VYZULTA. (latanoprostene bunod ophthalmic solution), 0.024%

Choosing the Right Treatment for the Right Patient

Shan Lin, Quang Nguyen, Gagan Sawhney, and Janet Serle share their experiences with VYZULTA® so far – including profiles of patients who have seen the best results

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VYZULTA® (latanoprostene bunod ophthalmic solution) 0.024% is indicated for the reduction of intraocular pressure in patients with open-angle glaucoma or ocular hypertension.

What types of patients may benefit from VYZULTA?

Gagan Sawhney: I use VYZULTA for a number of types of glaucoma because it is approved for both normal and high pressure. Though I have had success across the entire disease spectrum, I see the best results in patients previously on one or no medications.

Janet Serle: Unlike many other topical IOP-reducing products, VYZULTA is only administered once a day. Based on its well-documented efficacy, this drug is an excellent treatment option in patients with ocular hypertension, or early to moderate glaucoma. I would certainly consider trying VYZULTA in patients who are inadequately controlled following selective laser trabeculoplasty (SLT) and who need medical therapy.

Why might VYZULTA be a good option before adding medications?

Gagan Sawhney: Like all physicians, I have patients who are on medication and still not reaching their target pressure. If I want to get their pressure lower, I will put them on VYZULTA instead because I do believe that latanoprost combined with nitric oxide – a key component of VYZULTA – really helps reduce IOP.

What are your goals for treating newly-diagnosed patients?

Shan Lin: We often see patients who have already been treated by others and referred for further therapy, usually surgery, as well as newly-diagnosed patients. Like most doctors, I try to treat them with more conservative therapy first, such as glaucoma medications or laser trabeculoplasty. However, the majority of patients will choose to start off with a drop, as they deem laser to be a more invasive therapy.

The choice is primarily on the patient's part, though some physicians also favor medication therapy as they can be started straight away, getting the patient's pressure down more rapidly. Newer medications provide an alternative to laser for lowering IOP, in particular the prostaglandin class. VYZULTA, for example, has documented pressure lowering of over 30 percent (1).

Gagan Sawhney: Studies have shown that early aggressive treatment can help prevent visual field loss (2). In newly-diagnosed patients, I want to get a 30–40 percent IOP reduction – ideally achieve a pressure below 17 – and, with VYZULTA, we can achieve that; we get up to a 9-point reduction on average. What's exciting is that the APOLLO and LUNAR studies found that 60.5 percent of patients at three months achieved an IOP reduction of 35 percent or more (3), and that at least 30 percent of patients across all timepoints achieved an IOP reduction from baseline of 25 percent or more (4,5) – and that's what I am typically seeing in my clinic, too.

"Based on its well-documented efficacy, this drug is an excellent treatment option in patients with ocular hypertension, or early to moderate glaucoma."

Do you think that doctors should consider VYZULTA for patients with IOP in the normal range?

Janet Serle: The effect of VYZULTA in normal-tension or low-tension glaucoma patients with IOP essentially in the normal range was evaluated in a 1-year study of safety and efficacy in Japanese patients (6). The JUPITER study enrolled 130 patients with baseline IOPs ranging from 15–36 mmHg, and with a mean baseline IOP of 19.6 mmHg; approximately 75 percent of patients had a baseline IOP within 15–30 mmHg. Ninety-three percent of patients completed one year of dosing, and reductions in IOP were stable throughout the year, ranging from 22 to 26 percent. The JUPITER study clearly demonstrated that VYZULTA was effective, and showed its stability in reducing IOP. VYZULTA is well tolerated and certainly effective in patients with normal-tension glaucoma, and should be considered as a treatment option for patients with IOP in the normal range.

There are many therapies and surgical interventions that can lower IOP; does the method matter?

Shan Lin: I think I'm like most ophthalmologists in that I would like to avoid invasive penetrating glaucoma surgeries where possible. These days, surgical interventions tend to be interpreted as anything from minimally invasive procedures like laser trabeculoplasty to highly invasive trabeculectomies. I try to avoid going to the operating room and creating any potential situation where there may be risk of infection or severe bleeding because, for the glaucoma patient, doing a surgical procedure does not improve their vision. My colleagues and I would definitely prefer to have agents that can effectively lower IOP to a point that helps prevent further loss of vision, while being convenient for patients. In terms of the clinical use and side effect profile, it is incredibly useful to have a single agent that can lower the IOP in a single daily dose with a low side-effect profile. Such convenience is very beneficial in terms of compliance for some patients.

