Lancashire & South Cumbria Medicines Management Group

NHS Lancashire and South Cumbria Integrated Care Board

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Ophthalmology Macular Pathways Summary Guideline

Lancashire and South Cumbria ICB

October 2025

(Review date October 2028)

Contents

Version Number	Date	Amendments made
1.1	April 2024	Update to include biosimilars and National procurement for Anti-VEGF and Intravitreal Corticosteroids August 2022.
1.2	June 2025	Reflect NHSE Commissioning Guidance: Medical Retinal Treatment Pathway in Wet Age-related Macular Degeneration June 2025
1.3	July 2025	Update following Medical Directors, Clinical Directors and Chief Pharmacists meeting
1.4	October 2025	Update reflecting feedback from clinical meeting (September 2025) and NHSE Commissioning Guidance: Medical Retinal Treatment Pathway in Macular Oedema Secondary to Retinal Vein Occlusion and NHSE Commissioning Guidance: Medical Retinal Treatment Pathway for Centre-Involving Diabetic MacularOedema with Visual Impairment

1 Introduction

1.1 The introduction of biosimilars, new licenses and the 'National procurement for Anti-VEGF and Intravitreal Corticosteroids'[i] document published in August 2022 and the NHSE Commissioning Guidance: Medical Retinal Treatment Pathway in Wet Age-related Macular Degeneration (June 2025)[ii] has necessitated an update of the LSCMMG ophthalmology macular pathway.

1.2 In 2022, two ranibizumab biosimilars became licensed, Ongavia® and Byooviz®. Equivalent safety and efficacy to the originator ranibizumab (Lucentis®) has been confirmed in phase three clinical trials in patients with treatment naïve neovascular AMD (*see* https://www.sps.nhs.uk/articles/the-licence-and-supporting-evidence-for-ranibizumab-biosimilar/).[iii]

1.3 Ongavia® was the first licensed biosimilar to launch in the United Kingdom for use across all Indications (2022), Byooviz® and a further biosimilar Ximluci® were launched in 2023, with a significant reduction in acquisition cost.

1.4 The first aflibercept 2mg biosimilar is expected late 2025.

1.5 There are seven licenced and NICE approved intravitreal anti-VEGF and corticosteroid treatments available for medical retinal conditions which are used for the treatment of different indications as set out in this guideline. These are, with originator brand in brackets:

a. Aflibercept (Eylea®)
b. Brolucizumab (Beovu®)
c. Dexamethasone Intravitreal implant (Ozurdex®)
d. Faricimab (Vabysmo®)
e. Fluocinolone acetonide Intravitreal implant (Iluvien®)
f. Ranibizumab (Lucentis®)
g. Bevacizumab Gamma (Lytenava®)

1.6 Where NICE has already recommended the originator biological medicine, the same guidance will apply to the biosimilar. Biosimilars do not require a separate or additional Technology Appraisal.

1.7 This document provides treatment pathways for the following medical retinal conditions:

- Wet Age-related Macular Degeneration (Wet AMD)
- Diabetic Macular Oedema (DMO)
- Macular Oedema (MO) secondary to Central Retinal Vein Occlusion (CRVO)
- Macular Oedema (MO) secondary to Branch Retinal Vein Occlusion (BRVO)
- Choroidal NeoVascularisation (CNV) associated with pathological myopia
- Vitreomacular Traction – use of Ocriplasmin only.

1.8 **NB:** Unlicensed / Off label products eg Bevacizumab (Avastin) should not be used. Licensed products should not be used for unlicensed indications

2 Wet Age-Related Macular Degeneration (Wet AMD)

2.1 According to NICE technology appraisal guidance (TA 155,[iv] TA 294,[v] TA 672[vi], TA 800[vii] and TA1022[viii]), ranibizumab, aflibercept, brolucizumab, faricimab and bevacizumab gamma are all suitable options for the treatment of Wet AMD when used in accordance with the criteria outlined in the relevant NICE Technology Appraisal guidance. This includes only treating patients with visual acuity between 6/12 and 6/96 and if patients and their clinicians consider more than one treatment to be suitable, they should choose the least expensive option.

2.2 For patients commencing treatment for Wet AMD: subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should consider aflibercept 2mg biosimilar (when available) and ranibizumab biosimilar, where this is clinically appropriate and there is capacity to do so.

2.3 If aflibercept 2mg biosimilar/ranibizumab biosimilar is contraindicated or not clinically appropriate for a patient or there are specific clinical considerations (such as non-responder to ranibizumab / aflibercept 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 2mg (if treated with ranibizumab) as the second line option and aflibercept 8mg or faricimab as 3rd line options.

2.4 Following the three months loading phase, treatment should continue as per the summary of product characteristics (SPC). For patients who have a suboptimal response, clinicians should consider either stopping treatment or changing to an alternative anti-VEGF. If initial treatment selected was aflibercept 2mg biosimilar or ranibizumab biosimilar, clinicians should consider initially changing to aflibercept 2mg (if previously treated with ranibizumab biosimilar) and then aflibercept 8mg or faricimab.

