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### N&WICS - TA460 - Dexamethasone intravitreal implant - Non-infectious Uveitis

Before providing patient identifiable data on this form, please confirm that the patient (or in the case of a minor or vulnerable adult with the parent/legal guardian/carer) has given appropriate explicit consent for sensitive personal information on this form to be passed to the CCG and/or CSU for processing this funding request and validating subsequent invoices. Consent given: ☐

If there is more than one NICE-approved treatment available, a discussion between the responsible clinician and the patient has taken place about the advantages and disadvantages of the treatments available. This has taken into consideration therapeutic need and whether or not the patient is likely to adhere to treatment. The most appropriate, least expensive, will be chosen (taking into account administration costs, dosage and price per dose) unless an order of preference is stated in the TAs. ☐

<b>Patient NHS No:</b>	<b>Trust:</b>	<b>Practice Name:</b>
<b>Patient Hospital No:</b> <input type="text"/>	<b>Consultant Making Request:</b> <input type="text"/>	<b>Practice Postcode:</b>
<b>Patient's Initials and DoB:</b>		<b>Practice Code:</b>
<b>Notification Email Address:</b> <input type="text"/> (@NHS.net account ONLY)		<b>Contact name &amp; number:</b> <input type="text"/>
<b>Start date of requested treatment:</b> <input type="text"/>	<b>Provider:</b> <input type="checkbox"/> Private <input type="checkbox"/> NHS <b>Supplier:</b> <input type="checkbox"/> Homecare <input type="checkbox"/> Hospital	<b>Sub-Type:</b> <input type="text"/> N/A <input type="button" value="v"/> (if applicable)

By completing this form, you confirm that you intend to use the requested medicinal product described below as agreed in the local commissioning statement. Any requests which fall outside of this use will require an individual funding request (IFR).

For support regarding IFRs, please contact: [norfolkicd@nhs.net](mailto:norfolkicd@nhs.net)

For support regarding the criteria listed below, please contact: [norfolknontariff@nhs.net](mailto:norfolknontariff@nhs.net)

Please indicate whether patient meets the following NICE criteria:	Please tick
1. Adalimumab is recommended as an option for treating non-infectious uveitis in the posterior segment of the eye in adults with inadequate response to corticosteroids, only if there is: <ul style="list-style-type: none"> <li>• active disease (that is, current inflammation in the eye) and</li> <li>• inadequate response or intolerance to immunosuppressants and</li> <li>• systemic disease or both eyes are affected (or 1 eye is affected if the second eye has poor visual acuity) and</li> <li>• worsening vision with a high risk of blindness (for example, risk of blindness that is similar to that seen in people with macular oedema).</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Stop adalimumab for non-infectious uveitis in the posterior segment of the eye in adults with inadequate response to corticosteroids if there is 1 of the following: <ul style="list-style-type: none"> <li>• new active inflammatory chorioretinal or inflammatory retinal vascular lesions, or both or</li> <li>• a 2-step increase in vitreous haze or anterior chamber cell grade or</li> <li>• worsening of best corrected visual acuity by 3 or more lines or 15 letters.</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Dexamethasone intravitreal implant is recommended as an option for treating non-infectious uveitis in the posterior segment of the eye in adults, only if there is: <ul style="list-style-type: none"> <li>• active disease (that is, current inflammation in the eye) and</li> <li>• worsening vision with a risk of blindness.</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. As per NICE guidance, treatment should normally be started with the least expensive drug (considering the dose required, price per dose and any additional administration costs).	<input type="checkbox"/> Yes <input type="checkbox"/> No

**I confirm that the patient meets the criteria for treatment**

Name of person completing:

Contact Details:

Designation of person completing:

Date:

Trust Authorising Pharmacist

Name:

Date: