|  |  |
| --- | --- |
| Intervention | **Anti-VEGF (Vascular endothelial growth factor) Treatments in Ophthalmology** |
| For the treatment of | **Wet (neovascular) AMD (age related macular degeneration) and Diabetic Macular Oedema (DMO)**  Wet AMD is sometimes referred to as nAMD (neovascular AMD) |
| Commissioning Position | **Summary for Wet AMD and DMO:**   1. *All patients stabilised on ranibizumab (as Lucentis*®*) should be transferred to the least expensive option, currently biosimilar ranibizumab (Ongavia*®*).* 2. *Treatment naïve patients should be started on the least expensive option, currently biosimilar ranibizumab (Ongavia*®*).* 3. *Patients already on facricimab (Vabysmo*®*) should be reviewed to see if suitable for the least expensive option, currently biosimilar ranibizumab (Ongavia®).* 4. *Patients where it has not been possible to stabilise on injections of ranibizumab every eight weeks can be considered for treatment with alternative agents, the least expensive option should be selected.* 5. *Patients where it has not been possible to stabilise on injections of aflibercept (Eylea*®*) every eight weeks, can be considered for treatment with alternative agents, the least expensive should be selected.* 6. *Patients not stable on brolucizumab (Beovu*®*) can be considered for treatment with alternative agents, the least expensive option should be selected.* 7. *Patients currently using bevacizumab (Avastin*®*) may continue treatment if stable.*   Patient consent and consultation should be undertaken as per local trust policies.  When a more expensive agent is used, this needs to be justified, in advance, and recorded using a prior approval system, stating full reasons rationale for using a more expensive option. This data will be audited and monitored.  This policy refers specifically to wet-AMD and DMO, please also refer: Intravitreal Injections Used in Ophthalmology Algorithm, which takes into consideration broader indications for anti-VEGF treatments.  **Anti-VEGF and Intravitreal Corticosteroids Treatments**  There are six licenced and NICE approved intravitreal anti-VEGF and corticosteroid treatments in England for medical retinal conditions which are used for the treatment of a number of indications.  These are:  a. Aflibercept (Eylea®)  b. Brolucizumab (Beovu®)  c. Dexamethasone Intravitreal implant (Ozurdex®)  d. Faricimab (Vabysmo®)  e. Fluocinolone acetonide Intravitreal implant (Iluvien®)  f. Ranibizumab (Lucentis®) and available as ranibizumab biosimilars (Ongavia®) and (Byooviz®).  To note - Bevacizumab (Avastin®) at present only has a UK market authorisation for non-ophthalmology indications.  It is for the prescribing clinician and patient to determine together which treatment is clinically appropriate for an individual, based upon the specific needs of the patient and relevant NICE technology appraisal guidance for each indication.  These commissioning recommendations do not restrict a clinicians’ ability to make the most appropriate decision for an individual patient through shared decision making, considering the patient’s needs and wishes.  **Wet Age-Related Macular Degeneration (Wet AMD)**  Ranibizumab, aflibercept, brolucizumab and faricimab 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.**  The least expensive option is currently biosimilar ranibizumab (Ongavia®).  **NICE technology appraisal guidance related to anti-VEGF and Wet AMD**  [NICE TA 155](https://www.nice.org.uk/guidance/ta155)  [NICE TA 294](https://www.nice.org.uk/guidance/ta294)  [NICE TA 672](https://www.nice.org.uk/guidance/ta672)  [NICE TA 800](https://www.nice.org.uk/guidance/ta800)  [NICE clinical guidance (NG82)](https://www.nice.org.uk/guidance/ng82) acknowledges that anti-VEGF treatment in patients with age related macular degeneration with better visual acuity of 6/12 is clinically effective and may be cost effective depending on the treatment used.  As NICE clinical guidelines, including NG82 recommendations, are not mandatory for commissioners, the use of anti-VEGFs in patients with visual acuity better than 6/12 is outside the scope of this document.  **Treatment Selection Wet AMD**  **For patients commencing treatment** **(wet AMD)**   * Subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should consider the least expensive option, currently, ranibizumab biosimilar where this is clinically appropriate. * 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,, again the least expensive option should be chosen.   **Reviewing new treatment (wet AMD)**  Following the three months loading phase, treatment should continue as per the summary of product characteristics (SmPC).  