2.5 For patients already prescribed an anti-VEGF for the treatment of Wet AMD: subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should review patients currently prescribed ranibizumab (Lucentis®) or aflibercept 2mg (Eylea®) in order to change to the corresponding biosimilar. For patients currently prescribed faricimab, who have not been treated with aflibercept previously, clinicians should review these patients in order to change them to aflibercept 2mg (biosimilar once available), providing they have not reached greater than 12 weeks under Treat and Extend (TREX).

2.6 If the patient has failed at least TWO extended interval attempts and there is no clinical benefit, switch back to previous anti-VEGF if it is more cost-effective and clinically appropriate. Consider switching to an alternative anti-VEGF if this is the patient's second anti-VEGF.

2.7 It is recommended that a maximum of THREE lines of therapy should be commissioned per eye, with the expectation that the first anti-VEGF used should normally be first choice options [i.e. aflibercept 2mg (biosimilar when available) or ranibizumab biosimilar]. Subsequent lines of therapy can be second or third choice options depending on individual circumstances and local commissioning agreements.

2.8 Where one eye is already on treatment, but the other eye qualifies for another treatment, prioritise treatment harmonisation by choosing the best treatment options for both eyes (i.e. using only one drug for both eyes).

2.9 Treatment decision options:

Consider treatment switch or permanent discontinuation if:

- BCVA < 25 letters on 2 consecutive visits attributable to wet AMD in the absence of other pathology **OR**
- Persistent disease activity despite optimal treatment

REVIEW with consideration to STOP treatment if:

- visual acuity < 25 letters (absolute) on 2 consecutive visits despite optimum treatment **AND**
- attributable to wet AMD in the absence of other pathology **AND**
- structural results (e.g. OCT) suggest no prospect of visual improvement with continued treatment.

Treatment STOP recommended if:

- visual acuity < 15 letters (absolute) on 2 consecutive visits despite optimum

treatment **AND**

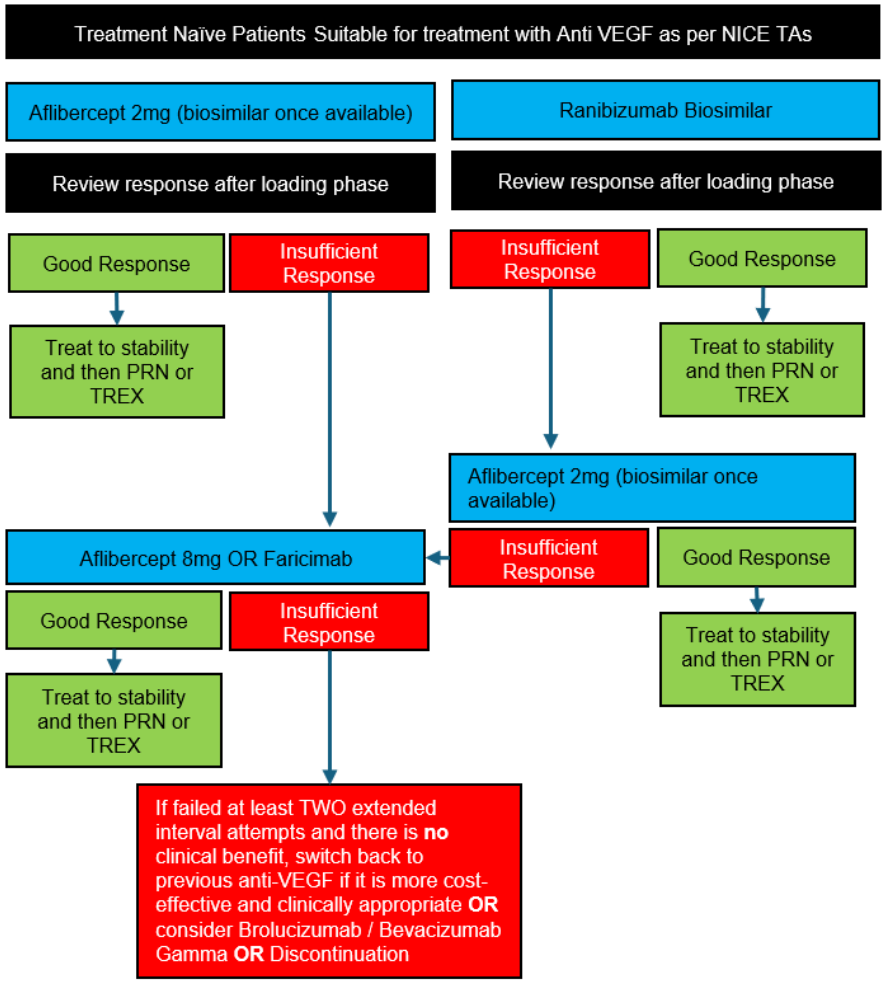
- attributable to wet AMD in the absence of other pathology

