North Central London
Joint Formulary Committee

Glaucoma Prescribing Guideline

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Document control

Date	Version	Amendments
Oct 2013	1.0	New guideline
Oct 2014	1.1	Update
Oct 2015	1.2	Update
Jun 2017	1.3	Minor amendment (advice regarding treatment period of apraclonidine 0.5%)
Jan 2018	2.0	Update – carteolol 1% and 2% removed

Document management

Groups / Individuals who have overseen the development of this guidance:	Emilia Lamberti – MEH Formulary Pharmacist
Groups which were consulted and have given approval:	NCL JFC
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Glaucoma Service Prescribing Guidelines For Open Angle Glaucoma And Ocular Hypertension

Moorfields Eye Hospital NHS
NHS Foundation Trust

Before offering medication any relevant comorbidities or potential drug interactions need to be checked carefully. A single drug should be started and its effectiveness at lowering eye pressure and any side effects should be assessed usually upon follow-up. If there is no IOP response and the patient has been compliant to treatment, the drug should be stopped and another tried from a different class. If there is a satisfactory IOP drop but insufficient to meet the target pressure then a second drug may be added. Medical therapy of more than three topical agents-one separate and one combination should trigger consideration for either laser or surgery. Maximal medical treatment would consist of all 4 classes of topical pressure lowering medication and possible oral acetazolamide

The Guidelines should be adhered to for all new patients. No change in treatment plan is recommended for patient already on different medications when there is satisfactory IOP response. Non-responders should be switched to a different class of drug.

Drug		With Preservative	Preservative Free Restricted to patients with true preservative allergy and/or evidence of epithelial toxicity from preservatives and/or severe dry eyes
prostaglandin analogues	**1st Line**	1st latanoprost 0.005% eye drops 2nd travoprost 0.004% eye drops 3rd bimatoprost 0.01% eye drops	1st latanoprost 0.005% single use eye drop 2nd bimatoprost 0.03% single use eye drop
ß-blockers	**2nd Line**	1st timolol 0.25% eye drops 2nd timolol 0.25% eye gel (long acting)	1st timolol 0.1% eye gel
carbonic anhydrase inhibitor	**3rd Line**	1st brinzolamide 1% eye drops 2nd dorzolamide 2% eye drops	1st dorzolamide 2% single use eye drop
alpha-adrenergic agonist	**4th Line**	1st brimonidine 0.2% eye drops	

1st LINE: prostaglandin analogues
Safer than ß-Blockers and probably more effective at lowering IOP

2nd LINE: ß-blockers
Used as first line for unilateral glaucoma patients or for cosmetic reasons. Not to be prescribed if there is history of bronchospasm and stopped immediately if patient develops wheezing or other ß-blocker related side effects

STEP 1

USE prostaglandin analogue **PLUS** ß-blockers

STEP 2

When prostaglandin and beta-blocker is insufficient to achieve the desired target IOP.
ADD carbonic anhydrase inhibitor
OR alpha-adrenergic agonist

STEP 3

Combination Therapies TO BE USED WHEN COMPLIANCE/ COST ISSUES ARISE.

Choice needs to be made according to patient's concurrent and/or previous therapy:
Latanoprost/Timolol, Bimatoprost/Timolol, Travoprost/Timolol, Dorzolamide/Timolol, Brinzolamide/Timolol, Brimonidine/Timolol, Dorzolamide/Timolol P.F, Bimatoprost/Timolol P.F, Brinzolamide/Brimonidine

Other glaucoma drugs on Moorfields Eye Hospital Formulary

FOR RESTRICTED USE ONLY.
Pilocarpine various strengths, Betaxolol 0.25% MR, Betaxolol 0.25% MR PF UD, Levobunolol 0.5%, Levobunolol 0.5% PF UD, Timolol 0.25% multidose PF (unlicensed), Timolol 0.5% (long acting), Tafluprost UD*
*Existing patients only.

ADD Apraclonidine 0.5% Eye Drop *used short term to delay laser treatment or surgery in patients with glaucoma not adequately controlled by another drug however, some patients may benefit from treatment with Apraclonidine 0.5% for longer periods*

Adjunct Therapy Oral Acetazolamide

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