

EFFECTIVE DATE: 11|01|2023

POLICY LAST UPDATED: 05|29|2024

OVERVIEW

An intravitreal implant is a drug delivery system, injected or surgically implanted in the vitreous of the eye, for sustained release of drug to the posterior and intermediate segments of the eye. Four intravitreal corticosteroid implants, ie, fluocinolone acetonide 0.59 mg (Retisert), fluocinolone acetonide 0.19 mg (Iluvien), fluocinolone acetonide 0.18 mg (Yutiq), and dexamethasone 0.7 mg (Ozurdex) are reviewed herein. Fluocinolone acetonide implants are nonerodible and deliver drug up to 30 to 36 months while dexamethasone implants are bioerodible and last up to 6 months. A punctum implant is a drug delivery device that is inserted through the lower lacrimal punctum into the canaliculus, for sustained release of a pharmacologic agent to the ocular surface. Dexamethasone ophthalmic insert 0.4 mg (Dextenza) is the first corticosteroid intracanalicular insert and is reviewed herein.

MEDICAL CRITERIA

Not applicable

PRIOR AUTHORIZATION

Not applicable

POLICY STATEMENT

Medicare Advantage Plans and Commercial Products

A fluocinolone acetonide intravitreal implant 0.59 mg (Retisert®) may be considered medically necessary for the treatment of:

- Chronic non-infectious intermediate, posterior, or panuveitis.

A fluocinolone acetonide intravitreal implant 0.19 mg (Iluvien®) may be considered medically necessary for the treatment of:

- Diabetic macular edema in individuals who have been previously treated with a course of corticosteroids and did not have a clinically significant rise in intraocular pressure.

A dexamethasone intravitreal implant 0.7 mg (Ozurdex™) may be considered medically necessary for the treatment of:

- Noninfectious ocular inflammation, or uveitis, affecting the intermediate or posterior segment of the eye, OR
- Macular edema following branch or central retinal vein occlusion, OR
- Diabetic macular edema.

A punctum dexamethasone insert 0.4 mg (Dextenza®) may be considered medically necessary for the treatment of:

- Ocular inflammation and pain following ophthalmic surgery.

A fluocinolone acetonide intravitreal implant 0.59 mg (Retisert®) or 0.19 mg (Iluvien®) or dexamethasone intravitreal implant 0.7 mg (Ozurdex™) is considered not covered for Medicare Advantage Plans and not medically necessary for Commercial Products as the evidence is insufficient to determine that the technology results in an improvement in the net health outcomes for the treatment of any of the following:

- Birdshot retinochoroidopathy
- Cystoid macular edema related to retinitis pigmentosa
- Idiopathic macular telangiectasia type 1

- Postoperative macular edema
- Circumscribed choroidal hemangiomas
- Proliferative vitreoretinopathy
- Radiation retinopathy.
- Prophylaxis of cystoid macular edema in individuals with noninfectious intermediate uveitis or posterior uveitis and cataract undergoing cataract surgery

The following are not covered for Medicare Advantage Plans and not medically necessary for Commercial Products as the evidence is insufficient to determine that the technology results in an improvement in the net health outcomes:

- A fluocinolone acetonide intravitreal implant 0.18 mg (Yutiq) for the treatment of chronic noninfectious posterior uveitis affecting the posterior segment of the eye
- All other uses of a corticosteroid intravitreal implants

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Evidence of Coverage or Subscriber Agreement for applicable physician administered injectable drug benefits/coverage.

BACKGROUND

An intravitreal implant is a drug delivery system, injected or surgically implanted in the vitreous of the eye, for sustained release of a pharmacologic agent to the posterior and intermediate segments of the eye. Three intravitreal corticosteroid implants, ie, fluocinolone acetonide 0.59 mg (Retisert), fluocinolone acetonide 0.19 mg (Iluvien), and dexamethasone 0.7 mg (Ozurdex) are reviewed herein. Fluocinolone acetonide implants are nonerodible and deliver drug up to 30 to 36 months while dexamethasone implants are bioerodible and last up to 6 months.

A punctum implant is a drug delivery device that is inserted through the lower lacrimal punctum into the canaliculus, for sustained release of a pharmacologic agent to the ocular surface. Dexamethasone ophthalmic insert 0.4 mg (Dextenza) is the first corticosteroid intracanalicular insert and is reviewed herein.

Uveitis

For individuals with chronic noninfectious intermediate or posterior uveitis who receive an intravitreal fluocinolone acetonide implant (0.59 mg), the evidence includes 4 randomized controlled trials (RCTs). Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Two of the 4 RCTs compared 2 doses of implants, and 2 trials compared implants with systemic steroids (and immunosuppression when indicated). All trials supported the efficacy of intravitreal fluocinolone acetonide implants in preventing recurrence and improving visual acuity over 4-year follow-up. The head-to-head trial comparing implants with systemic corticosteroids did not show substantial superiority in the overall effectiveness of either approach. After 24 and 54 months of follow-up, visual acuity improved from baseline in the implant groups compared with the systematic therapy groups by +6.0 and +3.2 letters ($p=0.16$) and +2.4 and 3.1 letters ($p=0.073$), respectively. However, nearly all phakic patients receiving implants developed cataracts and required cataract surgery. Further, most also developed glaucoma, with 75% of patients requiring intraocular pressure lowering medications and 35% requiring filtering surgeries. Systemic adverse events such as hyperlipidemia, diabetes, osteoporosis, fractures, and blood count/chemistry abnormalities were infrequent and not statistically distinguishable between groups. The incidence of hypertension was greater in the systemic therapy group (27%) than in the implant group (13%), but rates of antihypertensive treatment initiation did not differ. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals with noninfectious intermediate or posterior uveitis who receive an intravitreal dexamethasone implant (0.7 mg), the evidence includes an RCT. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Results of this trial at 8 weeks showed that the implant was effective in reducing inflammation (the proportion of eyes with no