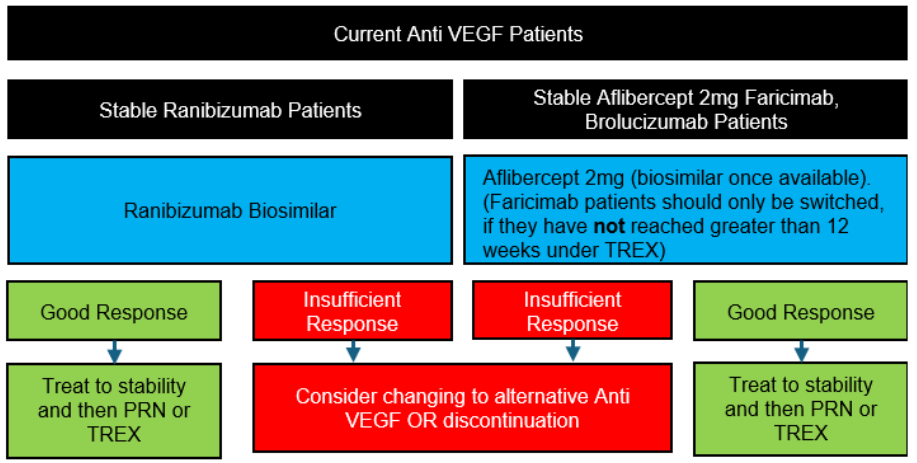
The NHSE Commissioning Guidance: Medical Retinal Treatment Pathway in Wet Age-related Macular Degeneration[21] (June 2025) also states that treating patients with "good" vision (i.e. VA ≥6/12 or ≥70 letters) should also be considered. Aflibercept 2mg biosimilars (once available) or ranibizumab biosimilars should be used as treatment options for this cohort of patients.

Examples of specific clinical considerations where aflibercept or ranibizumab may not be appropriate are also provided within the NHSE Commissioning Guidance[21]:

- Non-responder to ranibizumab/ aflibercept in fellow eye previously
- Ranibizumab-specific contraindications: subretinal bleed >50% of lesion, idiopathic polypoidal choroidal vasculopathy [PCV]

3 Wet Age-Related Macular Degeneration (Wet AMD), Preferred Pathway





Definitions and Actions
Insufficient response - post loading
Improvement in disease activity on OCT but with signs of active disease. e.g. OCT: anatomical features of active disease (e.g. fluid in
retina, new haemorrhage or SRHM).
Continue with REGULAR intervals, SWITCH if active disease 4-8 weeks after last injection
Insufficient response or unstable disease – maintenance phase
No improvement in BCVA OR improvement in anatomical features but signs of persistent activity. e.g. BCVA worsens/ no improvement (≤5-letter improvement) OR OCT: anatomical features of persistent active disease (e.g. non resolving fluid in retina, new haemorrhage or SRHM).
REDUCE intervals, SWITCH after 3 consecutive monthly injections
TREX = treat and extend
PRN = when required

4 Diabetic Macular Oedema (DMO)

4.1 NICE guidance (TA 237,[9] TA 346,[10] TA 799[11] &TA 820[12]) recommends ranibizumab, aflibercept, faricimab and brolucizumab as suitable options for the treatment of DMO when used in line with the criteria specified in the relevant NICE technology appraisal guidance. If patients and their clinicians consider ranibizumab, aflibercept, faricimab and brolucizumab to be suitable treatments, the least costly should be used.

4.2 For patients commencing treatment for DMO, clinicians should consider aflibercept 2mg biosimilar (once available) or ranibizumab biosimilar where this is clinically appropriate and there is capacity to do so. If aflibercept 2mg / ranibizumab biosimilars are 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 aflibercept 8mg or faricimab.

4.3 Dexamethasone (NICE TA824[13]) or fluocinolone (NICE TA301[14] & NICE TA953[15]) may also be considered in adults only if their condition has not responded well enough to, or if they cannot have non-corticosteroid therapy.

4.4 Following the loading phase, treatment should continue as per the SPC. For patients with suboptimal response, clinicians should consider changing to alternative anti-VEGF. If initial treatment selected was aflibercept 2mg or ranibizumab biosimilars, clinicians should consider changing to either aflibercept 2mg (if previously treated with ranibizumab biosimilar), aflibercept 8mg, faricimab or brolucizumab; dexamethasone or fluocinolone.

4.5 For patients already prescribed an anti-VEGF for the treatment of DMO, clinicians should consider reviewing patients currently prescribed originator ranibizumab (Lucentis®) or originator aflibercept 2mg (Eylea®) to assess suitability for a change to biosimilar. For patients currently prescribed faricimab, who have not been treated with aflibercept previously, clinicians should review these patients in order to change them to aflibercept 2mg (biosimilar once available), providing they have not reached greater than 12 weeks under TREX.

