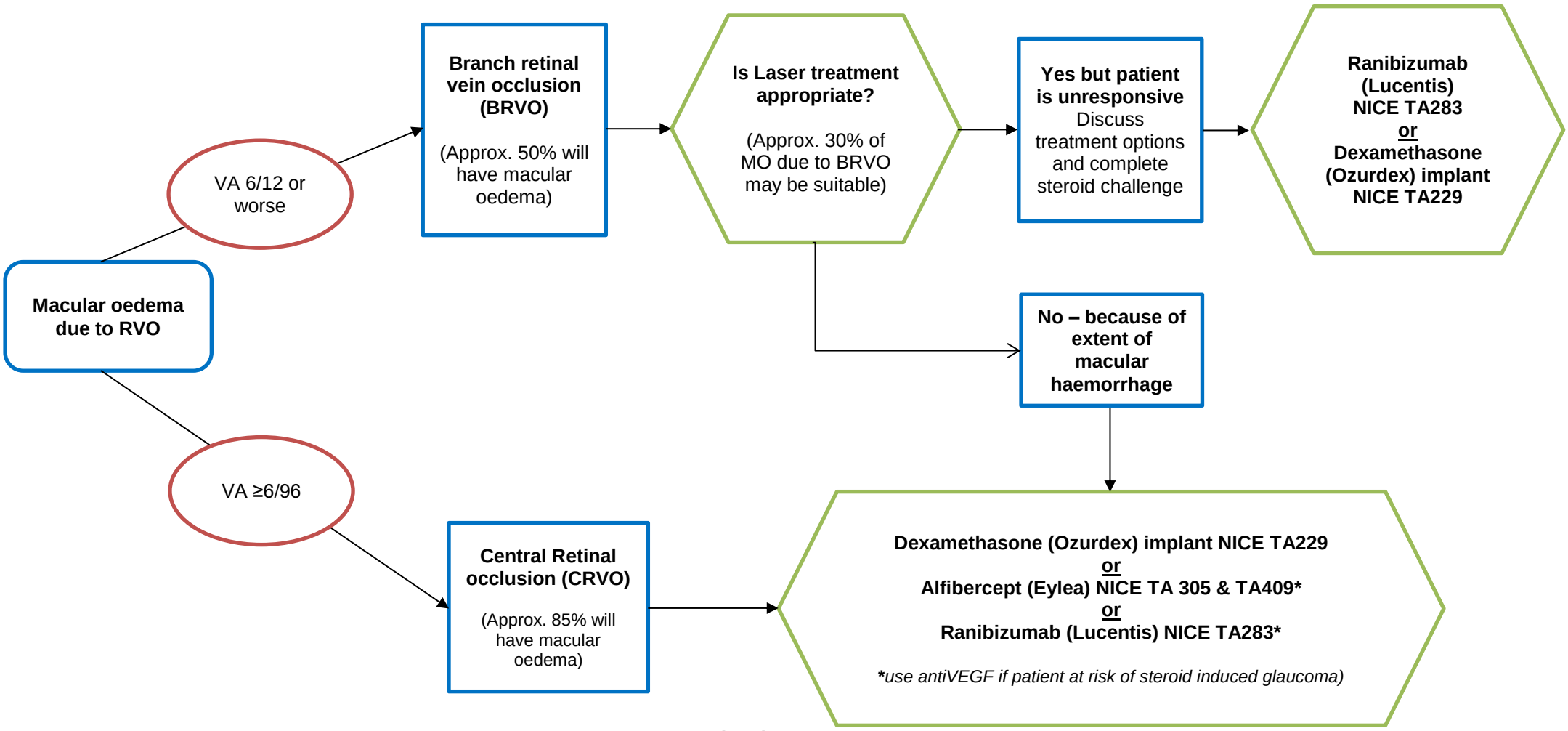
DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Derbyshire commissioning pathway for the treatment of macular oedema due to BRVO/CRVO
January 2020

This algorithm is a tool to aid the implementation of NICE guidance for the treatment of BRVO/CRVO. This treatment algorithm includes CCG commissioned drugs approved by NICE for the treatment.
Relevant NICE documents - Dexamethasone TA229, Ranibizumab TA283, Aflibercept TA305 and TA409



Last updated: January 2020
Review date: December 2022

NICE TA229 – Dexamethasone intravitreal implant for the treatment of macular oedema secondary to retinal vein occlusion.

- Dexamethasone intravitreal implant is recommended as an option for the treatment of macular oedema following **central retinal vein occlusion** and macular oedema following **branch retinal vein occlusion** when:
  - treatment with laser photocoagulation has not been beneficial, or
  - treatment with laser photocoagulation is not considered suitable because of the extent of macular haemorrhage.

Dexamethasone - 700mcg implant
Administered usually every 6 months in the affected eye and up to 6 implants may be given. (NICE). There is only very limited information on repeat dosing intervals less than 6 months. *There is currently no experience of repeat administrations beyond 2 implants in Retinal Vein Occlusion (SPC)*

- If VA 6/12 or worse and CRT>250microns, Regular review (every 1-3 months).
- Retreatment after 6 months VA>6/7.5 or CRT <250 microns.
- Patients who experience deterioration in vision, which is not slowed by dexamethasone, should not be retreated.

	Ranibizumab NICE TA283 (CRVO & BRVO)	**Aflibercept NICE TA 305 & TA409 (CRVO & BRVO)**
Initiation	Given monthly, until VA stable for 3 consecutive months	Given monthly, until VA stable and no signs of disease.
Continuation - extend an treat (as per SPC)	Once stable initiate treat-and-extend regimen, The treatment intervals can be extended stepwise until signs of disease activity or visual impairment recur. For RVO, treatment intervals may also be gradually extended, however there are *insufficient data to conclude on the length of these intervals*. If disease activity recurs, the treatment interval should be shortened accordingly.	Once stable initiate treat-and-extend regimen, Gradually increase treatment interval to maintain stable visual and/or anatomic outcomes, *however there is insufficient data to conclude on the length of these intervals*. If visual and/or anatomic outcomes deteriorate, the treatment interval should be shortened accordingly.
Discontinuation	• If there is no improvement in visual acuity over the course of the first 3 injections, continued treatment is not recommended • A change in the risk:benefit profile becomes unfavourable e.g. new MI or CVA • No evidence of benefit from treatment e.g. continued worsening/ lack of stabilisation of vision. (RCO- VA not improved by at least 5 letters and/or CMT has not reduced from baseline)	• If visual and anatomic outcomes indicate that the patient is not benefiting from continued treatment, aflibercept should be discontinued. • A change in the risk:benefit profile becomes unfavourable e.g. new MI or CVA • No evidence of benefit from treatment e.g. continued worsening/ lack of stabilisation of vision. (RCO- VA not improved by at least 5 letters and/or CMT has not reduced from baseline)
Treatment interval between two doses	One month	One month