inflammation was 47% and 12% with implant and sham, respectively) and resulted in clinically meaningful improvement in vision at week 8 compared with sham controls (the proportion of patients with a gain of ≥ 15 letters in best-corrected visual acuity from baseline was $\gg 40\%$ with implants and 10% with sham). Further, at week 26, patients treated with implants reported meaningful increases in vision-related functioning. The major limitation of this trial was its lack of long-term follow-up. Use of implants resulted in higher incidences of cataracts and elevated intraocular pressure. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals with chronic noninfectious posterior uveitis affecting the posterior segment of the eye and who receive intravitreal fluocinolone acetonide implant (0.18 mg), the evidence includes 2 pivotal RCTs. Relevant outcomes are symptom improvement, change in disease status, functional status, and quality of life. Harmful outcomes of interest are treatment-related morbidity. Both RCTs consistently found statistically significantly lower uveitis recurrence rates for intravitreal fluocinolone acetonide implant (0.18 mg), at both 6 and 12 months. However, serious limitations of these findings include inconsistency in the magnitude of the benefit at 12 months (odds ratio [OR] 67.09; 95% confidence interval [CI] 8.81 to 511.06 in published RCT and OR 3.04; 95% CI 1.52 to 6.08 in the unpublished RCT) and, with more imputed recurrences in the sham groups than the treatment groups, we also can't rule out an overestimation of the treatment effect. For the remainder of key outcomes, results were inconsistent between RCTs, appearing more favorable in the published trial. Most notable were the differences between RCTs in mean change in best-corrected visual acuity at 12 months (higher for fluocinolone acetonide in the published trial, lower in the unpublished trials) and risk of increased intraocular pressure within 12 months (increased risk in the unpublished trial, but not in the published trial). Due to these inconsistencies and serious methodological limitations, the evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Macular Edema

For individuals with macular edema after retinal vein occlusion who receive an intravitreal dexamethasone implant (0.7 mg), the evidence includes 2 RCTs. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Compared with sham controls, implants resulted in clinically meaningful improvements in visual acuity within 1 to 3 months postimplant and improvement in vision occurred faster. The difference in the proportion of patients with gain of 15 or more letters in best-corrected visual acuity from baseline was more than 10% in favor implants versus sham in both studies at 30, 60 and 90 days, but not at 180 days postimplant. Use of implants resulted in higher incidences of cataracts and elevated intraocular pressure. Several additional RCTs and a meta-analysis have evaluated the comparative effects of dexamethasone intravitreal implants versus other therapies and found mixed results. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals with macular edema after retinal vein occlusion who receive an intravitreal fluocinolone acetonide implant (0.59 mg), no studies were identified. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Diabetic Macular Edema

For individuals with refractory (persistent or recurrent) diabetic macular edema who receive an intravitreal fluocinolone acetonide implant (0.59 mg), the evidence includes an RCT. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Compared with the standard of care (as needed laser or observation), a greater proportion of patients with implants reported clinically significant improvement in vision at 6 months (1.4% vs. 16.8% respectively) and subsequent time points assessed but not at or beyond 30 months of follow-up. Ninety percent of patients with phakic eyes who received implants required cataract surgery, and 60% developed elevated intraocular pressure. Due to the substantial increase in adverse events and availability of agents with better tolerability profiles (eg, antivascular endothelial growth factor inhibitors), implant use in diabetic macular edema is questionable. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with diabetic macular edema who receive an intravitreal fluocinolone acetonide implant (0.19 mg), the evidence includes 2 RCTs. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Implant-treated eyes showed clinically meaningful improvements in vision at 2 and 3 years postimplant. The percentage of patients who gained 15 letters or more was 28.7% in the implant group versus 18.9% in the sham group at 3 years. Subgroup analysis showed greater improvements in visual acuity in patients who were pseudophakic compared with those who were phakic (difference in mean change in number of letters at 2 years from baseline was 5.6 letters in pseudophakic patients vs. 1 letter in phakic patients). A major limitation of these implants is that nearly 80% of all phakic patients will develop cataracts and will require cataract surgery. Further, intraocular pressure was elevated in 34% of patients who received this implant compared with 10% of controls. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals with diabetic macular edema who receive an intravitreal dexamethasone implant (0.7 mg), the evidence includes 3 RCTs. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Compared with sham control, 2 identically designed RCTs showed clinically meaningful improvements in vision with dexamethasone implants that peaked at 3 months and maintained 39 months (with retreatment). The difference in the proportion of patients with a gain of 15 or more letters in best-corrected visual acuity from baseline was 9.3% and 13.0% in the 2 trials, respectively, favoring implant versus sham at 39 months postimplant. Subgroup analysis of these trials showed greater improvements in visual acuity in patients who were pseudophakic compared with those who were phakic. Additionally, evidence from various small and/or short-term trials and retrospective studies have found that, compared with primarily anti-vascular endothelial growth factor treatments, intravitreal dexamethasone implant (0.7 mg) was consistently associated with larger reductions in retinal thickness, but visual acuity changes were similar between treatment groups. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals with diabetic macular edema who receive an intravitreal dexamethasone implant (0.7 mg) plus anti-vascular endothelial growth factor therapy, the evidence includes 2 RCTs. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Findings from both RCTs were consistent in demonstrating that although adding dexamethasone to an anti-vascular endothelial growth factor treatment can lead to a greater mean reduction in central subfield thickness, it does not improve visual acuity and can lead to a higher risk of intraocular pressure elevation. Based on the consistent lack of improvement in visual acuity, increased risk of intraocular pressure elevation, and imprecision, these RCTs provide insufficient evidence to determine that the technology results in an improvement in the net health outcome.

For individuals with diabetic macular edema who receive an intravitreal dexamethasone implant (0.7 mg) plus laser photocoagulation, the evidence includes an RCT. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. One RCT with 1-year follow-up demonstrated that combination implants plus laser photocoagulation compared with laser photocoagulation alone resulted in better visual acuity (as measured by a gain of ≥ 10 letters) at 9 months but not at 12 months. However, the generally accepted standard outcome measure for change is 15 or more letters, and this standard was not used in this trial. The use of dexamethasone implants resulted in higher incidences of cataracts and elevated intraocular pressure. Further, a differential loss to follow-up, lack of power calculations for sample size estimation, and lack of intention-to-treat analysis preclude interpretation of results. A larger RCT with adequate power is needed to confirm these findings. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with age-related macular degeneration who receive an intravitreal dexamethasone implant (0.7 mg) plus anti-vascular endothelial growth factor inhibitor, the evidence includes an RCT. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Results of this trial did not demonstrate clinically meaningful reductions in the ranibizumab injection-free interval between combined treatments (34 days) and anti-vascular endothelial growth factor alone (29 days; $p=0.016$). Further, intraocular pressure was elevated in a greater proportion of patients receiving implants

without any additional clinical benefit. The evidence is insufficient to determine the effects of the technology on health outcomes.

