## Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/retina-clinic-current-treatment-options-in-namd/13983/

Released: 09/09/2022
Valid until: 09/09/2023
Time needed to complete: 15 minutes

**ReachMD**
www.reachmd.com
info@reachmd.com
(866) 423-7849

---

# Retina Clinic: Current Treatment Options in nAMD

**Announcer:**
Welcome to CME on ReachMD. This activity, entitled **"Retina Clinic: Current Treatment Options in nAMD"** is provided by **Prova Education**.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

**Dr. Danzig:**
We're fortunate to live in a time where new treatment modalities are now available for our patients with neovascular age-related macular degeneration [nAMD]. But when faced with multiple second-generation treatment options, how do we decide which is best for each patient we see in clinic?

This is CME on ReachMD, and I am Dr. Carl Danzig.

**Dr. Khanani:**
And I am Arshad Khanani.

**Dr. Danzig:**
Before we dive into our patient cases today, Arshad, can you briefly remind us why second-generation agents are an attractive option for our patients with neovascular AMD?

**Dr. Khanani:**
Absolutely, Carl. We are very lucky to have current available agents that work really, really well, but of course, the problem is that patients need frequent injections, anywhere from every 4 weeks to up to every 12 weeks. And the second-generation agents are needed so that we can have greater durability, whether it's with an intravitreal injection or a drug delivery system. And as we know as practicing physicians, that these frequent visits are very burdensome for our patients as well as caregivers. And what happens over time is this injection fatigue, and patients either miss appointment and stop coming to their clinic visits. And the last problem is the capacity issues, where we have an aging population and more patients need treatment. And soon, hopefully, we'll have an FDA approval for patients with geographic atrophy who will also need frequent injections. So, really, to address all these issues, I think second-generation agents are needed so our patients can have good long-term visual outcomes while decreasing their treatment burden.

**Dr. Danzig:**
You know, I couldn't agree more. You know, treatment burden and capacity is a big issue in my clinic, and I'm afraid that with an aging population, it is going to get a little bit worse.

Could maybe you highlight some of the phase 3 trial results that we've recently seen with TENAYA and LUCERNE?

**Dr. Khanani:**
Yeah, absolutely. So I recently presented the first time 2-year results for the pivotal phase 3 TENAYA and LUCERNE studies with faricimab. And remember, the studies met the primary endpoint in the first year. In the second year, patients were actually treated with a

personalized treatment interval, where they could get treatment anywhere from q8 weeks to up to q16 weeks. And what we saw in the second-year data is impressive durability. At week 112, we had over 60% of faricimab-treated patients that achieved q16-week dosing, and around 80% of patients achieving q12-weeks dosing or greater.

So the bottom line is that with faricimab in the second year, we saw 8 out of 10 patients that could go 3 months or longer, which is great news for our patients suffering from neovascular AMD, because we have not seen this durability with any other agent, intravitreal injections. And of course, as a new treatment, we are also very careful about looking at safety, and what we saw was, you know, of course the anatomy and the visual outcomes were comparable with aflibercept every 8 weeks, and the safety was not different either, where the intraocular inflammation rates were comparable, and we had no cases of retinal vasculitis or retinal artery occlusion. So looking at this data, Carl, for patients who were treated in TENAYA and LUCERNE, these were naïve patients, and they ended up with great durability because of the dual inhibition of VEGF-A as well as ANG-2 with faricimab.

Now, in addition, we also saw some new data from brolucizumab, Carl, about the TALON study to look at treat-and-extend regimen for brolucizumab and comparing it to aflibercept. And again, we saw that the brolucizumab patients did better in terms of dry retina. There were more patients who were extended to q12-week dosing with brolucizumab. It was 38.5% compared to 19.8% with aflibercept. But of course, the problem we have seen with brolucizumab is the safety profile that's not comparable to aflibercept or any other agent. And in this study we did see higher rates of intraocular inflammation with brolucizumab, which was 5.5% compared to aflibercept at 1.1, and we did have cases of retinal vasculitis and retinal artery occlusion. And if you look at those numbers, there were 5 patients, which was 1.4%, with brolucizumab that had retinal artery occlusion, compared to 1 patient, or 0.3%, with aflibercept. So the safety profile is different. That's why brolucizumab is not a first-line agent, but it's nice to see the confirmation of the fact that brolucizumab can dry the retina better and is more durable.

