Supplementary Table 1. 2010 EULAR Recommendations for the management of RA with non-biological and biological DMARDs[3]

Overarching principles	
A.	Rheumatologists are the specialists who should primarily care for patients with RA
B.	Treatment of patients with RA should aim at the best care and must be based on a shared decision between the patient and the rheumatologist
C.	RA is expensive in regards to medical costs and productivity costs, both of which should be considered by the treating rheumatologist
Final set of 15 recommendations on the management of RA	
1.	Treatment with synthetic DMARDs should be started as soon as the diagnosis of RA is made
2.	Treatment should be aimed at reaching a target of remission or low disease activity as soon as possible in every patient; as long as the target has not been reached, treatment should be adjusted by frequent (every 1-3 months) and strict monitoring
3.	MTX should be part of the first treatment strategy in patients with active RA
4.	When MTX contraindications (or intolerance) are present, the following DMARDs should be considered as part of the (first) treatment strategy: leflunomide, sulfasalazine or injectable gold
5.	In DMARD naïve patients, irrespective of the addition of glucocorticoids, synthetic DMARD monotherapy rather than combination therapy of synthetic DMARDs may be applied

6.	Glucocorticoids added at low to moderately high doses to synthetic DMARD monotherapy (or combinations of synthetic DMARDs) provide benefit as initial short term treatment, but should be tapered as rapidly as clinically feasible
7.	If the treatment target is not achieved with the first DMARD strategy, addition of a biological DMARD should be considered when poor prognostic factors are present; in the absence of poor prognostic factors, switching to another synthetic DMARD strategy should be considered
8.	In patients responding insufficiently to MTX and/or other synthetic DMARDs with or without glucocorticoids, biological DMARDs should be started; current practice would be to start a TNF inhibitor (adalimumab, certolizumab, etancercept, golimumab, infliximab) which should be combined with methotrexate
9.	Patients with RA for whom a first TNF inhibitor has failed, should receive another TNF inhibitor, abatacept, rituximab or tocilizumab
10.	In cases of refractory severe RA or contraindications to biological agents or the previously mentioned synthetic DMARDs, the following synthetic DMARDs might be also considered, as monotherapy or in combination with some of the above: azathioprine, ciclosporine A (or exceptionally cyclophosphamide)
11.	Intensive medication strategies should be considered in every patient, although patients with poor prognostic factors have more to gain
12.	If a patient is in persistent remission, after having tapered

	glucocorticoids, one can consider tapering biological DMARDs, especially if this treatment is combined with a synthetic DMARD
13.	In cases of sustained long-term remission, cautious titration of synthetic DMARD dose could be considered, as a shared decision between patient and doctor
14.	DMARD naïve patients with poor prognostic markers might be considered for combination therapy of methotrexate plus a biological agent
15.	When adjusting therapy, factors apart from disease activity, such as progression of structural damage, comorbidities and safety concerns should be taken into account