Other Conditions

For individuals with birdshot retinochoroidopathy refractory or intolerant to standard therapy who receive an intravitreal fluocinolone acetonide implant (0.59 mg) or intravitreal dexamethasone implant (0.7 mg), the evidence includes multiple observational studies. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Multiple observational studies have noted improvements in anatomic and visual acuity outcomes. Long-term follow-up for efficacy and safety is limited. RCTs are needed to permit conclusions on the efficacy of corticosteroid implants in patients with refractory or intolerant birdshot retinopathy. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with cystoid macular edema who receive an intravitreal dexamethasone implant (0.7 mg), the evidence includes 1 observation-controlled RCT (n=14), 3 comparative observational studies and numerous case series. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. The RCT found improved mean visual acuity and eye anatomy outcomes with intravitreal dexamethasone compared to the control eyes, but these differences were not sustained at 6 months. The comparative observational studies included 269 patients (range, 60 to 135) and also lacked responder analysis of the proportion of patients with a 15-or-more letter improvement. One case series evaluated the proportion of patients with a 3-line improvement in best-corrected visual acuity; although 88% of patients achieved this outcome at 2 months, the proportion with improvement was not sustained at 6 months (27.8%). Additional blinded, multicenter RCTs are needed that compare intravitreal dexamethasone to another established treatment. The trials should be adequately powered for measuring proportion of patients in whom vision had improved by 15 letters or more. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with idiopathic macular telangiectasia type 1 who receive an intravitreal dexamethasone implant (0.7 mg), the evidence includes multiple case reports. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Case reports have noted mixed results for visual acuity and inflammation-related outcomes. Long-term follow-up for efficacy and safety is limited. Better quality studies with long-term follow-up are needed to permit conclusions on the efficacy of corticosteroid implants in patients with idiopathic macular telangiectasia type 1. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with postoperative chronic macular edema (pseudophakic cystoid macular edema, Irvine-Gass syndrome) who receive an intravitreal dexamethasone implant (0.7 mg), the evidence includes 1 RCT (n=29) that compared dexamethasone intravitreal implant, 0.7 mg to triamcinolone intravitreal injection, 4 mg, 2 comparative observational studies and numerous case series. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. The RCT found no statistically significant difference between treatments in mean visual acuity improvement at 3 or 6 months. The proportion of patients in whom vision had improved by 15 letters or more was not reported. The comparative observational studies included only small numbers of patients and also lack responder analysis of the proportion of patients with a 15-or-more letter improvement. In the largest case series (n=100), 2 of every 5 patients experienced clinically meaningful improvements in visual acuity after 1 year of follow-up. Additional RCTs are needed that have clearly defined and representative populations (ie, for chronic and refractory patients, documentation of intensity and duration of the first-line therapy regimens) and are adequately powered for measuring proportion of patients in whom vision had improved by 15 letters or more. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with circumscribed choroidal hemangiomas who receive an intravitreal dexamethasone implant (0.7 mg) plus photodynamic therapy, the evidence includes a case report. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity.

Results of the case report do not permit conclusions about the efficacy or safety of adding dexamethasone implants for circumscribed choroidal hemangiomas to photodynamic therapy. RCTs are needed to permit conclusions on the efficacy of corticosteroid implants in this population. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with proliferative vitreoretinopathy who receive an intravitreal dexamethasone implant (0.7 mg), the evidence includes a case series and a case report. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. These studies have reported multiple interventions, including dexamethasone implants in conjunction with surgery and laser for preventing proliferative retinopathy after retinal detachment surgery. RCTs are needed to permit conclusions on the efficacy of corticosteroid implants in patients with proliferative retinopathy. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with radiation retinopathy who receive an intravitreal dexamethasone implant (0.7 mg), the evidence includes multiple observational studies. Relevant outcomes are symptoms, change in disease status, functional outcomes, quality of life, and treatment-related morbidity. Multiple observational studies have noted improvements in anatomic and visual acuity outcomes. Long-term follow-up for efficacy and safety is limited. RCTs are needed to permit conclusions on the efficacy of corticosteroid implants in patients with radiation retinopathy. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals scheduled to undergo clear corneal cataract surgery who receive punctum dexamethasone insert (0.4 mg), the evidence includes 3 RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. All 3 trials noted significant improvements with the punctum dexamethasone insert (0.4 mg) across both coprimary efficacy endpoints of absence of pain at 8 days and absence of anterior chamber cells at day 14. Adverse events were generally similar between punctum dexamethasone insert (0.4 mg) and sham. Based on the consistent benefits and lack of important increases in adverse event risk, evidence is sufficient to determine that the technology results in improvement in the net health outcome.

