DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Derbyshire commissioning pathway for the treatment of Age-Related Macular Degeneration (ARMD)
June 2022

This algorithm is a tool to aid the implementation of NICE guidance for the treatment of ARMD. This treatment algorithm includes ICB commissioned drugs approved by NICE for treatment and local variations to the commissioning algorithm
Relevant NICE documents: NICE TA68 – PDT; NICE TA155 – Ranibizumab; NICE TA294 – Aflibercept; NICE TA800 - Faricimab

Wet/exudative/ neovascular ARMD

For use in
All lesions types: classic, predominantly classic, minimally classic, occult and RAP lesions.

- BCVA 6/12 to 6/96
- There is no permanent damage to central fovea
- Lesion ≤ 12disc areas in greatest linear dimension
- There is evidence of recent presumed disease progression (blood vessel growth, as indicated by fluorescein angiography or recent visual acuity changes) (See appendix 2)

Anti-VEGF treatments

Ranibizumab (Lucentis) – 1st line option as per NICE TA155
(For dosing details see appendix 1)
***for switching**

or

Aflibercept (Eylea) – 1st line option as per NICE TA294
(For dosing details see appendix 1)

or

Faricimab (Vabysmo) – 1st line option as per NICE TA800
(For dosing details see appendix 1)

Monoclonal antibody

Brolucizumab – 1st line option as per NICE TA672
(For dosing details see appendix 1)

Minority pathway
e.g. caution, CI to anti-VEGF, unable to attend 4-8weekly etc

Recommended only if:

- Classic (no occult) subfoveal CNV only
- BC VA 6/60 or better

Photodynamic therapy (PDT)

Verteporfin (Visudyne) as per NICE NG82
Monitor every 3 months.
In the event of recurrent CNV leakage, verteporfin therapy may be given up to 4 times per year (SPC)

Local variation to NICE

Local variation to NICE

*Suboptimal responders have the option of switching to aflibercept if:

- >6 consecutive injections from initiation or
- >4 consecutive after loading or
- >8 per year

Existing patients will be switched to brolucizumab only where it is not possible to extend their respective treatment regimen to a 12 weekly schedule.

Last updated: June 2022

Biologic	NICE TA	Loading dose	Maintenance dose	Response measured	Prescribing information
Anti-VEGF preparations					
Ranibizumab (Lucentis)	TA155	Inject 0.5mg monthly for the first 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 should be extended by no more than two weeks at a time, up to a maximum of 12 weeks.
Aflibercept (Eylea)	TA294	Inject 2mg monthly for the first 3 months	Continue 2 monthly injections until vision stable	Discontinue if no improvement after 3 injections	Treatment may be maintained at two months or further extended using a treat-and-extend dosing regimen based on the physician's judgement of visual and/or anatomic outcomes. Injection intervals are increased in 2 or 4-weekly increments to maintain stable visual and/or anatomic outcomes, up to a maximum of 12 weeks. If visual and/or anatomic outcomes deteriorate, the treatment interval should be shortened accordingly.
Faricimab (Vabysmo)	TA800	Inject 6mg every 4 weeks for 4 months	In patients without disease activity, treatment every 16 weeks should be considered. In patients with disease activity, treatment every 8 weeks or 12 weeks should be considered.	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. An assessment of disease activity based on anatomic and/or visual outcomes is recommended 20 and/or 24 weeks after treatment initiation so treatment can be individualised.
Monoclonal antibody					
Brolucizumab	TA672	6mg every 4 weeks for the first 3 doses	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.	A disease activity assessment is suggested 16 weeks (4 months) after treatment start	MHRA alert January 2022: Maintenance doses of brolucizumab (after the first 3 doses) should not be given at intervals of less than 8 weeks apart due to risk of intraocular inflammation and retinal vascular occlusion increased with short dosing intervals
Photodynamic therapy					
Verteporfin (Visudyne)	TA68	Monitor every 3 months	Patients should be re-evaluated every 3 months	In the event of recurrent CNV leakage, Visudyne therapy may be given up to 4 times per year SPC 4.2	Do not offer photodynamic therapy as an adjunct to anti-VEGF as first-line treatment for late AMD (wet active). Only offer photodynamic therapy as an adjunct to anti-VEGF as second-line treatment for late AMD (wet active) in the context of a randomised controlled trial.