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 ranibizumab biosimilar, clinicians should consider changing to aflibercept, brolucizumab or faricimab, again the least expensive option should be chosen.  **Reviewing current treatment (wet AMD)**  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 consider reviewing patients currently prescribed more expensive options – i.e., aflibercept, brolucizumab or faricimab and assess suitability to change to the least expensive option, currently ranibizumab biosimilar.   **Discontinuing treatment (wet AMD)**  NICE guidance (NG 82) recommends that treatment be continued only in people who maintain an adequate response to therapy.  Criteria for permanent discontinuation should include persistent deterioration in visual acuity and the identification of anatomical changes in the retina that indicate an inadequate response to therapy despite an optimally delivered treatment regimen.  Treatment with an anti-VEGF should be stopped if the eye develops late AMD (wet inactive) with no prospect of functional improvement or hypersensitivity to an anti-VEGF.  **Diabetic Macular Oedema (DMO)**  **NICE technology appraisal guidance related to anti-VEGF and DMO**  [NICE TA 274](https://www.nice.org.uk/guidance/ta274)  [NICE TA 346](https://www.nice.org.uk/guidance/ta346)  [NICE TA 799](https://www.nice.org.uk/guidance/ta799)  NICE recommend ranibizumab, aflibercept and faricimab 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 both ranibizumab, aflibercept and faricimab to be suitable treatments, the least costly option should be used.  **For patients commencing treatment (DMO)**   * Subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should consider the least expensive option, currently, ranibizumab biosimilar where this is clinically appropriate. * 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 or faricimab, dexamethasone or fluocinolone, the least expensive option should be chosen.   **Reviewing new treatment (DMO)**   * Following the loading phase, treatment should continue as per the SmPC. * For patients with suboptimal response, clinicians should consider changing to alternative anti-VEGF, the least expensive option should be chosen. * If initial treatment selected was ranibizumab biosimilar, clinicians should consider changing to either aflibercept or faricimab, dexamethasone or fluocinolone, the least expensive option should be chosen.   **Reviewing current treatment (DMO)**  For patients already prescribed an anti-VEGF for the treatment of DMO:   * Subject to the criteria specified in the relevant NICE technology appraisal guidance, clinicians should consider reviewing patients currently prescribed ranibizumab (Lucentis®) to assess suitability for a change to ranibizumab biosimilar. * We do not recommend changing to ranibizumab biosimilar where patients are currently prescribed aflibercept in this condition.   **Alternative/Additional therapy (DMO)**  ([NICE TA 301](https://www.nice.org.uk/guidance/ta301), & [NICE TA 824)](https://www.nice.org.uk/guidance/TA824) recommend fluocinolone acetonide intravitreal implant as a suitable option for treating diabetic macular oedema and dexamethasone intravitreal implant as a suitable option for treating chronic diabetic macular oedema after an inadequate response to prior therapy or where ongoing treatment burden is a concern, irrespective of whether the patient has a phakic or pseudophakic lens.  **When to consider intra-vitreal steroids (dexamethasone and fluocinolone acetonide)**  If anti-VEGF treatment is contra-indicated or does not achieve a sufficient response (despite an appropriate injection frequency and regular monitoring), then intravitreal corticosteroid implants (dexamethasone intravitreal implant or fluocinolone acetonide intravitreal implant) should be considered (assuming the patient meets NICE guidance criteria [TA 301](https://www.nice.org.uk/guidance/ta301) and [TA 824](https://www.nice.org.uk/guidance/ta824), and there are no contra-indications to steroid usage).  Equally, patients may achieve good efficacy with anti-VEGF, but the frequency of repeated injections may not be tolerable for the patient due to individualised patient factors. In this last scenario, intravitreal steroids, with their potentially longer duration of action, may be useful.  The two main reasons for considering intravitreal steroid therapy for a patient previously treated with anti-VEGF are:   * inadequate efficacy with anti-VEGF * intolerable anti-VEGF treatment burden.   One approach is to consider a change to intravitreal steroid after six months of anti-VEGF therapy based on the efficacy of therapy at this time-point and then to consider again a change to intravitreal steroid after two years of anti-VEGF therapy based on treatment burden at this stage. |
