Treatment of Diabetic Macular Oedema (DMO) in Adults High Cost Drugs Pathway

Document control

Date	Version	Amendments
January 2026	2.0	Updated pathway. Pathway developed in accordance with NCL 'Principles for Commissioning High-Cost Drug Pathways for ICB Commissioned Indications', November 2023, and includes relevant published NICE TAs.
April 2015	1.0	Inaugural document

Groups / individuals who have overseen the development of this guidance:	NCL HCD Team, NCL Provider Trust Ophthalmology Specialist Clinicians, NCL Joint Formulary Committee Team
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This guideline is registered at North Central London (NCL) Joint Formulary Committee (JFC) and is intended solely for use by healthcare professionals to aid the treatment of patients within NCL. However, clinical guidelines are for guidance only, their interpretation and application remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Clinicians are advised to refer to the manufacturer's current prescribing information before treating individual patients.

The authors and NCL JFC accept no liability for use of this information beyond its intended use.

While we have tried to compile accurate information in this guideline, and to keep it updated in a timely manner, we cannot guarantee that it is fully complete and correct at all times. If you identify information within this guideline that is inaccurate, please report this to the admin.ncl-mon@nhs.net. If a patient is harmed as a consequence of following this guideline, please complete a local incident report and inform admin.ncl-mon@nhs.net.

NCL JFC is funded by and provides advice to Provider Trusts and the Integrated Care Board in NCL

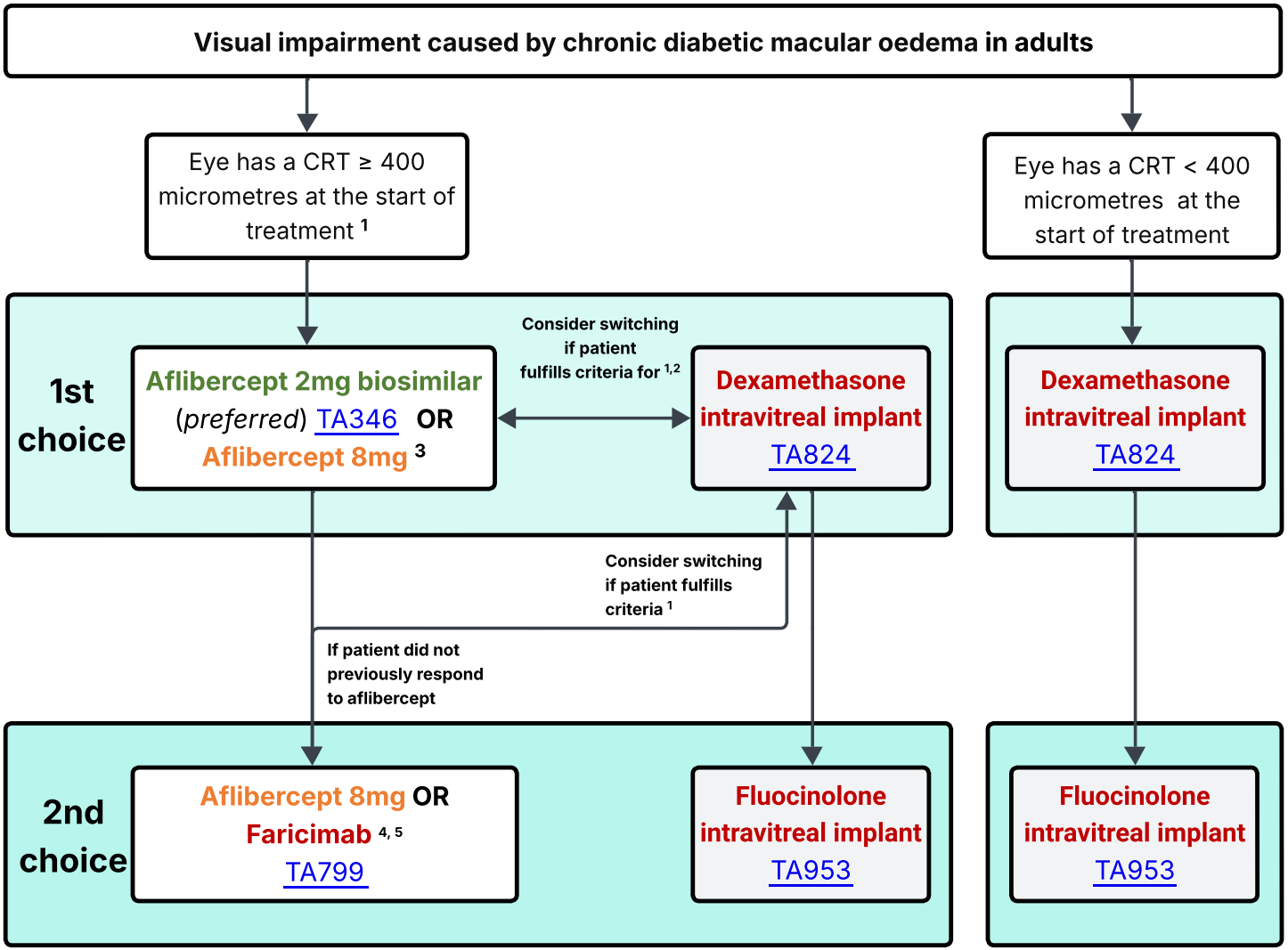
Treatment of centre-involving diabetic macular oedema (DMO) in adults

