Late wet AMD summary document

Patient must meet following criteria:
☑ The best-corrected visual acuity is between 6/12 and 6/96
☑ There is no permanent structural damage to the central fovea
☑ The lesion size ≤ 12 disc areas in greatest linear dimension
☑ Recent disease progression (e.g. blood vessel growth, shown by fluorescein angiography, or recent visual acuity changes)

*There are **no contraindications** for treatment:*
☒ Hypersensitivity to the active substances or excipients
☒ Active/suspected ocular/periocular infections
☒ Significant ocular inflammation

Is Ranibizumab biosimilar contraindicated? *see note (3)*

No contraindications → *Ranibizumab biosimilar - NICE TA155*

Contraindicated → *Faricimab NICE TA800*
Aflibercept NICE TA294
Brolucizumab NICE TA672

Review

Treatment success → Eye meets the defined criteria of late AMD wet inactive (2) → Consider permenant discontinuation of Anti-VEGF

Treatment failure → Eye meets the criteria for permenant discontinuation (1) → Consider permenant discontinuation of Anti-VEGF

Intolerance → Continued use is unsuitable because of an allergic response,
AND
There is still potential for improvement in vision with further treatment.

Inadequate ongoing response → Patients requires more than 8 injections of ranibizumab, or aflibercept, in the last 12 months

Inadequate early response → Where ranibizumab or aflibercept has not shown clinical benefit after optimum treatment
AND
Where there is still potential for improvement in vision with further treatment.

Switch Anti-VEGF treatment

(1). Further details on cause for permanent discontinuation due to treatment failure include:
- A hypersensitivity reaction is established or suspected
- Reduction of BCVA in the treated eye to less than 15 letters (absolute) on two consecutive visits in the treated eye attributable to AMD in the absence of other pathology
- Reduction in BCVA of 30 letters or more compared with either baseline and/or best recorded level since baseline
- There is evidence of deterioration of the lesion morphology despite optimum treatment. Such evidence includes progressive increase in lesion size confirmed with FFA, worsening of OCT indicators of CNV disease activity or other evidence of disease activity in the form of significant new haemorrhage or exudates despite optimum therapy over three consecutive visits.

(2) Defined criteria of late AMD wet inactive:
- Fibrous scar
- Sub foveal atrophy or fibrosis secondary to an RPE tear
- Atrophy (absence or thinning of RPE and/or retina)
- Cystic degeneration (persistent intraretinal fluid or tubulations unresponsive to treatment)

(3) If ranibizumab biosimilar is contraindicated or not clinically appropriate for the specific patient or there are specific clinical considerations (such as non-responder to ranibizumab in fellow eye previously, subretinal bleed >50% of lesion, idiopathic polypoidal choroidal vasculopathy (PCV)) then, subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should consider aflibercept, brolucizumab or faricimab.

Late wet AMD commissioning summary

1. Available treatment options

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

2. Preferred first line use

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

3. Switching guidelines

3.1. High frequency

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.

3.2 Intolerance

It is appropriate to change to the other treatment using the following definition of intolerance:

- Persistent sub-retinal or intra-retinal fluid on several consecutive occasions despite repeated intravitreal injections
- Where continued use of ranibizumab or aflibercept is unsuitable because of an allergic response, and, where there is still potential for improvement in vision with further treatment.

3.3 Inadequate response

It is appropriate to switch treatment if there has been insufficient clinical benefit after optimum treatment, and the treating clinician believes switching may yield a better response.

4. Maximum commissioned switches for patients

One switch to another Anti-VEGF is commissioned within pathway.

5. Ranibizumab dosing recommendations

Offer monthly injections for three months, reassess, and if needed continue with monthly intervals until there are no signs of disease activity on OCT. Once that is achieved continue with treatment, increasing the treatment intervals by 2/52 between each injection until a maximum interval of 12/52. If signs of recurrence on OCT or VA loss (5 letters or more), reduce treatment interval by 2/52 and monitor.

6. Aflibercept dosing recommendations

Treatment to be commenced with 1 injection every month for 3 months followed by injections every 2 months. Monitoring and treatment frequency are to be determined by the treating physician based on disease activity. For treat-and-extend regimens, interval may be increased by 2-4 weeks every successive visit (max. 16 weeks). If signs of disease activity or decreased VA interval may be reduced to no less than 4-weekly. Trial without treatment may be considered when no disease activity or VA reduction are noted on three consecutive visits at 16-week treatment interval

7. Faricimab dosing recommendations

Treatment to be commenced with 1 injection every 4-weeks for 4 doses. Thereafter, 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. In patients without disease activity, treatment should be extended to 16-weekly intervals In patients with disease activity, treatment at 8-weekly or 12-weekly intervals should be considered.