Carl, tell me about your experience with faricimab in the real world. Of course, we had naïve patients in TENAYA and LUCERNE. How are you using faricimab, and do you have any cases to share with us?

**Dr. Danzig:**
Right, it's definitely funny, because in this phase 3 trial, they only allowed treatment-naïve patients. But in the real world, when we have a new medication coming along that has improved durability, I think most physicians are thinking about that tough-to-treat, that high-need patient, you know, the type of patient that is getting injections every 6 weeks or more frequently than that.

And those are the patients that I think most of us are trying a new medicine like faricimab on and, you know, I have a patient that I know quite well, who is 94 years old. I started treating him 9 years ago, in 2013, and he has received all the medications. He was getting monthly injections. He was put into a clinical trial for patients getting monthly injections. He even had q2-week injections, alternating. And then, in the last year, he was alternating every 4 weeks between brolucizumab and aflibercept, and even with that, he still couldn't get rid of his subfoveal fluid. Now with this gentleman, over 9 years of treatment, you know, his vision couldn't maintain that 20/25, 20/30 – that over 9 years it did decline a little bit, but what he saw is after his first faricimab injection, the subfoveal fluid completely resolved. And for this patient, it has given him hope, and I've actually been able to extend him out after a few loading doses to about 6 weeks now, and I'm waiting to see him back at an 8-week visit to see how he does. But this gentleman is very excited. It's the first time in 9 years he's been able to go longer than, you know, 4 to 5 weeks between an injection.

How are you using it in the real world? Is this the type of patient you like to target first?

**Dr. Khanani:**
Yeah, Carl, that's an excellent case you just presented. So, you know, just like you, we have been investigators in the faricimab trials for several years, so of course, I feel confident based on efficacy, durability, and safety to use it in naïve patients. But you are right. In these previously treated patients, we have seen very impressive anatomic results in many of these patients with persistent fluid with monthly anti-VEGF, let's say aflibercept, in the past. So I actually had a very similar experience like yours, where patients treated with faricimab are looking better in terms of anatomy just after a single injection, and sometimes, actually, visual acuity improvements happen in these patients. So yeah, my experience is very similar to yours.

**Dr. Danzig:**
For those of you just tuning in, you're listening to CME on ReachMD. I'm Dr. Carl Danzig, and here with me today is Dr. Arshad Khanani. Together we're discussing second-generation treatments for neovascular AMD and how to best optimize therapeutic decision-making in clinic.

**Dr. Khanani:**
Carl, you recently presented real-world efficacy and safety data for faricimab. Can you tell us about those findings in the TRUCKEE study?

**Dr. Danzig:**
Yes, thank you. I did recently present that at the ASRS [American Society of Retina Specialists] meeting in New York City. The TRUCKEE study identified patients who received faricimab, and we really looked at those follow-up patients, though, yes, there were 377 patients and 421 eyes, for a total of 770 injections. But we were really looking at those patients who came back for a follow-up. They had faricimab and they came back, and that was 236 eyes, of which 16 were treatment naïve. And what we saw there was stable vision, which is what we expected. This was 1 injection in mostly previously treated patients. They had stable vision, improved CST [central subfield thickness], and improved PED [pigment epithelial detachment] height.