4.6 If anti-VEGF treatment is contraindicated or does not achieve a sufficient response (despite an appropriate injection frequency and regular monitoring) and there are no contra-indications to steroid usage, then intravitreal corticosteroid implants (dexamethasone intravitreal implant or fluocinolone acetonide intravitreal implant) should be considered.

4.7 In patients who may achieve good efficacy with anti-VEGF, but the frequency of repeated injections may not be tolerable for them due to individualised patient factors, then intravitreal steroids, with their potentially longer duration of action, may be useful.

4.8 NHSE have now published: Commissioning Guidance: Medical Retinal Treatment Pathway for Centre-Involving Diabetic Macular Oedema with Visual Impairment (Oct 2025) [16] and this is reflected in the following pathway.

Recommendations from the NHSE pathway include:

- Where clinically appropriate, use anti-VEGFs first. First choice options: Aflibercept 2mg (TA346)- switch to biosimilar once available OR ranibizumab biosimilar (TA274)
- Use aflibercept 8mg OR faricimab (TA799) as second choice anti-VEGF options. This is usually when high injection frequency is not acceptable with first choice options.
- Where one eye is already on an anti-VEGF, but the other eye qualifies for another treatment, prioritise treatment harmonisation by choosing the best anti-VEGF treatment option for both eyes (i.e using only one drug for both eyes).

- If the patient's condition has not responded well enough to, or if they cannot have non-corticosteroid therapy, use steroid implants. First choice: dexamethasone implant (NICE TA824) Second choice: fluocinolone implant (NICE TA953)

- Consider using the following criteria to define response:
  - Optimal response • CRT: ≥ 20% improvement AND • Visual acuity: > 5 letters improvement Suboptimal response • CRT: < 20% improvement OR • Visual acuity: ≤ 5 letters improvement
  - Poor response • CRT: < 20% improvement AND • Visual acuity: ≤ 5 letters improvement

- Switch to alternative drug class if:
  • Poor response, defined as:
  o Visual acuity: < 5 letters improvement or worsening
  o Anatomical changes: < 20% improvement in CRT
  • Adverse events whilst on therapy. Notable adverse events for treatment class include:
  o Anti-VEGFs: cardiovascular events
  o Steroid implants: raised intraocular pressure

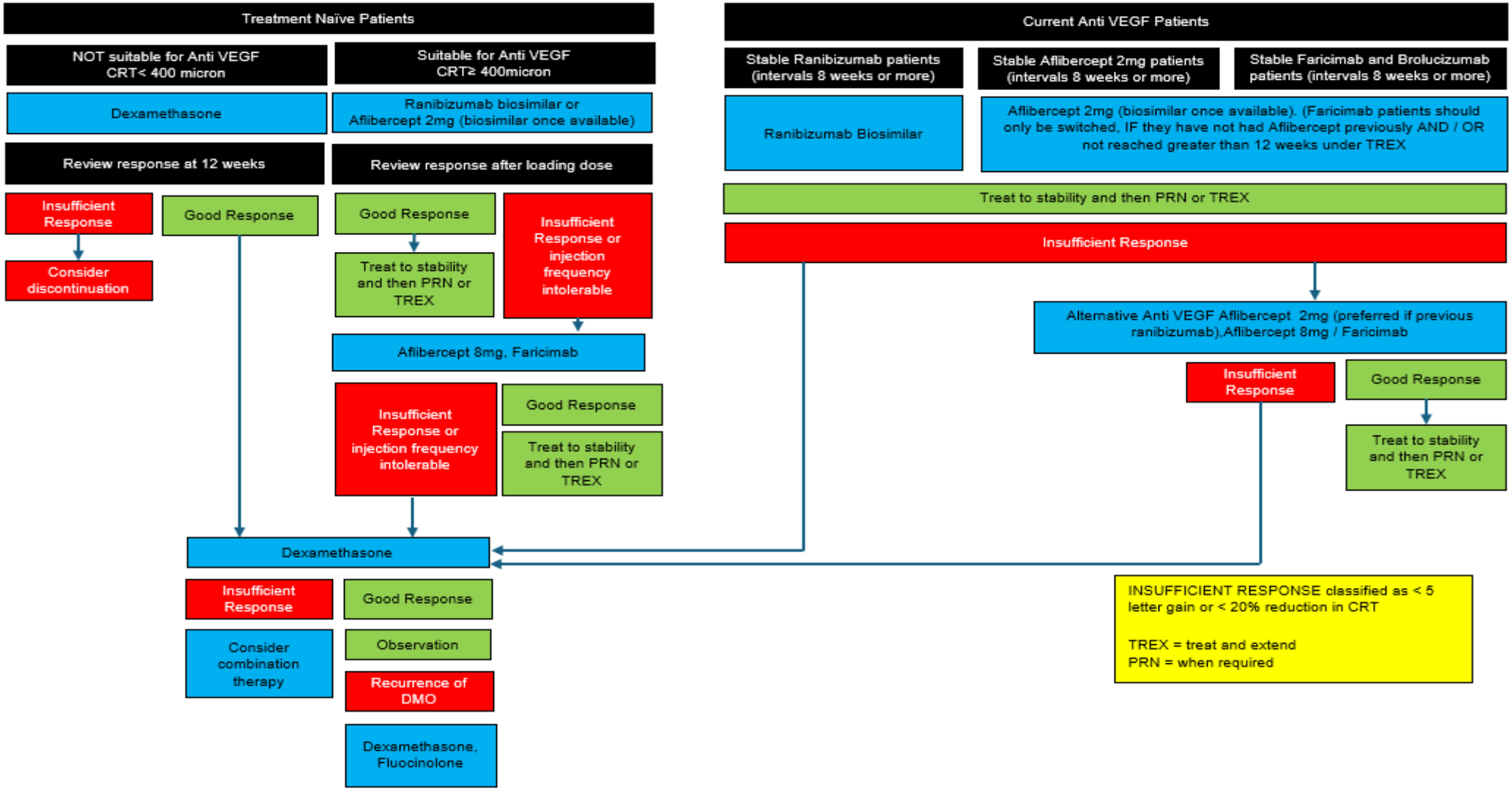
- Switch from an anti-VEGFs to alternative anti-VEGF, only if anti-VEGF is still appropriate and:
  • Frequent injections (e.g. inability to safely extend treatment intervals > 7 weeks) are required to maintain disease stability AND anti-VEGF treatment is still appropriate AND treatment burden not acceptable to either patient or service delivery
  • Poor response after completing loading or during maintenance phase
  • Adverse drug reaction