Quang Nguyen: A good conversation with a patient is key. Some patients are prepared for the method to be more aggressive – the clinician has to get a feel for how the patient might react to different treatments and choose a game plan that is comfortable for both the patient and the doctor. Generally, the goal should be to bring the IOP as low as possible with one wisely chosen therapy, before escalating to other treatments. Adding medication to an existing therapy brings a host of challenges with it – and, in my practice, we have moved away from the "stockpile mentality." Early in my career, we would choose a medication, then think about a laser procedure, and then add additional medications. But this attitude has now changed. For me, the maximum therapy tolerated by patients in the last decade has been two bottles/three medications, such as a prostaglandin analog and a fixed combination. If there is still progression, I make the decision to move to a laser procedure or surgery.

Gagan Sawhney: We're living in a "glaucoma renaissance," where we have multiple treatment options when it comes to reducing the IOP. We're not performing as many trabeculectomies or as much invasive surgery as we used to. We are now seeing a more stepwise approach, where we start off with medications before turning to minimally invasive surgery. If that fails, we move on to more invasive surgery. Fortunately, we're often able to control the pressure before we get to that final step. Typically, I like to start patients off with a prostaglandin with proven efficacy, like VYZULTA, which allows me to focus on two different pathways in a single medication. It is a great way to initiate treatment for glaucoma.

Why should your peers consider treating glaucoma with VYZULTA?

Shan Lin: In clinical trials, VYZULTA lowers pressure by approximately 32 percent (1,4,5). When you have a once-a-day drug that has a favorable side effect profile similar to that of prostaglandins for the reduction of IOP, you have a very strong first-line drug.

Janet Serle: Medications have a range of efficacy and tolerability in patients. In the case of VYZULTA, we know from clinical trials – and from anecdotal reported

experience – that in the majority of patients this drug is effective at lowering the IOP, and it is well tolerated. And that's why – if you haven't used VYZULTA yet – I suggest you begin to prescribe it to patients with early glaucoma or hypertension, as well as patients with moderate and advanced, and low-tension glaucoma – those patients in your practice who need additional IOP control. It is a great medication for those who may have low compliance with more than one daily drop.

Gagan Sawhney: Collectively, we need to do a better job of treating glaucoma. We're still getting visual field loss, and we're still seeing progression of glaucoma that we are missing. When we initiate treatment, we need to make sure we get the most out of it, which is why I choose VYZULTA. By targeting diseased tissue in the trabecular meshwork, in addition to the uveoscleral pathway, it can get up to a 9-point reduction as demonstrated in clinical trials. It also offers convenient once-a-day dosing, low incidence of ocular adverse events, and minimal systemic adverse events – and it is increasingly easy to prescribe. Our practice partners with a local specialty pharmacy who works with the patient and insurance company on our behalf to get the patient VYZULTA as prescribed. They even mail the medication directly to patients.

Quang Nguyen: It's a medication that can achieve an IOP of less than 18 in 69 percent of patients (7), and most patients tolerated it well in clinical trials (4–7)... I guess the question should be: Why wouldn't you treat your appropriate glaucoma patients with VYZULTA?

Shan Lin, Quang Nguyan, Gagan Sawhney and Janet Serle are consultants of Bausch + Lomb.

Find out more: https://www.vyzultahcp.com/

References

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IMPORTANT SAFETY INFORMATION

- Increased pigmentation of the iris and periorbital tissue (eyelid) can occur. Iris pigmentation is likely to be permanent
- Gradual changes to eyelashes, including increased length, increased thickness, and number of eyelashes, may occur. These changes are usually reversible upon treatment discontinuation
- Use with caution in patients with a history of intraocular inflammation (iritis/uveitis). VYZULTA should generally not be used in patients with active intraocular inflammation
- Macular edema, including cystoid macular edema, has been reported during treatment with prostaglandin analogs. Use with caution in aphakic patients, in pseudophakic patients with a torn posterior lens capsule, or in patients with known risk factors for macular edema
- There have been reports of bacterial keratitis associated with the use of multiple-dose containers of topical ophthalmic products that were inadvertently contaminated by patients
- Contact lenses should be removed prior to the administration of VYZULTA and may be reinserted 15 minutes after administration
- Most common ocular adverse reactions with incidence ≥2% are conjunctival hyperemia (6%), eye irritation (4%), eye pain (3%), and instillation site pain (2%)

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