For individuals with noninfectious intermediate uveitis or posterior uveitis and cataract undergoing cataract surgery who receive prophylaxis with intravitreal dexamethasone 0.7 mg (Ozurdex), the best evidence includes 1 single-center, open-label RCT of 43 patients in India. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Compared with oral corticosteroids, intravitreal dexamethasone 0.7 mg had similar benefits and avoided need for early steroid taper due to adverse effects on blood glucose, but potentially increased risk of developing intraocular pressure. Due to important study limitations including its small sample size, unclear allocation concealment methods and lack of blinding, evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

CODING

Medicare Advantage Plans and Commercial Products

The following code(s) are covered when filed with an approved ICD-10* diagnosis noted below:

- J1096** Dexamethasone, lacrimal ophthalmic insert, 0.1 mg
- J7311** Injection, fluocinolone acetonide, intravitreal implant (Retisert), 0.01 mg
- J7312** Injection, dexamethasone, intravitreal implant, 0.1 mg
- J7313** Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg
- J7314** Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg
- 68841** Insertion of drug-eluting implant, including punctal dilation when performed, into lacrimal canaliculus, each

***ICD-10 diagnosis**

E08.37X1-E08.37X9
E09.37X1-E09.37X9
E10.37X1-E10.37X9

E11.37X1-E11.37X9
E13.37X1-E13.37X9
H20.10-H20.13
H30.90-H30.93
H34.8110-H34.8192
H34.8310-H34.8392
H35.031-H35.039
H35.30-H35.3294
H35.81

RELATED POLICIES

None

PUBLISHED

Provider Update, August
Provider Update, May/September 2023
Provider Update, July 2022
Provider Update, June 2021
Provider Update, September 2020

REFERENCES

1. Haller JA, Bandello F, Belfort R, et al. Randomized, sham-controlled trial of dexamethasone intravitreal implant in patients with macular edema due to retinal vein occlusion. *Ophthalmology*. Jun 2010; 117(6): 1134-1146.e3. PMID 20417567
2. Haller JA, Bandello F, Belfort R, et al. Dexamethasone intravitreal implant in patients with macular edema related to branch or central retinal vein occlusion twelve-month study results. *Ophthalmology*. Dec 2011; 118(12): 2453-60. PMID 21764136
3. Bausch & Lomb Incorporated. Retisert (fluocinolone acetonide intravitreal implant) 0.59 mg: Prescribing Label. 2023; <https://www.bausch.com/Portals/69/-/m/BL/United%20States/USFiles/Package%20Inserts/Pharma/retisert-prescribing-information.pdf?ver=2018-04-23-125740-133>. Accessed February 6, 2024.
4. Jaffe GJ, Martin D, Callanan D, et al. Fluocinolone acetonide implant (Retisert) for noninfectious posterior uveitis: thirty-four-week results of a multicenter randomized clinical study. *Ophthalmology*. Jun 2006; 113(6): 1020-7. PMID 16690128
5. U.S. Food and Drug Administration. Center for Drug Evaluation and Research, Application number 21-737, Medical Review. 2005; http://www.accessdata.fda.gov/drugsatfda_docs/nda/2005/021737s000_MedR.pdf. Accessed February 5, 2024.
6. Pavesio C, Zierhut M, Bairi K, et al. Evaluation of an intravitreal fluocinolone acetonide implant versus standard systemic therapy in noninfectious posterior uveitis. *Ophthalmology*. Mar 2010; 117(3): 567-75, 575.e1. PMID 20079922
7. Kempen JH, Altaweel MM, Holbrook JT, et al. Randomized comparison of systemic anti-inflammatory therapy versus fluocinolone acetonide implant for intermediate, posterior, and panuveitis: the multicenter uveitis steroid treatment trial. *Ophthalmology*. Oct 2011; 118(10): 1916-26. PMID 21840602
8. Kempen JH, Altaweel MM, Drye LT, et al. Benefits of Systemic Anti-inflammatory Therapy versus Fluocinolone Acetonide Intraocular Implant for Intermediate Uveitis, Posterior Uveitis, and Panuveitis: Fifty-four-Month Results of the Multicenter Uveitis Steroid Treatment (MUST) Trial and Follow-up Study. *Ophthalmology*. Oct 2015; 122(10): 1967-75. PMID 26298715
9. Jaffe GJ, Branchaud B, Hahn P, et al. Quality of Life and Risks Associated with Systemic Anti-inflammatory Therapy versus Fluocinolone Acetonide Intraocular Implant for Intermediate Uveitis, Posterior Uveitis, or Panuveitis: Fifty-four-Month Results of the Multicenter Uveitis Steroid Treatment Trial and Follow-up Study. *Ophthalmology*. Oct 2015; 122(10): 1976-86. PMID 26298718