- If there is no clinical benefit after THREE months post-switching to an alternative anti-VEGF, consider switching back to previous anti-VEGF it is more cost effective. Consider switching to an alternative anti-VEGF or steroids where clinically indicated.

- REVIEW with consideration to stop treatment if, despite optimum treatment:
  • visual acuity < 25 letters attributable to DMO in the absence of other pathology OR
  • no response to treatment, defined as:
  o no change or worsening CRT AND
  o no change or worsening visual acuity

- Treatment STOP recommended if, despite optimum treatment:
  • visual acuity < 15 letters attributable to DMO in the absence of other pathology OR
  • there are irreversible structural changes WITH no prospect of visual improvement with continued treatment.

5 Diabetic Macular Oedema, Preferred Pathway



6 Central Retinal Vein Occlusion (CRVO)

6.1 NICE guidance (TA 229,[17] TA 283[18],TA 305[19] TA 1004[20]) states that dexamethasone intravitreal implant, ranibizumab, aflibercept 2mg and faricimab) are all suitable options for the treatment of CRVO when used in line with the criteria specified in the relevant NICE technology appraisal guidance. If patients and their clinicians consider more than one treatment to be suitable, they should choose the least expensive option.

6.2 For patients commencing treatment for CRVO: subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should consider ranibizumab biosimilar or aflibercept biosimilar (when available) 1st line where this is clinically appropriate and there is capacity to do so. If ranibizumab / aflibercept biosimilars are 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 dexamethasone intravitreal implant.

6.3 Following the three months loading phase, for patients with suboptimal response to ranibizumab biosimilar, consider changing to aflibercept 2mg (biosimilar once available) 2nd line, or faricimab / dexamethasone intravitreal implant 3rd-4th line where clinically appropriate subject to the criteria specified in the relevant NICE technology appraisal guidance.

6.4 For patients already prescribed an anti-VEGF treatment for CRVO: subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should consider reviewing patients currently prescribed originator aflibercept 2mg (Eylea®) or ranibizumab (Lucentis®) to assess suitability for a change to aflibercept 2mg / ranibizumab biosimilars.

6.5 If no improvement in visual acuity over the course of the first three injections is observed, cessation of treatment may be considered, and it is recommended after six injections.

7 Branch Retinal Vein Occlusion (BRVO)

7.1 NICE guidance (TA283,[18] TA409[21], TA229[17] and TA 1004[18]) states that ranibizumab, aflibercept 2mg ,dexamethasone intravitreal implant and faricimab are suitable treatment options for BRVO. If patients and their clinicians consider both ranibizumab and aflibercept to be suitable treatments, the least costly should be used.

7.2 For patients commencing treatment for BRVO: subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should consider ranibizumab / aflibercept 2mg biosimilars 1st line where this is clinically appropriate and there is capacity to do so. If ranibizumab / aflibercept 2mg biosimilars are contraindicated or not clinically appropriate for the specific patient then, subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should consider the dexamethasone intravitreal implant.

7.3 Following the three months loading phase, for patients with suboptimal response to ranibizumab / aflibercept 2mg biosimilars, consider changing to alternative biosimilar, or either faricimab or dexamethasone intravitreal implant where clinically appropriate subject to the criteria specified in the relevant NICE technology appraisal guidance.

7.4 For patients already prescribed treatment for BRVO: subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians may wish to consider reviewing patients currently prescribed originator ranibizumab (Lucentis®) or originator aflibercept 2mg (Eylea®) to assess suitability for a change to the available biosimilars.