| Summary of Rationale | **Purpose**  Eyecare is the highest volume outpatient specialty within the NHS and the medicines used for medical retinal vascular conditions account for some of the highest cost and volume treatments used within secondary care. Treatment aims to minimise vision loss and disability in order that patients remain independent.  Due to increasing life expectancy and an ageing population, the NHS expects that demand for medical retinal vascular treatments will continue to increase as more patients with eye disease are diagnosed and treated. Continually rising demand has also impacted ophthalmology outpatient services, worsened by the pandemic.  The intent of the national NHS England procurement exercise was to support delivery of the NHS Pathway Improvement Programme through the following key objectives:   1. Reduction in unwarranted variation   Reduce the number of patients who should be but are not currently treated; and reduce the number of patients who are treated, but for whom treatment is inappropriate or ineffective.   1. Maintain clinical choice   Clinicians will continue to determine, in discussion with their individual patients, which medical retinal vascular treatments are clinically appropriate for them and will be able to access all available treatments (in line with national guidance).   1. Make best use of NHS resources   To support the transformation of eyecare services (subject to the criteria specified in the relevant NICE technology appraisal guidance), clinicians should, in consultation with the patient, use the lowest cost treatment option where this is clinically appropriate.  Through consistently using the most clinically appropriate and cost-effective treatments and ensuring that patients receiving treatment are responding, we can drive efficiencies to support recovery and transformation in eyecare services.  This will create capacity so that patients can be seen in a timely manner and avoid permanent loss of vision, in line with the recommendations of the NHS England National Eye Care Recovery and Transformation Programme.  The NHS England commissioning recommendations outline the best value treatment choices and, if followed, will generate financial savings which can be invested in NHS services.  **Anti-VEGF and intravitreal corticosteroids treatments**  There are now nine licensed intravitreal anti-VEGF and corticosteroid treatments in England for medical retinal conditions, which are used for the treatment of several indications. These are:   * Aflibercept (Eylea®) * Brolucizumab (Beovu®) * Dexamethasone Intravitreal implant (Ozurdex®) * Faricimab (Vabysmo®) * Fluocinolone acetonide Intravitreal implant (Iluvien®) * Ranibizumab (Lucentis®) * Ranibizumab biosimilar (Byooviz®) * Ranibizumab biosimilar (Ongavia®) * Ranibizumab biosimilar (Ximluci®)   Equivalent safety and efficacy to the reference product ranibizumab (Lucentis®) has [been [confirmed in phase three clinical trials](https://www.sps.nhs.uk/home/planning/biosimilars-updates/) in eyes with treatment naïve neovascular AMD.](https://www.sps.nhs.uk/home/planning/biosimilars-updates/)  [NHS England » Operational note: updated commissioning recommendations for medical retinal vascular medicines following the national procurement for ranibizumab biosimilars](https://www.england.nhs.uk/long-read/operational-note-updated-commissioning-recommendations-for-medical-retinal-vascular-medicines-following-the-national-procurement-for-ranibizumab-biosimilars/)  Faricimab (Vabysmo®) is only currently licensed for DMO and wAMD. Aflibercept (Eylea®, Ranibizumab (Lucentis®) and ranibizumab biosimilars have a broader licence.  Approximately 75% of use of the agents is in DMO and wet AMD.  **Further Information**  In May 2022, the commercial medicines unit undertook a tender exercise to allow all manufacturers to offer the most competitive prices for their treatments. The results of this tender fed directly into a national commissioning document which was to advise which option was the most cost effective and represented the best value for the NHS. The national commissioning position advised that biosimilar ranibizumab was the most cost-effective option for patients with both Wet AMD and Diabetic Macular Oedema. The NHS England commissioning recommendations were updated in July 2023:  [NHS England » Operational note: updated commissioning recommendations for medical retinal vascular medicines following the national procurement for ranibizumab biosimilars](https://www.england.nhs.uk/long-read/operational-note-updated-commissioning-recommendations-for-medical-retinal-vascular-medicines-following-the-national-procurement-for-ranibizumab-biosimilars/)  The commissioning recommendations were also referenced in the [NHS England National Medicines Optimisation Opportunities 2023/24,](https://www.england.nhs.uk/long-read/national-medicines-optimisation-opportunities-2023-24/) published August 2023.  *NHS England is driving a step change in ICB uptake of best value biologic medicines when commissioning hospital trusts to provide such treatment, to ensure specialists can offer their patients the choice of switching to a new product.*  *The NHS can make significant savings by adopting best value new products.*  *The Medicines Value and Access directorate in NHS England ensures that systems are ready to deliver efficiency opportunities from new biologic and generic medicines when they become available. Horizon scanning processes are identifying medicines coming into the medicines supply pipeline early on to assess and plan opportunities for early uptake.*  *Ophthalmology is an example of a service that may particularly benefit from the opportunity to use biologics. Medical retinal vascular conditions currently account for some of the highest cost and volume treatments in secondary care, and with an ageing population the NHS expects that demand for medical retinal vascular treatments will continue to increase.*  It is recognised it is for the prescribing clinician and patient to determine together which treatment is clinically appropriate for an individual, based upon the specific needs of the patient and relevant NICE technology appraisal guidance for each indication.  These commissioning recommendations do not restrict a clinician’s ability to make the most appropriate decision for an individual patient through shared decision making, taking account of the patient’s needs and wishes.  **Humber and North Yorkshire ICB commissioning policy is that the prescriber should consider the treatment options, as outlined in this commissioning statement, i.e., where, when clinically appropriate, the least expensive option is the first line.**  **Treat and Extend Regimens**  The posology and method administration for each drug varies slightly depending on the drug and condition being treated (wet AMD or DMO).  The individual SmPC should be consulted for each individual drug however, in summary:  Aflibercept, faricimab and ranibizumab are all given as a loading dose of one injection per eye, per month (or 4 weeks), every month for 3 months.  Treatment should be given every month until maximum visual acuity is achieved and/or there are no signs of disease activity i.e., no change in visual acuity and in other signs and symptoms of the disease under continued treatment.  Thereafter, monitoring and treatment intervals should be determined by the physician and should be based on disease activity, as assessed by visual acuity and/or anatomical parameters.  If patients are being treated according to a treat-and-extend regimen, once maximum visual acuity is achieved and/or there are no signs of disease activity, the treatment intervals can be extended stepwise until signs of disease activity or visual impairment recur.  All 3 options have a treat and extend option, with a view to increase the interval as much as possible.  Faricimab manufacturers put forward a case for cost-effectiveness based on the need for fewer injections and monitoring visits compared with the comparators (branded aflibercept and ranibizumab). This was not compared to the cost of biosimilar ranibizumab and the data/evidence to state that fewer injections are given has not been evidenced from clinical practice – see below from NICE.  **NICE Recommendations – From the NICE appraisal committee**  **Clinical Effectiveness For wet-AMD**  <https://www.nice.org.uk/guidance/ta800/chapter/1-Recommendations>  *Wet age-related macular degeneration is usually treated with aflibercept or ranibizumab, which are already recommended by NICE for treating wet age-related macular degeneration. Faricimab is another treatment option that works in a similar way.*  *Evidence from clinical trials shows that faricimab is as effective as aflibercept. An indirect comparison of faricimab with ranibizumab also suggests similar clinical effectiveness.