Green: lowest cost **Amber**: moderate cost **Red**: highest cost.
If more than one treatment is suitable, the least expensive treatment should be used.

1 Consider initiating on OR switching from anti-VEGF to dexamethasone, if a patient fulfills any of the following criteria:
- Recent cardiovascular events.
- Pregnancy (if the benefits outweigh the risks).
- Patients unable to comply with injection frequency of anti-VEGFs (see treatment burden criteria in *Box 3)*.

2 Consider switching from dexamethasone intravitreal implant to anti-VEGF if:
- Adverse drug reaction (ADR) (e.g. raised IOP).
- Initial use was due to cardiovascular event and risk has decreased/resolved.
- Patient had a better response whilst on anti-VEGF compared to steroid implants.

3 Criteria for patients requiring an anti-VEGF with a reduced treatment burden
Aflibercept 8mg may be used first line in patients requiring an anti-VEGF with reduced treatment burden who have at least one of the following conditions:
- Advanced dementia, requires hospital transport, requires treatment under sedation / general anaesthesia in theatre, learning difficulties that may impact treatment regimen, co-morbidities requiring frequent hospital appointments / inpatient admissions



4 Ranibizumab biosimilar (TA274) and **brolucizumab** (TA820) are available and may be considered in specific situations e.g. allergy/ADR to previous anti-VEGF.

5 If **faricimab** or **aflibercept 8mg** offers no added clinical benefit **OR** if an ADR has occurred, clinicians may consider switching back to **aflibercept 2mg biosimilar**.
NB: This is only permitted **once**.

Treatment regimen
Options may include a 'treat and extend' regimen, where the interval for the next anti-VEGF injection is extended by 2 to 4 weeks, regular intervals or a 'PRN' regimen for DMO, depending on patient response. Please refer to individual Trust guidance for further information. This would be based on best-corrected VA and OCT. Any long term service capacity constraints should be discussed with the NCL ICB High Cost Drugs team to discuss any variations in the treatment pathway.

Monitoring (for commissioning purposes)
Best-corrected VA (Snellen) at baseline and at annual intervals should be recorded.

First line treatment options

- The first line anti-VEGF choice should be aflibercept 2mg biosimilar (or aflibercept 8mg for patients requiring an anti-VEGF with a reduced treatment burden- see Box 3 above.) Second line choices include aflibercept 8mg or faricimab and in specific cases ranibizumab or brolucuzimab.
- In certain cases, it may be clinically appropriate for dexamethasone intravitreal implant (Ozurdex®) to be used as an alternative first line option for patients who cannot have anti-VEGF treatment (see Box 1 above).