10. Brady CJ, Villanti AC, Law HA, et al. Corticosteroid implants for chronic non-infectious uveitis. *Cochrane Database Syst Rev.* Feb 12 2016; 2(2): CD010469. PMID 26866343
11. Reddy A, Liu SH, Brady CJ, et al. Corticosteroid implants for chronic non-infectious uveitis. *Cochrane Database Syst Rev.* Jan 16 2023; 1(1): CD010469. PMID 36645716
12. Holbrook JT, Sugar EA, Burke AE, et al. Dissociations of the Fluocinolone Acetonide Implant: The Multicenter Uveitis Steroid Treatment (MUST) Trial and Follow-up Study. *Am J Ophthalmol.* Apr 2016; 164: 29-36. PMID 26748056
13. Lowder C, Belfort R, Lightman S, et al. Dexamethasone intravitreal implant for noninfectious intermediate or posterior uveitis. *Arch Ophthalmol.* May 2011; 129(5): 545-53. PMID 21220619
14. Lightman S, Belfort R, Naik RK, et al. Vision-related functioning outcomes of dexamethasone intravitreal implant in noninfectious intermediate or posterior uveitis. *Invest Ophthalmol Vis Sci.* Jul 18 2013; 54(7): 4864-70. PMID 23761087
15. Gillespie BW, Musch DC, Niziol LM, et al. Estimating minimally important differences for two vision-specific quality of life measures. *Invest Ophthalmol Vis Sci.* Jun 06 2014; 55(7): 4206-12. PMID 24906863
16. Allergan Inc. Ozurdex (dexamethasone intravitreal implant): Prescribing Label 2022; <https://media.allergan.com/actavis/actavis/media/allergan-pdf-documents/product-prescribing/20180515-OZURDEX-USPI-v1-0USPI3348.pdf>. Accessed February 6, 2024.
17. U.S. Food and Drug Administration. Center for Drug Evaluation and Research, Application number 210331, Medical Review. 2018; https://www.accessdata.fda.gov/drugsatfda_docs/nda/2018/210331Orig1s000MedR.pdf. Accessed February 4, 2024.
18. Jaffe GJ, Foster CS, Pavesio CE, et al. Effect of an Injectable Fluocinolone Acetonide Insert on Recurrence Rates in Chronic Noninfectious Uveitis Affecting the Posterior Segment: Twelve-Month Results. *Ophthalmology.* Apr 2019; 126(4): 601-610. PMID 30367884
19. Jaffe GJ, Pavesio CE. Effect of a Fluocinolone Acetonide Insert on Recurrence Rates in Noninfectious Intermediate, Posterior, or Panuveitis: Three-Year Results. *Ophthalmology.* Oct 2020; 127(10): 1395-1404. PMID 32624244
20. Yeh S, Kim SJ, Ho AC, et al. Therapies for macular edema associated with central retinal vein occlusion: a report by the American Academy of Ophthalmology. *Ophthalmology.* Apr 2015; 122(4): 769-78. PMID 25576994
21. Pichi F, Specchia C, Vitale L, et al. Combination therapy with dexamethasone intravitreal implant and macular grid laser in patients with branch retinal vein occlusion. *Am J Ophthalmol.* Mar 2014; 157(3): 607-15.e1. PMID 24528934
22. Ehlers JP, Kim SJ, Yeh S, et al. Therapies for Macular Edema Associated with Branch Retinal Vein Occlusion: A Report by the American Academy of Ophthalmology. *Ophthalmology.* Sep 2017; 124(9): 1412-1423. PMID 28551163
23. Maturi RK, Chen V, Raghinaru D, et al. A 6-month, subject-masked, randomized controlled study to assess efficacy of dexamethasone as an adjunct to bevacizumab compared with bevacizumab alone in the treatment of patients with macular edema due to central or branch retinal vein occlusion. *Clin Ophthalmol.* 2014; 8: 1057-64. PMID 24940042
24. Gado AS, Macky TA. Dexamethasone intravitreal implant versus bevacizumab for central retinal vein occlusion-related macular oedema: a prospective randomized comparison. *Clin Exp Ophthalmol.* 2014; 42(7): 650-5. PMID 24612095
25. Kuppermann BD, Blumenkranz MS, Haller JA, et al. Randomized controlled study of an intravitreal dexamethasone drug delivery system in patients with persistent macular edema. *Arch Ophthalmol.* Mar 2007; 125(3): 309-17. PMID 17353400
26. Kumar P, Sharma YR, Chandra P, et al. Comparison of the Safety and Efficacy of Intravitreal Ranibizumab with or without Laser Photocoagulation Versus Dexamethasone Intravitreal Implant with or without Laser Photocoagulation for Macular Edema Secondary to Branch Retinal Vein Occlusion. *Folia Med (Plovdiv).* Jun 01 2019; 61(2): 240-248. PMID 31301668
27. Ji K, Zhang Q, Tian M, et al. Comparison of dexamethasone intravitreal implant with intravitreal anti-VEGF injections for the treatment of macular edema secondary to branch retinal vein occlusion: A meta-analysis. *Medicine (Baltimore).* May 2019; 98(22): e15798. PMID 31145307

28. Thorne JE, Sugar EA, Holbrook JT, et al. Periocular Triamcinolone vs. Intravitreal Triamcinolone vs. Intravitreal Dexamethasone Implant for the Treatment of Uveitic Macular Edema: The PeriOcular vs. INTravitreal corticosteroids for uveitic macular edema (POINT) Trial. *Ophthalmology*. Feb 2019; 126(2): 283-295. PMID 30269924
29. Fraser-Bell S, Kang HK, Mitchell P, et al. Dexamethasone intravitreal implant in treatment-naïve diabetic macular oedema: findings from the prospective, multicentre, AUSSIEDEX study. *Br J Ophthalmol*. Jan 2023; 107(1): 72-78. PMID 34433549
30. Zhang M, Liu Y, Song M, et al. Intravitreal Dexamethasone Implant Has Better Retinal Perfusion than Anti-Vascular Endothelial Growth Factor Treatment for Macular Edema Secondary to Retinal Vein Occlusion: A Five-Year Real-World Study. *Ophthalmic Res*. 2023; 66(1): 247-258. PMID 36215955
31. Rittiphairoj T, Mir TA, Li T, et al. Intravitreal steroids for macular edema in diabetes. *Cochrane Database Syst Rev*. Nov 17 2020; 11(11): CD005656. PMID 33206392
32. Grover D, Li TJ, Chong CC. Intravitreal steroids for macular edema in diabetes. *Cochrane Database Syst Rev*. Jan 23 2008; (1): CD005656. PMID 18254088
33. Pearson PA, Comstock TL, Ip M, et al. Fluocinolone acetonide intravitreal implant for diabetic macular edema: a 3-year multicenter, randomized, controlled clinical trial. *Ophthalmology*. Aug 2011; 118(8): 1580-7. PMID 21813090
34. Campochiaro PA, Brown DM, Pearson A, et al. Long-term benefit of sustained-delivery fluocinolone acetonide vitreous inserts for diabetic macular edema. *Ophthalmology*. Apr 2011; 118(4): 626-635.e2. PMID 21459216
35. Alimera Sciences Inc. Iluvien (fluocinolone acetonide intravitreal implant) 0.19 mg for Intravitreal Injection: Prescribing Label. 2016; <https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=BasicSearch.process>. Accessed February 6, 2024.
36. Campochiaro PA, Brown DM, Pearson A, et al. Sustained delivery fluocinolone acetonide vitreous inserts provide benefit for at least 3 years in patients with diabetic macular edema. *Ophthalmology*. Oct 2012; 119(10): 2125-32. PMID 22727177
37. Cunha-Vaz J, Ashton P, Iezzi R, et al. Sustained delivery fluocinolone acetonide vitreous implants: long-term benefit in patients with chronic diabetic macular edema. *Ophthalmology*. Oct 2014; 121(10): 1892-903. PMID 24935282
38. Massin P, Erginay A, Dupas B, et al. Efficacy and safety of sustained-delivery fluocinolone acetonide intravitreal implant in patients with chronic diabetic macular edema insufficiently responsive to available therapies: a real-life study. *Clin Ophthalmol*. 2016; 10: 1257-64. PMID 27468222
39. Boyer DS, Yoon YH, Belfort R, et al. Three-year, randomized, sham-controlled trial of dexamethasone intravitreal implant in patients with diabetic macular edema. *Ophthalmology*. Oct 2014; 121(10): 1904-14. PMID 24907062
40. Gillies MC, Lim LL, Campain A, et al. A randomized clinical trial of intravitreal bevacizumab versus intravitreal dexamethasone for diabetic macular edema: the BEVORDEX study. *Ophthalmology*. Dec 2014; 121(12): 2473-81. PMID 25155371
41. U.S. National Library of Medicine. Dexamethasone Intravitreal Implant for the Treatment of Persistent Diabetic Macular Edema (DIME) NCT02471651. 2019. <https://clinicaltrials.gov/ct2/show/results/NCT02471651?term=NCT02471651&draw=2&rank=1> Accessed February 6, 2024.
42. Callanan DG, Loewenstein A, Patel SS, et al. A multicenter, 12-month randomized study comparing dexamethasone intravitreal implant with ranibizumab in patients with diabetic macular edema. *Graefes Arch Clin Exp Ophthalmol*. Mar 2017; 255(3): 463-473. PMID 27632215
43. Sharma A, Bellala K, Dongre P, et al. Anti-VEGF versus dexamethasone implant (Ozurdex) for the management of Centre involved Diabetic Macular Edema (CiDME): a randomized study. *Int Ophthalmol*. Jan 2020; 40(1): 67-72. PMID 31377905
44. U.S. National Library of Medicine. Dexamethasone Intravitreal Implant for the Treatment of Persistent Diabetic Macular Edema (DIME) NCT02471651. 2019. <https://clinicaltrials.gov/ct2/show/results/NCT02471651?term=NCT02471651&draw=2&rank=1> Accessed February 6, 2024.