*  *A cost comparison suggests faricimab has similar costs and overall health benefits to aflibercept or ranibizumab. So, faricimab is recommended for treating wet age-related macular degeneration if it is used in the same population as aflibercept and ranibizumab.*  ***Cost Comparison for Wet-AMD***  *The company base case assumed there would be fewer injections and monitoring visits needed for faricimab compared with the comparators. But the committee was aware that in NHS clinical practice faricimab may have a similar dosing regimen as aflibercept and ranibizumab. This is to reduce inconsistencies in clinical practice and chance of error in busy clinical settings. Because of this, along with the lack of long-term data, the committee considered scenarios in which the number of injections and monitoring visits was the same for faricimab, aflibercept and ranibizumab after the initial loading doses. The committee acknowledged that if the time needed between injections is lengthened, then the cost of faricimab would reduce. When taking account of the commercial arrangements for all treatments, the committee was satisfied that the total cost associated with faricimab was similar or lower than aflibercept or ranibizumab (the exact results are confidential and cannot be reported here). The committee therefore recommended faricimab for treating wet age-related macular degeneration in line with the previous recommendations for aflibercept and ranibizumab.*  **Clinical effectiveness for DMO**  [*https://www.nice.org.uk/guidance/ta799/chapter/3-Committee-discussion*](https://www.nice.org.uk/guidance/ta799/chapter/3-Committee-discussion)  *Faricimab is likely to have similar clinical effectiveness as ranibizumab.*  **Cost comparison for DMO**  [*https://www.nice.org.uk/guidance/ta799/chapter/3-Committee-discussion*](https://www.nice.org.uk/guidance/ta799/chapter/3-Committee-discussion)  *The company base case assumed there would be fewer injections and monitoring visits needed for faricimab compared with the comparators. But clinical experts explained that in NHS clinical practice faricimab may have a similar dosing regimen as aflibercept and ranibizumab. They explained that this is to reduce the inconsistencies in clinical practice and chance of error in busy clinical settings. Because of this, along with the lack of long-term data, the committee considered scenarios in which the number of injections and monitoring visits was the same for faricimab, aflibercept and ranibizumab after the initial loading doses. The committee acknowledged that if the time needed between injections is lengthened, then the cost of faricimab would reduce. When taking account of the commercial arrangements for all treatments, the committee was satisfied that the total cost associated with faricimab was similar or lower than aflibercept or ranibizumab (the exact results are confidential and cannot be reported here). The committee agreed that choosing the least expensive option from the available treatment options at the same point in the pathway was appropriate. The committee therefore recommended faricimab for treating diabetic macular oedema in line with the previous recommendations for aflibercept and ranibizumab.*  **Summary**  NICE TA for faricimab based the cost-comparison on the cost of branded aflibercept and ranibizumab and did not take into consideration the significantly lower cost of biosimilar ranibizumab.  NICE stated all 3 agents have similar clinical effectiveness.  NICE states if patients and their clinicians consider aflibercept, faricimab and ranibizumab to be suitable treatments, choose the least expensive treatment.  On this basis, this clinical commissioning policy states to use the least expensive option, currently biosimilar ranibizumab.  If a clinician determines that more expensive options are more appropriate, this should be fully documented.  When a more expensive agent is used, this needs to be justified, in advance, and recorded using a prior approval system, stating full reasons rationale for using a more expensive option. This data will be audited and monitored. |
