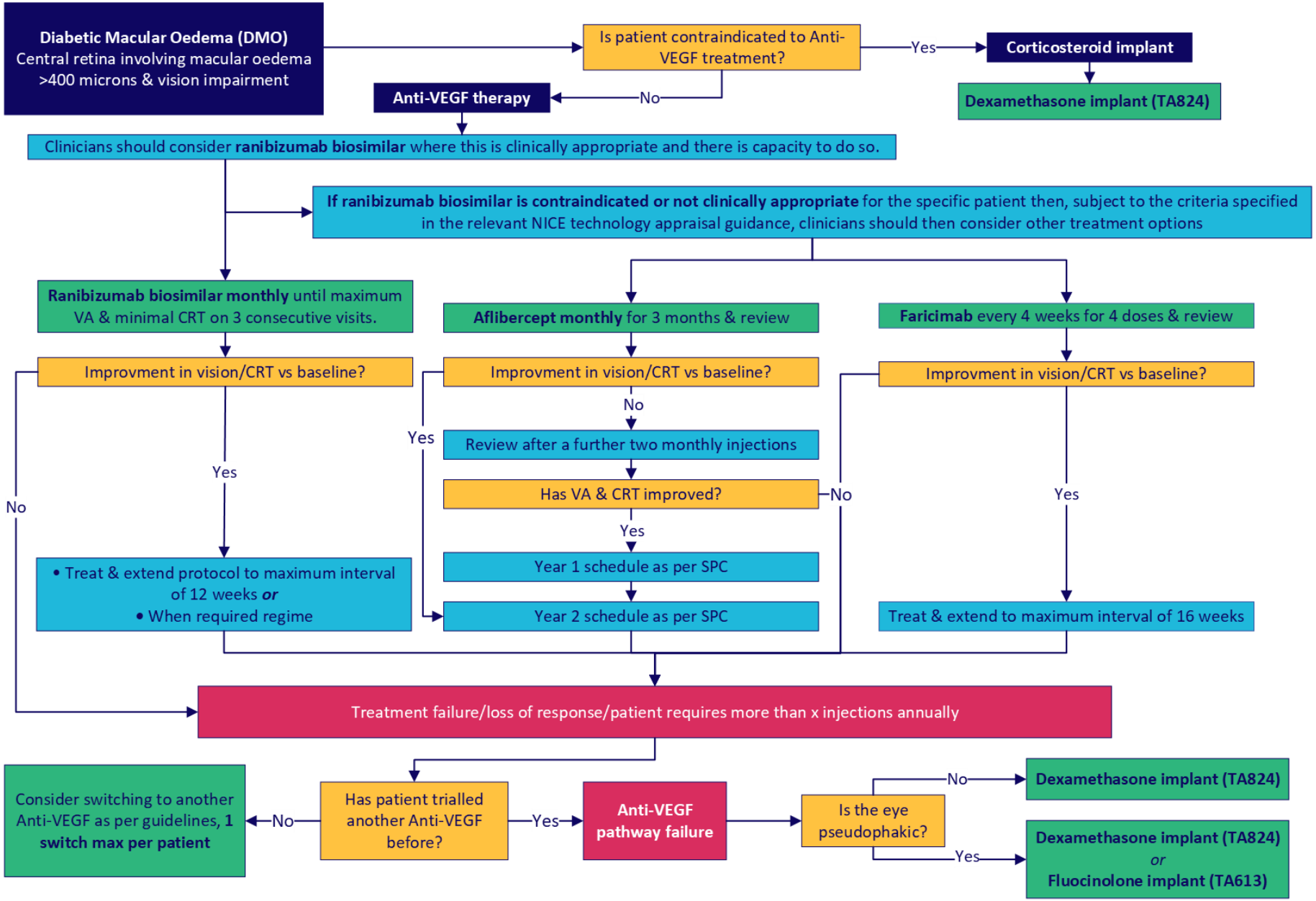
Diabetic Macular Oedema (DMO)
Central retina involving macular oedema >400 microns & vision impairment
Is patient contraindicated to Anti-VEGF treatment?
Yes
Corticosteroid implant
Dexamethasone implant (TA824)
No
Anti-VEGF therapy
Clinicians should consider ranibizumab biosimilar where this is clinically appropriate and there is capacity to do so.
If ranibizumab biosimilar is contraindicated or not clinically appropriate for the specific patient then, subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should then consider other treatment options
Ranibizumab biosimilar monthly until maximum VA & minimal CRT on 3 consecutive visits.
Aflibercept monthly for 3 months & review
Faricimab every 4 weeks for 4 doses & review
Improvment in vision/CRT vs baseline?
Improvment in vision/CRT vs baseline?
Improvment in vision/CRT vs baseline?
No
Yes
Review after a further two monthly injections
Yes
No
Has VA & CRT improved?
No
Yes
Yes
No
Year 1 schedule as per SPC
• Treat & extend protocol to maximum interval of 12 weeks or
• When required regime
Year 2 schedule as per SPC
Treat & extend to maximum interval of 16 weeks
Treatment failure/loss of response/patient requires more than x injections annually
Consider switching to another Anti-VEGF as per guidelines, 1 switch max per patient
No
Has patient trialled another Anti-VEGF before?
Yes
Anti-VEGF pathway failure
Is the eye pseudophakic?
No
Dexamethasone implant (TA824)
Yes
Dexamethasone implant (TA824)
or
Fluocinolone implant (TA613)

