DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

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

This algorithm is a tool to aid the implementation of NICE guidance for the treatment of BRVO/CRVO.
This treatment algorithm includes ICB commissioned drugs approved by NICE for the treatment.

Macular oedema due to RVO

VA 6/12 or worse

Branch retinal vein occlusion (BRVO)
(Approx. 50% will have macular oedema)

Is Laser treatment appropriate?
(Approx. 30% of MO due to BRVO may be suitable)

Yes but patient is unresponsive
Discuss treatment options and complete steroid challenge

If more than 1 treatment is suitable, the least expensive should be chosen.
Choices are listed in most cost-effective order:

- Ranibizumab biosimilar (Ongavia) (TA283) **or**
- Aflibercept (Eylea) (TA409) **or**
- Faricimab (Vabysmo) (TA1004) **or**
- Ranibizumab (Lucentis) (TA283) **or**
- Dexamethasone (Ozurdex) implant (TA229)

*use antiVEGF if patient at risk of steroid induced glaucoma

No – because of extent of macular haemorrhage

VA ≥6/96

Central Retinal occlusion (CRVO)
(Approx. 85% will have macular oedema)

If more than 1 treatment is suitable, the least expensive should be chosen.
Choices are listed in most cost-effective order*:

- Ranibizumab biosimilar (Ongavia) (TA283) **or**
- Alfibercept (Eylea) (TA305) **or**
- Faricimab (Vabysmo) (TA1004) **or**
- Ranibizumab (Lucentis) (TA283) **or**
- Dexamethasone (Ozurdex) (TA229)

*use antiVEGF if patient at risk of steroid induced glaucoma

Has patient benefitted from treatment after 12 months evidenced by:

- Stabilised or improved visual acuity **and/or**
- Stabilised or reduced retinal thickness
- Improvement in other anatomical parameters if VA and CRT have deteriorated?

No

If the patient is a non-responder to their **first** anti-VEGF treatment, they may switch to a second anti-VEGF treatment
If the patient has failed **two** anti-VEGF treatments **and** a steroid treatment – **STOP TREATMENT**

Yes – maintain same treatment and monitor patient at appropriate intervals

Date reviewed: January 2024

Biologic	NICE TA	Loading dose	Maintenance dose	Response measured	Prescribing information
Anti-VEGF preparations					
Ranibizumab (Biosimilar and Lucentis)	TA283	Given monthly, until VA stable for 3 consecutive months.	Once stable initiate treat-and-extend regimen. The treatment intervals can be extended stepwise until signs of disease activity or visual impairment recur.	If there is no improvement in visual acuity over the course of the first 3 injections, continued treatment is not recommended.	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. 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).
Aflibercept (Eylea)	TA305 & TA409	Given monthly, until VA stable and no signs of disease.	Once stable initiate treat-and-extend regimen. Gradually increase treatment interval to maintain stable visual and/or anatomic outcomes.	If visual and anatomic outcomes indicate that the patient is not benefiting from continued treatment, aflibercept should be discontinued.	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. 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).
Faricimab (Vabysmo)	TA1004	Given monthly, until VA stable for 3 consecutive months.	Once stable initiate treat-and-extend regimen. The treatment intervals can be extended stepwise until signs of disease activity or visual impairment recur.	If visual and/or anatomic outcomes indicate that the patient is not benefitting from continued treatment, Vabysmo should be discontinued.	Based on the physician's judgement of the patient's anatomic and/or visual outcomes, the dosing interval may be extended in increments of up to 4 weeks. If anatomic and/or visual outcomes change, the treatment interval should be adjusted accordingly, and interval reduction should be implemented if anatomic and/or visual outcomes deteriorate Treatment intervals shorter than 21 days and longer than 16 weeks have not been studied. Monitoring between the dosing visits should be scheduled based on the patient's status and at the physician's discretion, but there is no requirement for monthly monitoring between injections.

					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).
Steroid treatment					
Dexamethasone (Ozurdex)	TA229	Administered usually every 6 months in the affected eye.	Up to 6 implants may be given.		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. 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.