45. Cornish EE, Teo KY, Gillies MC, et al. Five-year outcomes of eyes initially enrolled in the 2-year BEVORDEX trial of bevacizumab or dexamethasone implants for diabetic macular oedema. *Br J Ophthalmol*. Jan 2023; 107(1): 79-83. PMID 34340975
46. Bolukbasi S, Cakir A, Erden B, et al. Comparison of the short-term effect of aflibercept and dexamethasone implant on serous retinal detachment in the treatment of naive diabetic macular edema. *Cutan Ocul Toxicol*. Dec 2019; 38(4): 401-405. PMID 31438736
47. Cakir A, Erden B, Bolukbasi S, et al. Comparison of the effect of ranibizumab and dexamethasone implant in diabetic macular edema with concurrent epiretinal membrane. *J Fr Ophtalmol*. Sep 2019; 42(7): 683-689. PMID 31088741
48. Coelho J, Malheiro L, Melo Beirão J, et al. Real-world retrospective comparison of 0.19 mg fluocinolone acetonide and 0.7 mg dexamethasone intravitreal implants for the treatment of diabetic macular edema in vitrectomized eyes. *Clin Ophthalmol*. 2019; 13: 1751-1759. PMID 31571814
49. Maturi RK, Glassman AR, Liu D, et al. Effect of Adding Dexamethasone to Continued Ranibizumab Treatment in Patients With Persistent Diabetic Macular Edema: A DRCR Network Phase 2 Randomized Clinical Trial. *JAMA Ophthalmol*. Jan 01 2018; 136(1): 29-38. PMID 29127949
50. Maturi RK, Bleau L, Saunders J, et al. A 12-MONTH, SINGLE-MASKED, RANDOMIZED CONTROLLED STUDY OF EYES WITH PERSISTENT DIABETIC MACULAR EDEMA AFTER MULTIPLE ANTI-VEGF INJECTIONS TO ASSESS THE EFFICACY OF THE DEXAMETHASONE-DELAYED DELIVERY SYSTEM AS AN ADJUNCT TO BEVACIZUMAB COMPARED WITH CONTINUED BEVACIZUMAB MONOTHERAPY. *Retina*. Aug 2015; 35(8): 1604-14. PMID 25829346
51. Callanan DG, Gupta S, Boyer DS, et al. Dexamethasone intravitreal implant in combination with laser photocoagulation for the treatment of diffuse diabetic macular edema. *Ophthalmology*. Sep 2013; 120(9): 1843-51. PMID 23706947
52. Kuppermann BD, Goldstein M, Maturi RK, et al. Dexamethasone Intravitreal Implant as Adjunctive Therapy to Ranibizumab in Neovascular Age-Related Macular Degeneration: A Multicenter Randomized Controlled Trial. *Ophthalmologica*. 2015; 234(1): 40-54. PMID 26088793
53. Bajwa A, Aziz K, Foster CS. Safety and efficacy of fluocinolone acetonide intravitreal implant (0.59 mg) in birdshot retinochoroidopathy. *Retina*. Nov 2014; 34(11): 2259-68. PMID 24999722
54. Burkholder BM, Wang J, Dunn JP, et al. Postoperative outcomes after fluocinolone acetonide implant surgery in patients with birdshot chorioretinitis and other types of posterior and panuveitis. *Retina*. Sep 2013; 33(8): 1684-93. PMID 23549097
55. Rush RB, Goldstein DA, Callanan DG, et al. Outcomes of birdshot chorioretinopathy treated with an intravitreal sustained-release fluocinolone acetonide-containing device. *Am J Ophthalmol*. Apr 2011; 151(4): 630-6. PMID 21277557
56. Srouf M, Querques G, Leveziel N, et al. Intravitreal dexamethasone implant (Ozurdex) for macular edema secondary to retinitis pigmentosa. *Graefes Arch Clin Exp Ophthalmol*. Jun 2013; 251(6): 1501-6. PMID 23275039
57. Erdoğan G, Aydoğan T, Ünlü C, et al. Dexamethasone Implant for the Treatment of Type 1 Idiopathic Macular Telangiectasia. *J Ocul Pharmacol Ther*. May 2016; 32(4): 211-5. PMID 26985700
58. Donati S, Gandolfi C, Caprani SM, et al. Evaluation of the Effectiveness of Treatment with Dexamethasone Intravitreal Implant in Cystoid Macular Edema Secondary to Retinal Vein Occlusion. *Biomed Res Int*. 2018; 2018: 3095961. PMID 30175123
59. Laine I, Lindholm JM, Ylinen P, et al. Intravitreal bevacizumab injections versus dexamethasone implant for treatment-naïve retinal vein occlusion related macular edema. *Clin Ophthalmol*. 2017; 11: 2107-2112. PMID 29225460
60. Spaide RF. RETINAL VASCULAR CYSTOID MACULAR EDEMA: Review and New Theory. *Retina*. Oct 2016; 36(10): 1823-42. PMID 27328171
61. Ozkok A, Saleh OA, Sigford DK, et al. THE OMAR STUDY: Comparison of Ozurdex and Triamcinolone Acetonide for Refractory Cystoid Macular Edema in Retinal Vein Occlusion. *Retina*. Jul 2015; 35(7): 1393-400. PMID 25748280
62. Csaky KG, Richman EA, Ferris FL. Report from the NEI/FDA Ophthalmic Clinical Trial Design and Endpoints Symposium. *Invest Ophthalmol Vis Sci*. Feb 2008; 49(2): 479-89. PMID 18234989