DMO commissioning summary

1. Available treatment options

Anti-VEGF: **Ranibizumab** , **Aflibercept** , **Faricimab** & **Brolucizumab** (not included in algorithm due to local clinical preferences)

Steroid implant : **Dexamethasone** (phakic/pseudophakic) & **Fluocinolone** (pseudophakic)

2. Preferred first line use

Ranibizumab biosimilar should be considered as the first line option where clinically appropriate

3. Treatment regimen: Ranibizumab

Offer monthly injections for three months, reassess, if needed continue with monthly intervals. Improvement measured as improvement in VA by at least 5 letters and CMT reduction from baseline after 3 months of treatment. Maintain monthly injections until maximum VA & minimal CRT on 3 consecutive visits then suspend treatment

3. Treatment regimen: Aflibercept

Treatment to be commenced with 1 injection every month for 5 months followed by injections every 2 months . After 3rd & 5th injection review, skip to year 2 schedule if appropriate (see pathway for details), otherwise complete year 1 as per SPC. In year 2 review/recommence treatment as required or follow treat and extend protocol .

3. Treatment regimen: Faricimab

Offer 4-weekly injections for first 4 doses. Treatment may be individualised using a treat-and-extend approach following an assessment of the patient's anatomic and visual outcomes . Dosing interval may be extended from 4 to 16 weeks, in increments of up to 4. 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

3. Treatment regimen: Brolucizumab

1 injection every 6 weeks for the first 5 doses. Thereafter, the physician may individualise treatment intervals based on disease activity as assessed by visual acuity and/or anatomical parameters. 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 .

3. High frequency switching guidelines

If a patient is requiring more than the following doses per year:

Biologic	Year 1 annual injections	Year 2 onwards	Y2 dosing interval
Ranibizumab	8	8	≥7 weeks
Aflibercept	8	8	≥7 weeks
Faricimab	6	4	≥13 weeks

Consider switching to a different Anti-VEGF in pathway. If patient has sub-optimal response to the new Anti-VEGF, a switch back is commissioned .

4. Maximum treatments commissioned – Steroid implants

Note: Administration to both eyes concurrently is not recommended . Retreatment may be performed .

Dexamethasone intravitreal implant (phakic or pseudophakic eye):

- If required more frequently than 6 monthly, or a total of more than 7, submit as individual funding request (IFR).

Fluocinolone acetonide intravitreal implant (pseudophakic eye):

- Any patient requiring a total of 3 or more implants require an individual funding request (IFR)

5. Switching options for patients – TO BE COMMISIONED

One switch to another Anti-VEGF is commissioned within pathway after failure with 1 Anti-VEGF. After 2 failures with Anti-VEGF treatment a steroid implant should be used. If clinician is switching due to high frequency usage, then a switch back to the original Anti-VEGF is commissioned .

Switching from steroid implants to Anti-VEGF is not commissioned .