Steroid intravitreal implants

- It is acknowledged that in clinical practice, patients may require re-treatment of dexamethasone (Ozurdex®) every 4-6 months (<6 monthly off-label). NCL ICB commissions up to three implants per eye per year.
- The SPC states there is no experience of the efficacy or safety on repeat administration of dexamethasone (Ozurdex®) beyond seven implants. However, it is recognised some patients may benefit from repeated administration beyond seven implants (off-label use).
- Fluocinolone intravitreal implant (Iluvien®) is indicated for patients who have insufficiently responded to other available treatments. Each implant can last for up to 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 DMO. Retreatments should not be administered unless the potential benefits outweigh the risks. NCL ICB commissions up to two implants per eye.
- In rare cases, in the event of an ADR or recurrence of DMO following fluocinolone treatment, the use of an anti-VEGF may be considered and will need to be discussed with the HCD team via a Blueteq request. (NHSE DMO commissioning guidance).

Switching between treatments and a sub-optimal response

1. Consider switching treatment options after the loading phase or after 12 months if vision has not improved or stabilised.
2. Consider switching to an alternative anti-VEGF in patients who respond to treatment but for whom the treatment interval cannot be extended to ≥8 weeks.
3. Suboptimal response is defined as:
   a. Persistent intraretinal fluid or subretinal fluid on OCT **OR**
   b. Unchanged (less than or equal to 5-letter improvement) / reduced VA due to DMO **OR**
   c. Unchanged/increase in retinal thickness related to DMO.
4. Patients established on anti-VEGF treatment may be switched to dexamethasone intravitreal implant (Ozurdex®) either temporarily or permanently. (See Box 1 above). NB: If this were a temporary switch, patients would revert to their original anti-VEGF once clinically appropriate.

Fellow eye
Consider harmonisation of treatment of the fellow eye; this includes current treatment and previous historical treatment of the fellow eye.
The safety and efficacy of dexamethasone (Ozurdex® SPC) intravitreal implants administered to both eyes concurrently, have not been studied and therefore, administration to both eyes concurrently is not recommended. This also applies to fluocinolone (Iluvien® SPC) intravitreal implants.

Treatment cessation

Treatment cessation is recommended when there has been no change or worsening of CRT despite optimal treatment, **AND**

1. There has been no change or worsening in VA, and there are irreversible structural changes with no potential for VA improvement, **OR**
2. Best recorded VA is less than 15 letters on two consecutive visits when:
   i. The deterioration in VA is attributed to DMO and not any other pathology AND
   ii. It is not the patient's better seeing eye.

Commissioned treatments with RAG rating based on cost:

Drug	Cost *	Maintenance dosing interval		Additional Information
		Minimum	Maximum	
Aflibercept 2mg biosimilar	£	1 month	4 months	
Ranibizumab biosimilar	£	~1 month (4 weeks as per SPC)	Not stated	May be considered if there is an allergy/ADR to a previous anti-VEGF.
Aflibercept 8mg	££	2 months	6 months	
Dexamethasone intravitreal implant	£££	4 months	Not stated	Up to a maximum of three implants per eye per year (<6 monthly off-label).
Faricimab	£££	~1 month (4 weeks as per SPC)	~4 months (16 weeks as per SPC)	
Brolucizumab	£££	~2 months (8 weeks as per SPC)	~4 months (16 weeks as per SPC)	May be considered if there is an allergy/ADR to a previous anti-VEGF.
Fluocinolone intravitreal implant	£££		36 months	Up to a maximum of two implants per eye.

***Green (£)**: lowest cost **Amber (££)**: moderate cost **Red (£££)**: highest cost

Glossary

Anti-VEGF	Drugs that block the action of Vascular Endothelial Growth Factor
CRT	Central Retinal Thickness
DMO	Diabetic Macular Oedema
VA	Visual Acuity
OCT	Optical Coherence Tomography
SPC	Summary of Product Characteristics

References

1) NICE Guideline [NG242]: Diabetic Retinopathy: management and monitoring (published: 13 August 2024). Available at: https://www.nice.org.uk/guidance/ng242. Accessed on 28/10/2025.
2) NHS England. Commissioning Guidance: Medical Retinal Treatment Pathway for Centre-Involving Diabetic Macular Oedema with Visual Impairment. October 2025. Available at https://future.nhs.uk/. Accessed on 28/10/25