DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Derbyshire commissioning pathway for the treatment of Diabetic Macular Oedema (DMO)

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

Does patient have centre involving Clinically Significant Macular Oedema (CSMO) and impaired vision?

No → **NO TREATMENT**
Asymptomatic
No visual impairment
Declined treatment

Yes → Is central retinal thickness (CRT) ≥ 400 microns?

Yes → Is anti-VEGF treatment suitable?

Laser:
i. Non-Centre-involved
ii. CI: CMT < 400um
ii. 'Rescue' Laser

Laser treatment RESCUE

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

- **Ranibizumab biosimilar (Ongavia) (TA274)** or
- Aflibercept (Eylea) (TA346) or
- Faricimab (Vabysmo) (TA799) or
- Brolucizumab (Beovu) (TA820) or
- Ranibizumab (Lucentis) (TA274)

Switch to steroid treatment after two anti-VEGF treatment failures

No → **Steroid treatment:**
Reserved for use in subgroup population only if used in the eye with an intraocular (pseudophakic) or phakic (natural) lens and whose condition did not respond well enough to, or who could not have non-corticosteroid therapy:

- Dexamethasone intravitreal implant (TA824)
- Fluocinolone intravitreal implant (TA953)

Has the 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?

Yes – maintain same treatment and monitor patient at appropriate intervals

No →

If the patient is a non-responder to their **first** anti-VEGF treatment, they may switch to a second anti-VEGF treatment option

If the patient has failed **two** anti-VEGF treatments **and** a steroid treatment – **STOP TREATMENT**

Last updated: January 2024

Biologic	NICE TA	Loading dose	Maintenance dose	Response measured	Prescribing information
Anti-VEGF preparations					
Ranibizumab (Lucentis +biosimilar)	TA274	Inject 0.5mg monthly for 3 months	Continue until vision stable for 3 consecutive months	Discontinue if no improvement after 3 injections	Treatment may be extended using a treat-and-extend regimen, once maximum visual acuity is achieved and/or there are no signs of disease activity, the treatment intervals can be extended stepwise until signs of disease activity or visual impairment recur. The treatment interval may be extended by up to one month at a time.
Aflibercept (Eylea)	TA346	Inject 2mg monthly for 5 months	Continue 2 monthly injections until vision stable	Discontinue if no improvement after 3 injections	After the first 12 months, treatment may be extended using a treat-and-extend approach based on the physician's judgement of visual and/or anatomic outcomes. The dosing intervals are usually increased by 2-week increments to maintain stable visual and/or anatomic outcomes. There is limited data for treatment intervals longer than 4 months. If visual and/or anatomic outcomes deteriorate, the treatment interval should be shortened accordingly.
Faricimab (Vabysmo)	TA799	Inject 6mg every 4 weeks for 4 months	Continue 4 – 16 weekly injections	Discontinue if no improvement after 3 injections	Treatment may be individualised using a treat-and-extend approach following an assessment of the individual patient's anatomic and visual outcomes. The dosing interval may be extended from every 4 to every 16 weeks, with extensions in increments of up to 4 weeks. If anatomic and/or visual outcomes change, the treatment interval should be adjusted accordingly, and interval reductions of up to 8 weeks may be implemented if deemed necessary.
Brolucizumab (Beovu)	TA820	Inject 6mg every 6 weeks for the first 5 doses	Continue 8 – 12 weekly injections	Discontinue if no improvement after 3 injections	Treatment may be individualised using a treat-and-extend approach following an assessment of the individual patient's anatomic and visual outcomes. In patients without disease activity, treatment every 12 weeks (3 months) should be considered. In patients with disease activity, treatment every 8 weeks (2 months) should be considered.

Steroid treatment					
Dexamethasone (Ozurdex)	TA824	700 micrograms over a period of 6 months or more	Re-treatment can be performed approximately 6 months if the patient experiences decreased vision with or without an increase in retinal thickness with recurrent or worsening diabetic macular oedema	There is currently no experience of the efficacy or safety of repeat administrations beyond 7 implants. SPC 4.2	Patients treated with OZURDEX who have experienced an initial response and in the physician's opinion may benefit from retreatment without being exposed to significant risk should be considered for retreatment.
Fluocinolone (Iluvien)	TA953	190 micrograms, releasing 0.2 micrograms/day for approximately 36 months	An additional implant may be administered after 12 months if the patient experiences decreased vision or an increase in retinal thickness secondary to recurrent or worsening diabetic macular oedema		Retreatments should not be administered unless the potential benefits outweigh the risks. Only patients who have been insufficiently responsive to prior treatment with laser photocoagulation or other available therapies for diabetic macular oedema should be treated with ILUVIEN.