clinicians should consider the following, depending on treatment response:
 - If no response at all then these therapies should be stopped at this point.⁶
 - If severe, prolonged disease (e.g. SALT > 95 at baseline and/or disease duration ≥ 4 years) **and** showing improvement with terminal hair growth and 40-50% improvement in SALT score during 12 months of treatment, **consider extending treatment to 18 months.**
 - **Consider the addition of adjunctive treatments (topical or low-dose oral minoxidil (LDM) /intralesional corticosteroid injections).**
 - Stop treatment if no evidence of continuing improvement in SALT and/or SALT < 20 not achieved by 18 months.
- Consider adjusting SALT scoring for men with male pattern hair loss (MPHL). MPHL may become apparent after regrowth in some cases with reduced density over the temples and vertex. There is an online tool available which can help in these scenarios to calculate the SALT score: [Alopecia Areata Calculator](#).⁷
- For those with SALT scores of 21-49 **plus** additional factors categorising the AA as severe:
 - Continuation should depend on the improvement of the parameters discussed by the clinician and patient prior to commencing the treatment.

4. CONSIDERATIONS

- For deuruxolitinib, **CYP2C9 genotyping test** is required before commencing treatment to determine patients' ability to metabolize the drug.
- Monitoring blood tests:
 - Full blood count (FBC) should be performed after 4 weeks for ritlecitinib and periodically for deuruxolitinib.
 - Lipid profile should be monitored with deuruxolitinib.
 - We do not recommend routine monitoring of creatinine kinase, unless clinically indicated.
- People with AA will still require prescriptions for wigs while regrowing their hair during treatment with JAK inhibitors; therefore, services for wig provision and prescriptions need to be maintained.⁸
- Clinicians should consider psychological support (e.g. [Alopecia UK](#); [Changing Faces](#); [Anxiety UK](#); [Samaritans](#)) required for people with AA due to discontinuation of JAK inhibitors, resulting in hair loss. People with AA experiencing hair loss all over again may find this traumatising.
- Clinicians should counsel people with AA prior to initiation of JAK inhibitors on the likelihood of it being a life-long treatment.
- We encourage dermatology departments to engage with an AA-related pharmacovigilance register such as GRASS-UK to help collect real-world data on treatment response and long-term safety. These data can help us gain greater understanding of the condition/treatment trajectory and ultimately inform future clinical practice.

APPENDIX

Support for people with AA

Alopecia UK is a national charity providing support, community and education to improve the lives of those affected by alopecia. The charity provides online resources and face-to-face peer support for people struggling with the psychological impact of living with a visible difference.

Alopecia UK's website is the best starting point for anyone seeking help and advice. The website includes a wealth of information, including, but not limited to:

- Guidance for living well with alopecia
- Resources for children and young people, including a Schools' Pack
- Advice for parents
- Links to peer support options for all ages, including both online and face-to-face groups, national events and personal experience blogs
- A Service Directory of businesses offering alopecia-related products and services (e.g. wigs, headwear, permanent make up)
- A sign-up form for the charity's monthly newsletter
- Research updates
- Links to other useful organisations (e.g. Samaritans, Mind, Anxiety UK).

Visit [Alopecia UK](#) for more information.

References

- 1 UK Parliament. NICE-Approved Products: Patient Access. Available at: <https://hansard.parliament.uk/commons/2021-11-30/debates/1894785E-C272-405C-BFD1-F9F566D934DB/NICE-ApprovedProductsPatientAccess#:~:text=It%20is%20very%20clear%20in,be%20the%20only%20possible%20solution.> (last accessed 10 September 2026).
- 2 Harries MJ, Ahmed A, Ascott A *et al*. British Association of Dermatologists living guideline for managing people with alopecia areata 2025. *Br J Dermatol* 2026; **194**:e56-e73.
- 3 King BA, Mesinkovska NA, Craiglow B *et al*. Development of the alopecia areata scale for clinical use: Results of an academic-industry collaborative effort. *J Am Acad Dermatol* 2022; **86**:359-64.

- 4 King B, Zhang X, Harcha WG *et al.* Efficacy and safety of ritlecitinib in adults and adolescents with alopecia areata: a randomised, double-blind, multicentre, phase 2b-3 trial. *Lancet* 2023; **401**:1518-29.
- 5 King B, Senna MM, Mesinkovska NA *et al.* Efficacy and safety of deuruxolitinib, an oral selective Janus kinase inhibitor, in adults with alopecia areata: results from the Phase 3 randomized, controlled trial (THRIVE-AA1). *J Am Acad Dermatol* 2024; **91**:880-8.
- 6 Datapharm. The electronic medicines compendium (emc): Litfulo 50mg Hard Capsules. Available at: <https://www.medicines.org.uk/emc/product/15257>. (last accessed 22 July 2026).
- 7 Speeckaert R, van Geel N. Alopecia areata calculator (VESALT). Available at: <https://www alopecia-areata-calculator.com/>. (last accessed 10 September 2026).
- 8 Alopecia UK. Charter for Best Practice for NHS Wig Provision. Available at: <https://www alopecia.org.uk/charter-for-best-practice-for-nhs-wig-provision>. (last accessed 10 September 2026).