But when we took out the treatment naïve, and we looked at patients who were switched from any anti-VEGF to faricimab, we found that the vision was stable, CST reduction was almost 27 micrometers [µm], with a small PED height reduction. But the important thing here was that the treatment interval was kept the same with faricimab as it was with the prior anti-VEGF. Now, we also looked at safety. So there were a total of 770 injections. There were no cases of intraocular inflammation, retina vasculitis, or retinal artery occlusion. There was 1 case of endophthalmitis that was culture positive, treated with tap-and-inject, and that patient's vision returned to baseline.

**Dr. Khanani:**
Carl, this is a great data set. You know, TANAYA and LUCERNE provided us information on the naïve patients, and here you and the TRUCKEE group has really provided us with information that faricimab is appearing to work better in terms of drying the retina compared to other available agents, and the safety appears to be comparable. So this is great.

Now let's talk a little bit about the port delivery system [PDS], which is another treatment option. Carl, can you briefly remind us of what the 96-week data from the ARCHWAY trial showed?

**Dr. Danzig:**
Absolutely. Many of you have seen this data already. But in the 96-week ARCHWAY trial, those patients were randomized to PDS or monthly ranibizumab. The patients with PDS had a mandatory q24-week refill-exchange, and in the treatment arms, the CST or the center point thickness was stable in both arms, and the vision was non-inferior in the PDS arms to the monthly ranibizumab arm. In terms of safety, the PDS arm had a 6% vitreous hemorrhage and a 1.6% endophthalmitis. Now, even in the ranibizumab arm, there was a case of endophthalmitis, and there was some vitreous hemorrhage noted, but I do believe that as the surgical technique has been refined, we will further see decreased rates of adverse events.

Now, Arshad, my question for you is, you were part of this trial. Now you're using it in the real world. What type of patient are you looking at using PDS for, and in the real world, when are you planning on seeing them back? What's the follow-up going to be?

**Dr. Khanani:**
Thanks, Carl. Great summary of the data, and I think my experience in phase 2 Ladder, as well as ARCHWAY, has been very positive, where patients are very pleased with the port delivery system. And since the FDA approval, I have actually implanted many of these in patients without any serious adverse events.

So when I'm using these technologies in patients who are high need, getting injections every 4 to 8 weeks, and they get injection fatigue and they really cannot come in for their visits, I think port delivery system is not a first-line treatment, but it's a very good treatment for a subset of patients who are high need. So we can really decrease their treatment burden with the port delivery system. One of the patients that comes to mind is a 74-year-old male that I've treated with bilateral neovascular AMD, and patient received 51 injections prior to getting the port delivery system. And they received the surgery earlier this year and have done really, really well. And we just saw them last week for their refill-exchange procedure 6.5 months from the surgery, and patient is doing really well in terms of visual acuity as well as anatomy and has not seen any or haven't had any adverse events from the PDS procedure.

**Dr. Danzig:**
Thank you. Well, this has been a fascinating discussion. Before we go, Arshad, what's your one take-home message for our listeners today, perhaps in terms of PDS?

**Dr. Khanani:**
Being involved in the PDS trial and having used PDS in a commercial setting, I think it provides a really good option for patients who are high need, and for your subset of patients that need frequent injections, PDS is a great option as long as patients understand the risk and benefits. And for surgeons out there who have not tried it, I would highly recommend getting the training and really offer this option for your patients with neovascular AMD.

**Dr. Danzig:**
And I'll add, with these novel molecules available, we now have a molecule, with faricimab, that appears to be safe. We saw that in the TRUCKEE study, though the data is early, and we're hopeful that it's durable. I think this is a great option for our hard-to-treat, high-need

patients, along with treatment-naïve patients, as well.

Well, that's all the time we have today. Thank you, Arshad, for joining me. It was a real pleasure speaking with you today.

**Dr. Khanani:**
Thanks, Carl. It's my pleasure.

**Announcer:**
You have been listening to CME on ReachMD. This activity is provided by **Prova Education**.

To receive your free CME credit, or to download this activity, go to ReachMD.com/Prova. Thank you for listening.