7.5 If no improvement in visual acuity over the course of the first three injections is observed, cessation of treatment may be considered, and it is recommended after six injections.

7.6 NHSE have now published: Commissioning Guidance: Medical Retinal Treatment Pathway in Macular Oedema Secondary to Retinal Vein Occlusion (October 2025)[22] and this is reflected in the following pathway.

Recommendations from the NHSE pathway include:

- For BRVO, the following anti-VEGF sequence is recommended where clinically appropriate:

First line: Aflibercept 2mg- switch to biosimilar once available (TA409) OR ranibizumab biosimilar (TA283)

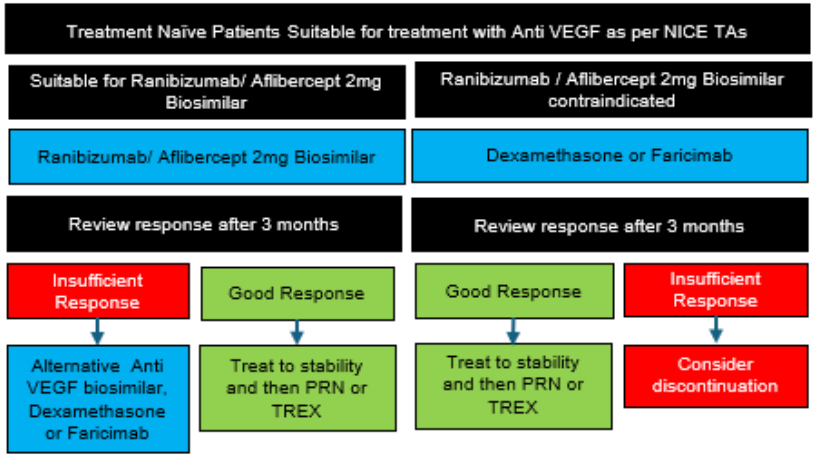
Second line onwards: First line options OR faricimab (TA1004)

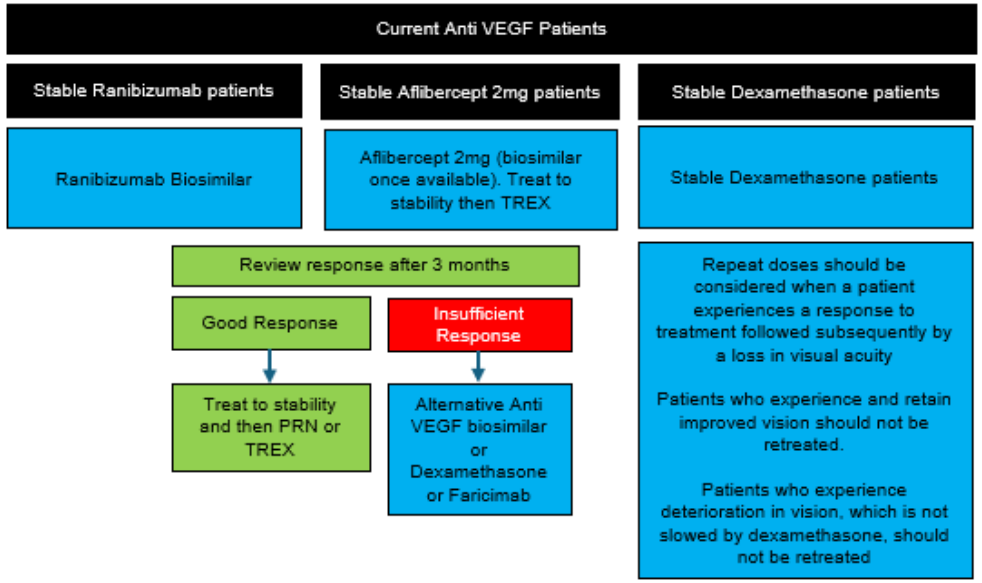
For CRVO, the following anti-VEGF sequence is recommended where clinically appropriate:
First line: Aflibercept 2mg- switch to biosimilar once available (TA305) OR ranibizumab biosimilar (TA283).

Second line onwards: First line options OR faricimab (TA1004)

- Consider the use of steroid implants over anti-VEGFs if:
    - Recent cardiovascular events within the last 6 months
    - Unable to comply with anti-VEGF injection frequency (patient factors)
    - Pregnancy, provided the benefits of treatment outweigh the risk
- Where one eye is already on anti-VEGF treatment, but the other eye qualifies for another anti-VEGF treatment, prioritise treatment harmonisation by choosing the best treatment options for both eyes (i.e. using only one drug for both eyes).
- Treat-and-extend is the preferred regimen. If PRN regimen is chosen, it is recommended that these patients are monitored 4-8 weekly intervals and treated appropriately for optimal visual outcomes.
- REVIEW with consideration to stop treatment if:
    - Visual acuity of <25 letters attributable to RVO in the absence of other pathology despite optimum treatment **OR**
    - Poor response to treatment (i.e. no change or worsening CMT AND visual acuity)
- Treatment STOP recommended if, despite optimum treatment:
    - Visual acuity < 15 letters attributable to RVO in the absence of other pathology AND is the WORSE seeing eye.
- Treatment STOP recommended if complete resolution of centre-involving macular oedema with no potential for visual acuity improvement.

