Wet Age-related Macular Degeneration (wet AMD) – Surrey Heartlands Drug Pathway
November 2022

Do all of the following apply?
- Best corrected visual acuity (VA) is between 6/12 and 6/96
- There is no permanent structural damage to central fovea
- The lesion size is ≤ 12 disc areas in greatest linear dimension
- There is evidence of recent presumed disease progression (blood vessel growth, as indicated by FA, or recent VA changes)

No

Does patient have late active wet-AMD and VA > 6/12F

Yes

Consider early treatment with Bevacizumab - load with 3 x monthly injections, thereafter PRN (NG82) (note 9)

Yes

Loading phase and assessment of disease activity:
1st choice: Biosimilar ranibizumab (TA155) **2nd choice**: aflibercept (TA294)
3rd choice: faricimab (TA800) **4th choice:** brolucizumab (TA672)

Is there a response (i.e. improvement/stabilisation in VA and reduction in signs of disease activity)?

No

Suboptimal Primary response:
- Consider switch to alternative anti-VEGF (with or without reloading) **OR**
- Continue with existing anti-VEGF

Yes

Has patient improved (i.e. OCT fluid decreased and VA increased)?

Yes

Consider Treat and extend:
Ranibizumab: Treat-and-extend by 2 weekly increments (up to 1 injection/12 weeks used in studies)
Aflibercept: Treat-and-extend by 2-4 weekly increments (up to 1 injection/4 months used in studies)
Faricimab: Treat-and-extend by 4 weekly increments (up to 1 injection/ 4 months used in studies)
Brolucizumab: Increase dose interval (up to 1 injection/3 months used in studies)

➔ When Visual Acuity (VA) stable and Optical coherence tomography (OCT) dry: consider suspending treatment and monitor

No

Reduce frequency of dosing back to standard dosing

Disease stability achieved?

Yes

No

Continue treatment:
Ranibizumab: No more than 1 injection/month
Aflibercept: No more than 1 injection/2 months
Faricimab: No more than 1 injection/2 months
Brolucizumab: no more than 1 injection/2 months

Yes

Disease stability achieved?

No

- Is response sub-optimal in the first year of treatment **or**
- Is response deteriorating in long term users who are now heavy users?
- Are frequent (monthly) injections required to maintain disease stability?

Then consider
- switch to alternative anti-VEGF (with or without reloading) OR
- Continue with existing anti-VEGF

NOTE: Max 3 switches (between 4 anti-VEGFs) per eye

Yes

Annual formal review at 12 months with feedback through Blueteq:
Has patient responded adequately to treatment and qualifies for further treatment as per locally modified RCO criteria (Sept 2013))

Yes

No

Have all switches per eye been exhausted?

No

Yes

Does patient have active wet-AMD and VA <6/96 and overall vision is expected to benefit from ongoing treatment (e.g. only seeing eye)?

Yes

Discontinue licensed anti-VEGF; consider Bevacizumab (NG82)

No

Discontinue high cost drug treatment or if atypical wet AMD suspected (e.g. Idiopathic Polypoidal Choiroidal Vasculopathy (IPCV)) refer to a tertiary centre for review

PLEASE NOTE:
In line with the NHS England Commissioning recommendations for medical retinal vascular medicines (August 2022). Clinicians should consider biosimilar ranibizumab as 1st line treatment where this is clinically appropriate and there is capacity to do so.
Blueteq forms will be used to ascertain clinical contraindications to this recommendation.

PLEASE NOTE:
Biosimilar ranibizumab is not considered a switch within the wet AMD pathway i.e. it is a 'free switch'

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