63. Park UC, Park JH, Ma DJ, et al. A RANDOMIZED PAIRED-EYE TRIAL OF INTRAVITREAL DEXAMETHASONE IMPLANT FOR CYSTOID MACULAR EDEMA IN RETINITIS PIGMENTOSA. *Retina*. Jul 2020; 40(7): 1359-1366. PMID 31166248
64. Veritti D, Sarao V, De Nadai K, et al. Dexamethasone Implant Produces Better Outcomes than Oral Acetazolamide in Patients with Cystoid Macular Edema Secondary to Retinitis Pigmentosa. *J Ocul Pharmacol Ther*. Apr 2020; 36(3): 190-197. PMID 31886707
65. Novais EA, Maia M, Filho PA, et al. Twelve-Month Follow-Up of Dexamethasone Implants for Macular Edema from Various Diseases in Vitrectomized and Nonvitrectomized Eyes. *J Ophthalmol*. 2016; 2016: 7984576. PMID 27721989
66. Bansal P, Agarwal A, Gupta V, et al. Spectral domain optical coherence tomography changes following intravitreal dexamethasone implant, Ozurdex® in patients with uveitic cystoid macular edema. *Indian J Ophthalmol*. May 2015; 63(5): 416-22. PMID 26139803
67. Fortoul V, Denis P, Kodjikian L. Anatomical and functional recurrence after dexamethasone intravitreal implants: a 6-month prospective study. *Eye (Lond)*. Jun 2015; 29(6): 769-75. PMID 25853447
68. Bezatis A, Spital G, Höhn F, et al. Functional and anatomical results after a single intravitreal Ozurdex injection in retinal vein occlusion: a 6-month follow-up -- the SOLO study. *Acta Ophthalmol*. Aug 2013; 91(5): e340-7. PMID 23638803
69. Lei S, Lam WC. Efficacy and safety of dexamethasone intravitreal implant for refractory macular edema in children. *Can J Ophthalmol*. Jun 2015; 50(3): 236-41. PMID 26040225
70. Loutfi M, Papathomas T, Kamal A. Macular oedema related to idiopathic macular telangiectasia type 1 treated with dexamethasone intravitreal implant (ozurdex). *Case Rep Ophthalmol Med*. 2014; 2014: 231913. PMID 25045562
71. Holló G, Aung T, Cantor LB, et al. Cystoid macular edema related to cataract surgery and topical prostaglandin analogs: Mechanism, diagnosis, and management. *Surv Ophthalmol*. 2020; 65(5): 496-512. PMID 32092363
72. Grzybowski A, Sikorski BL, Ascaso FJ, et al. Pseudophakic cystoid macular edema: update 2016. *Clin Interv Aging*. 2016; 11: 1221-1229. PMID 27672316
73. Mylonas G, Georgopoulos M, Malamos P, et al. Comparison of Dexamethasone Intravitreal Implant with Conventional Triamcinolone in Patients with Postoperative Cystoid Macular Edema. *Curr Eye Res*. Apr 2017; 42(4): 648-652. PMID 27612922
74. Dang Y, Mu Y, Li L, et al. Comparison of dexamethasone intravitreal implant and intravitreal triamcinolone acetonide for the treatment of pseudophakic cystoid macular edema in diabetic patients. *Drug Des Devel Ther*. 2014; 8: 1441-9. PMID 25258512
75. Guclu H, Pelitli Gurlu V. Comparison of topical nepafenac 0.1% with intravitreal dexamethasone implant for the treatment of Irvine-Gass syndrome. *Int J Ophthalmol*. 2019; 12(2): 258-267. PMID 30809482
76. Klamann A, Böttcher K, Ackermann P, et al. Intravitreal Dexamethasone Implant for the Treatment of Postoperative Macular Edema. *Ophthalmologica*. 2016; 236(4): 181-185. PMID 27915343
77. Sudhalkar A, Chhablani J, Vasavada A, et al. Intravitreal dexamethasone implant for recurrent cystoid macular edema due to Irvine-Gass syndrome: a prospective case series. *Eye (Lond)*. Dec 2016; 30(12): 1549-1557. PMID 27858937
78. Keilani C, Halalchi A, Wakpi Djeugue D, et al. Evaluation of best corrected visual acuity and central macular thickness after intravitreal dexamethasone implant injections in patients with Irvine-Gass syndrome: A retrospective study of six cases. *Therapie*. Oct 2016; 71(5): 457-465. PMID 27203164
79. Mayer WJ, Kurz S, Wolf A, et al. Dexamethasone implant as an effective treatment option for macular edema due to Irvine-Gass syndrome. *J Cataract Refract Surg*. Sep 2015; 41(9): 1954-61. PMID 26603404
80. Landré C, Zourhani A, Gstaude P, et al. [Treatment of postoperative cystoid macular edema (Irvine-Gass syndrome) with dexamethasone 0.7 mg intravitreal implant]. *J Fr Ophtalmol*. Jan 2016; 39(1): 5-11. PMID 26520410
81. Degoumois A, Akesbi J, Laurens C, et al. [Efficacy of intravitreal dexamethasone implants in macular edema excluding venous occlusions: results for a cohort of 80 patients]. *J Fr Ophtalmol*. Feb 2015; 38(2): 126-33. PMID 25592383