8 Central Retinal Vein Occlusion (CRVO) / Branch Retinal Vein Occlusion (BRVO), Preferred Pathway





INSUFFICIENT RESPONSE classified as < 5 letter gain or < 20% reduction in CRT

TREX = treat and extend
PRN = when required

9 Myopic Choroidal Neovascularisation (CNV)

9.1 NICE guidance (TA 298[23] & TA 486[24]) states that ranibizumab and aflibercept 2mg are both suitable options for the treatment of CNV when used in line with the criteria specified in the relevant NICE Technology Appraisal guidance. If patients and their clinicians consider both ranibizumab and aflibercept to be suitable treatments, the least costly should be used.

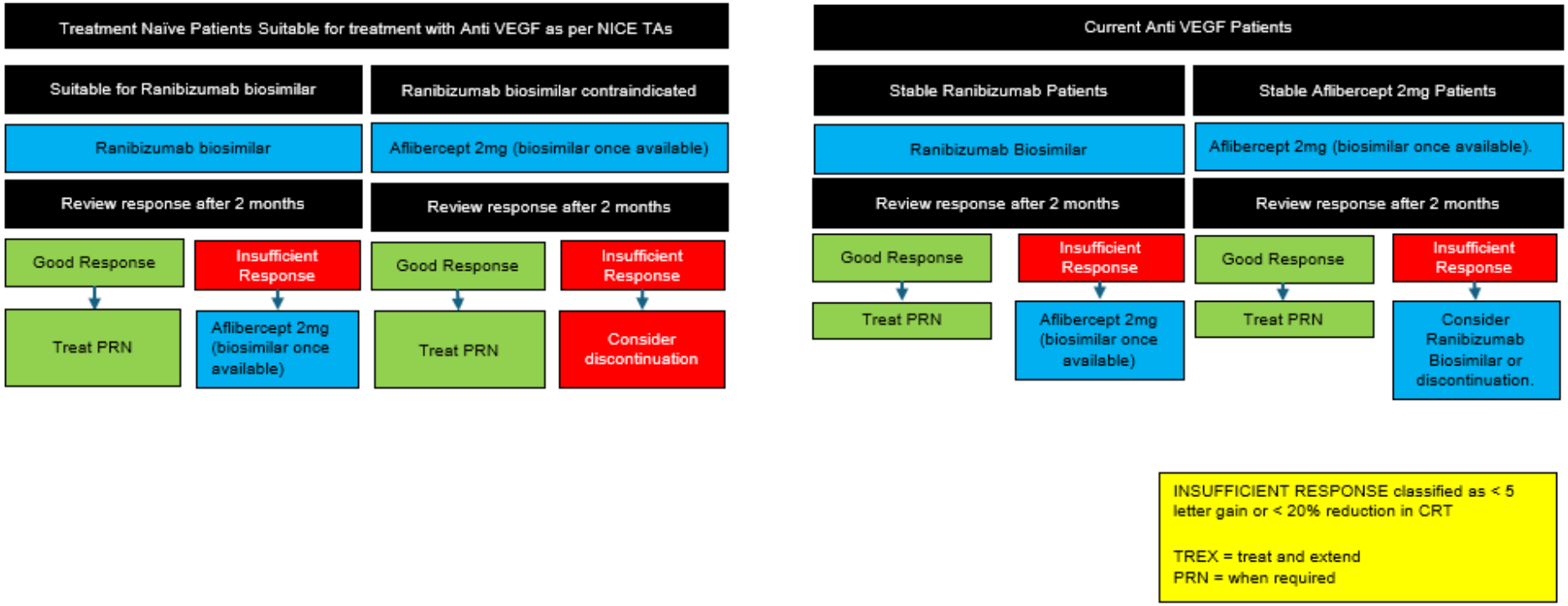
9.2 For patients commencing treatment for CNV: subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should consider ranibizumab biosimilar where this is clinically appropriate and there is capacity to do so. If ranibizumab biosimilar is contraindicated or not clinically appropriate for the specific patient then, subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should then consider aflibercept 2mg (biosimilar once available).

9.3 Following the two months loading phase, for patients with suboptimal response, clinicians should consider changing to alternative anti-VEGF. If initial treatment selected was ranibizumab biosimilar, consider changing to aflibercept 2mg (biosimilar once available)

9.4 For patients already prescribed an anti-VEGF for the treatment of CNV: subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should consider reviewing patients currently prescribed originator ranibizumab (Lucentis®) or originator aflibercept 2mg (Eylea®) to assess suitability for a change to ranibizumab / aflibercept biosimilars.