| References | **NICE technology appraisal guidance related to anti-VEGF and Wet AMD**  [NICE TA 155](https://www.nice.org.uk/guidance/ta155)  [NICE TA 294](https://www.nice.org.uk/guidance/ta294)  [NICE TA 672](https://www.nice.org.uk/guidance/ta672)  [NICE TA 800](https://www.nice.org.uk/guidance/ta800)  **NICE technology appraisal guidance related to anti-VEGF and DMO**  [NICE TA 274](https://www.nice.org.uk/guidance/ta274)  [NICE TA 346](https://www.nice.org.uk/guidance/ta346)  [NICE TA 799](https://www.nice.org.uk/guidance/ta799)  [NHS England » Operational note: updated commissioning recommendations for medical retinal vascular medicines following the national procurement for ranibizumab biosimilars](https://www.england.nhs.uk/long-read/operational-note-updated-commissioning-recommendations-for-medical-retinal-vascular-medicines-following-the-national-procurement-for-ranibizumab-biosimilars/)  [**NHS England National Medicines Optimisation Opportunities 2023/24,**](https://www.england.nhs.uk/long-read/national-medicines-optimisation-opportunities-2023-24/) **published August 2023.**  **Alternative/Additional therapy (DMO)**  **(**[**NICE TA 301**](https://www.nice.org.uk/guidance/ta301)**, &** [**NICE TA 824)**](https://www.nice.org.uk/guidance/TA824)  [**NICE clinical guidance (NG82)**](https://www.nice.org.uk/guidance/ng82)  **SmPC (summary of medicine and product characteristics)**  [**Aflibercept (Eylea®)**](https://www.medicines.org.uk/emc/product/11273/smpc)  [**Brolucizumab (Beovu®)**](https://www.medicines.org.uk/emc/product/11145)  [**Dexamethasone Intravitreal implant (Ozurdex®)**](https://www.medicines.org.uk/emc/product/5654)  [**Faricimab (Vabysmo®)**](https://www.medicines.org.uk/emc/product/13741/smpc#about-medicine)  [**Fluocinolone acetonide Intravitreal implant (Iluvien®)**](https://www.medicines.org.uk/emc/product/3061/smpc)  **Ranibizumab (**[**Lucentis®**](https://www.medicines.org.uk/emc/product/307/smpc)**) and available as ranibizumab biosimilars ([Ongavia®](https://www.medicines.org.uk/emc/product/13885)) and ([Byooviz®](https://www.medicines.org.uk/emc/product/14606)).**  **Resources to support implementation:**   * [**Commissioning framework for biological medicines**](https://www.england.nhs.uk/publication/commissioning-framework-for-biological-medicines/)**, NHS England** * [**Commissioning recommendations for medical retinal vascular medicines following the national procurement for ranibizumab biosimilars**](https://www.england.nhs.uk/publication/operational-note-commissioning-recommendations-following-the-national-procurement-for-medical-retinal-vascular-medicines/)**, NHS England** * [**Clinical webinars,**](https://www.prescqipp.info/our-resources/clinical-webinars/biosimilar-ranibizumab-webinars/)**PrescQIPP (log-in access required)** * [**Good governance when implementing ranibizumab biosimilar**](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.sps.nhs.uk%2Farticles%2Fgood-governance-when-implementing-ranibizumab-biosimilar%2F&data=05%7C01%7Cmary-jo.pryor%40nhs.net%7C636c5739204d4150fce008dafaf7e5af%7C37c354b285b047f5b22207b48d774ee3%7C0%7C1%7C638098239875094263%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=7R%2BOfzVE088cbLPofCzTbW18oMJSep0HYuR7zfFnxAk%3D&reserved=0)**, Specialist Pharmacy Service (SPS)** * [**Guidance on the licensing of biosimilar products**](https://www.gov.uk/government/publications/guidance-on-the-licensing-of-biosimilar-products)**, MHRA** * [**Preparing to use ranibizumab biosimilar**](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.sps.nhs.uk%2Farticles%2Fpreparing-to-use-ranibizumab-biosimilar%2F&data=05%7C01%7Cmary-jo.pryor%40nhs.net%7C636c5739204d4150fce008dafaf7e5af%7C37c354b285b047f5b22207b48d774ee3%7C0%7C1%7C638098239875094263%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=adZNUSBJ0Oyobs266KO%2BHxERFP9sur%2FSjh34canIrWc%3D&reserved=0)**, SPS** * [**The licence and supporting evidence for ranibizumab biosimilar**](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.sps.nhs.uk%2Farticles%2Fthe-licence-and-supporting-evidence-for-ranibizumab-biosimilar%2F&data=05%7C01%7Cmary-jo.pryor%40nhs.net%7C636c5739204d4150fce008dafaf7e5af%7C37c354b285b047f5b22207b48d774ee3%7C0%7C1%7C638098239875250481%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=F%2FLZRikujE2DJ7NQAjfPfeMs85R67kBpegA8em7LO50%3D&reserved=0)**, SPS** * [**Understanding biological and biosimilar medicines**](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.sps.nhs.uk%2Farticles%2Funderstanding-biological-and-biosimilar-medicines%2F&data=05%7C01%7Cmary-jo.pryor%40nhs.net%7C636c5739204d4150fce008dafaf7e5af%7C37c354b285b047f5b22207b48d774ee3%7C0%7C1%7C638098239875094263%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=Ax2lYdLFM%2B2IR8WD4iIdRYv9REQrs%2BzmqvzEB9woc2g%3D&reserved=0)**, SPS** * [**What is a biosimilar medicine?**](https://www.england.nhs.uk/long-read/what-is-a-biosimilar-medicine/)**, NHS England** |
| Effective from |  |
| Policy Review Date | October 2024 |