82. Dutra Medeiros M, Navarro R, Garcia-Arumí J, et al. Dexamethasone intravitreal implant for treatment of patients with recalcitrant macular edema resulting from Irvine-Gass syndrome. *Invest Ophthalmol Vis Sci*. May 07 2013; 54(5): 3320-4. PMID 23599334
83. Freisinger S, Vounotrypidis E, Wolf A, et al. Evaluation of Functional Outcomes and OCT-Biomarkers after Intravitreal Dexamethasone Implant for Postoperative Cystoid Macular Edema in Vitrectomized Eyes. *J Ophthalmol*. 2020; 2020: 3946531. PMID 32411428
84. Bellocq D, Pierre-Kahn V, Matonti F, et al. Effectiveness and safety of dexamethasone implants for postsurgical macular oedema including Irvine-Gass syndrome: the EPISODIC-2 study. *Br J Ophthalmol*. Mar 2017; 101(3): 333-341. PMID 27190126
85. Bazin L, Gambrelle J. [Combined treatment with photodynamic therapy and intravitreal dexamethasone implant (Ozurdex®) for circumscribed choroidal hemangioma]. *J Fr Ophtalmol*. Dec 2012; 35(10): 798-802. PMID 23040445
86. Sherif M, Wolfensberger TJ. Intraocular Dexamethasone Implant as Adjunct to Silicone Oil Tamponade for Proliferative Vitreoretinopathy. *Klin Monbl Augenheilkd*. Apr 2017; 234(4): 501-504. PMID 28147403
87. Reibaldi M, Russo A, Longo A, et al. Rhegmatogenous Retinal Detachment with a High Risk of Proliferative Vitreoretinopathy Treated with Episcleral Surgery and an Intravitreal Dexamethasone 0.7-mg Implant. *Case Rep Ophthalmol*. Jan 2013; 4(1): 79-83. PMID 23687501
88. Caminal JM, Flores-Moreno I, Arias L, et al. INTRAVITREAL DEXAMETHASONE IMPLANT FOR RADIATION MACULOPATHY SECONDARY TO PLAQUE BRACHYTHERAPY IN CHOROIDAL MELANOMA. *Retina*. Sep 2015; 35(9): 1890-7. PMID 26035401
89. Bui KM, Chow CC, Mieler WF. Treatment of recalcitrant radiation maculopathy using intravitreal dexamethasone (Ozurdex) implant. *Retin Cases Brief Rep*. 2014; 8(3): 167-70. PMID 25372430
90. Baillif S, Maschi C, Gastaud P, et al. Intravitreal dexamethasone 0.7-mg implant for radiation macular edema after proton beam therapy for choroidal melanoma. *Retina*. Oct 2013; 33(9): 1784-90. PMID 23652581
91. Tyson SL, Bafna S, Gira JP, et al. Multicenter randomized phase 3 study of a sustained-release intracanalicular dexamethasone insert for treatment of ocular inflammation and pain after cataract surgery. *J Cataract Refract Surg*. Feb 2019; 45(2): 204-212. PMID 30367938
92. Walters T, Bafna S, Vold S, Wortz G, Harton P, et al. (2016) Efficacy and Safety of Sustained Release Dexamethasone for the Treatment of Ocular Pain and Inflammation after Cataract Surgery: Results from Two Phase 3 Studies. *J Clin Exp Ophthalmol* 7:1000572. doi: 10.4172/2155-9570.1000572
93. Sudhalkar A, Vasavada A, Bhojwani D, et al. Intravitreal dexamethasone implant as an alternative to systemic steroids as prophylaxis for uveitic cataract surgery: a randomized trial. *Eye (Lond)*. Mar 2020; 34(3): 491-498. PMID 31320735
94. Flaxel CJ, Adelman RA, Bailey ST, et al. Retinal Vein Occlusions Preferred Practice Pattern®. *Ophthalmology*. Feb 2020; 127(2): P288-P320. PMID 31757503
95. Flaxel CJ, Adelman RA, Bailey ST, et al. Diabetic Retinopathy Preferred Practice Pattern®. *Ophthalmology*. Jan 2020; 127(1): P66-P145. PMID 31757498
96. Flaxel CJ, Adelman RA, Bailey ST, et al. Age-Related Macular Degeneration Preferred Practice Pattern®. *Ophthalmology*. Jan 2020; 127(1): P1-P65. PMID 31757502
97. National Institute for Health and Care Excellence (NICE). Fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema in phakic eyes after an inadequate response to previous therapy Technology appraisal guidance [TA613], 2019. <https://www.nice.org.uk/guidance/ta613> Accessed February 2, 2024.
98. National Institute for Health and Care Excellence (NICE). Fluocinolone acetonide intravitreal implant for treating recurrent non-infectious uveitis Technology appraisal guidance [TA590] 2019; <https://www.nice.org.uk/guidance/TA590/chapter/1-Recommendations> Accessed February 1, 2024.
99. National Institute for Health and Care Excellence (NICE). Adalimumab and dexamethasone for treating non- infectious uveitis [TA460]. 2017; <https://www.nice.org.uk/guidance/ta460>. Accessed February 5, 2024.

100. National Institute for Health and Care Excellence (NICE). Dexamethasone intravitreal implant for the treatment of macular oedema secondary to retinal vein occlusion [TA229]. 2011; <https://www.nice.org.uk/guidance/ta229>. Accessed February 6, 2024.
101. National Institute for Health and Care Excellence (NICE). Dexamethasone intravitreal implant for treating diabetic macular oedema [TA349]. 2022; <https://www.nice.org.uk/guidance/TA824>. Accessed February 4, 2024.
102. National Institute for Health and Care Excellence (NICE). Fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema after an inadequate response to prior therapy [TA301]. 2013; <https://www.nice.org.uk/guidance/ta301>. Accessed February 3, 2024.

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