9.5 The schedule for monitoring should be determined by the treating clinician and should be discontinued if the patient is not benefiting from continued treatment.

10 Myopic Choroidal Neovascularisation (CNV), Preferred Pathway



11 Vitreomacular Traction

11.1 Ocriplasmin (NICE TA297[25]) is recommended as an option for treating vitreomacular traction in adults, only if:

- an epiretinal membrane is not present

  and

- they have a stage 2 full-thickness macular hole with a diameter of 400 micrometres or less **and/or**
- they have severe symptoms.

11.2 The recommended dose is 0.125 mg in 0.1 mL of the solution administered by intravitreal injection to the affected eye once as a single dose. Treatment with ocriplasmin in the other eye is not recommended concurrently or within 7 days of the initial injection in order to monitor the post-injection course including the potential for decreased vision in the injected eye. Repeated administration in the same eye is not recommended.

12 References

[i] Operational note: Commissioning recommendations following the national procurement for medical retinal vascular medicines National procurement for Anti-VEGF and Intravitreal Corticosteroids August 2022. NHSE, ***since superseded by*** Operational note: updated commissioning recommendations for medical retinal vascular medicines following the national procurement for ranibizumab biosimilars NHSE Version 2, updated 24 July 2023 https://www.england.nhs.uk/publication/operational-note-commissioning-recommendations-following-the-national-procurement-for-medical-retinal-vascular-medicines/

[ii] NHSE Commissioning Guidance - Medical Retinal Treatment Pathway in Wet Age-related Macular Degeneration https://future.nhs.uk/nhsbiosimilarhub/view?objectID=249769797

[iii] The licence and supporting evidence for ranibizumab biosimilar SPS online last updated March 2023 https://www.sps.nhs.uk/articles/the-licence-and-supporting-evidence-for-ranibizumab-biosimilar/

[iv] Ranibizumab and pegaptanib for the treatment of age-related macular degeneration NICE TA155 https://www.nice.org.uk/guidance/ta155/chapter/1-Guidance

[v] Aflibercept solution for injection for treating wet age-related macular degeneration NICE TA294 https://www.nice.org.uk/guidance/ta294

[vi] Brolucizumab for treating wet age-related macular degeneration NICE TA672 https://www.nice.org.uk/guidance/ta672

[vii] Faricimab for treating wet age-related macular degeneration NICE TA800 https://www.nice.org.uk/guidance/ta800

[viii] Bevacizumab gamma for treating wet age-related macular degeneration NICE TA1022 https://www.nice.org.uk/guidance/ta1022

[9] Ranibizumab for the treatment of diabetic macular oedema NICE TA237 https://www.nice.org.uk/guidance/ta237

[10] Aflibercept for treating diabetic macular oedema NICE TA346 https://www.nice.org.uk/guidance/ta346

[11] Faricimab for treating diabetic macular oedema NICE TA799 https://www.nice.org.uk/guidance/ta799

[12] Brolucizumab for treating diabetic macular oedema NICE TA820 https://www.nice.org.uk/guidance/ta820

[13] Dexamethasone intravitreal implant for treating diabetic macular oedema NICE TA824 https://www.nice.org.uk/guidance/ta824/chapter/1-Recommendations

[14] Fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema after an inadequate response to prior therapy NICE TA301 https://www.nice.org.uk/guidance/ta301/chapter/1-Guidance

[15] Fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema NICE TA953 https://www.nice.org.uk/guidance/TA953/chapter/1-Recommendations

[16]

[17] Dexamethasone intravitreal implant for the treatment of macular oedema secondary to retinal vein occlusion NICE TA229 https://www.nice.org.uk/guidance/ta229

[18] Ranibizumab for treating visual impairment caused by macular oedema secondary to retinal vein occlusion NICE TA283 https://www.nice.org.uk/guidance/ta283

[19] Aflibercept for treating visual impairment caused by macular oedema secondary to central retinal vein occlusion NICE TA305 https://www.nice.org.uk/guidance/ta305
[20] Faricimab for treating visual impairment caused by macular oedema after retinal vein occlusion https://www.nice.org.uk/guidance/ta1004
[21] Aflibercept for treating visual impairment caused by macular oedema after branch retinal vein occlusion https://www.nice.org.uk/guidance/ta409
[22] NHSE Commissioning Guidance: Medical Retinal Treatment Pathway in Macular Oedema Secondary to Retinal Vein Occlusion (October 20235) Retinal Vein Occlusion - The NHS Biosimilar Hub - Futures
[23] Ranibizumab for treating choroidal neovascularisation associated with pathological myopia NICE TA298 https://www.nice.org.uk/guidance/ta298
[24] Aflibercept for treating choroidal neovascularisation NICE TA486 https://www.nice.org.uk/guidance/ta486
[25] Ocriplasmin for treating vitreomacular traction NICE TA297 https://www.nice.org.uk/guidance/ta297