

SUSTAINED DRUG DELIVERY IN PRACTICE



Pointers for navigating patient education, practice considerations, insurance coverage, and more.

BY SAVAK TEYMOORIAN, MD, MBA

1. GT: In your experience, which patients are the ideal candidates for the implantation of a bimatoprost intracameral implant (Durysta, Allergan)?

Savak Teymoorian, MD, MBA (S.T.): I consider several types of patients to be candidates for a bimatoprost implant. These individuals typically present with complaints about their eye drops, primarily related to one (or more) of the following factors: cost, side effects, and problems with adherence such as missed doses and improper administration. If physicians are open to hearing about their patients' challenges with drops and invite patients to discuss them, they will likely find that most patients struggle to use the agents as prescribed. To me, this translates to candidacy for a sustained drug delivery option.

The patients whom I consider to be the low-hanging fruit for a bimatoprost implant—the ones who are the most receptive to this treatment option and do best with it clinically—are those who are pseudo-phakic, use one or two IOP-lowering medications, and have the appropriate insurance coverage. For physicians who have not yet adopted the bimatoprost implant, these are the patients I recommend starting with.

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2. GT: At what point in the education process do you present the option of a bimatoprost implant to patients?

S.T.: I usually present the option of a bimatoprost implant after a patient gains experience using a drop. If 10 patients were asked about their challenges with drops, nine of them would reference cost and/or difficulty remembering to administer them or administering them properly. It does not take much time or multiple medications even for patients to experience the challenges associated with this treatment modality. We have long known that medication nonadherence is a significant issue, but we lacked a pharmacology-based solution. Now that we have one available, we must listen to the issues patients are having.

It is more difficult to propose an injection versus an eye drop as an initial treatment option. Therefore, I typically start patients on a drop, have them come back in, and ask them about their experience in order to give them the opportunity to discuss any challenges or frustrations. If they mention one or more of the chief complaints, I mention that there is a different way to administer the medication that might be a better solution for them. We took what is perceived as the more conservative route first, and from there patients are usually open to trying another approach.

3. GT: How do you manage conversations surrounding insurance coverage?

S.T.: Each practice's patient demographics differ in terms of economic

status and insurance coverage. In my setting, patients primarily have a Medicare plan with supplemental coverage. I have found that the bimatoprost implant is covered for these patients. For patients with Medicare and supplemental coverage, I have been reimbursed for all implantations of this device. Physicians with different primary patient bases, such as those with commercial insurance or health maintenance organization plans, may have to take different steps for coverage, but there are workarounds.

For my patients, insurance coverage is noted in their chart. When reviewing each case, I think intervisionally and ask myself: (1) Why is this patient on a drop? (2) Can we take a different approach? and (3) What can I offer to this patient? I look at their insurance status. If they have Medicare, a bimatoprost implant is an option.

A lot of patients are concerned about the cost of their eye drops. Most do not care that the use of a bimatoprost implant requires an injection. A lot of times, patients do not wait for me to explain the science behind it. Many have friends and family members with macular degeneration who regularly receive ocular injections, so they are familiar with the concept. I recently had a patient ask to come in every month for a bimatoprost implant. This tells me that barriers to adoption of this sustained drug delivery option may be more on the physician side than the patient side.

4. GT: Do you find that patients who received a bimatoprost implant are open to future treatment?

S.T.: Colleagues often say to me, “Glaucoma is a chronic disease, and the bimatoprost implant is a one-time treatment. How do you wrap your brain around the indication?” I consider the bimatoprost implant to be a gateway to other interventional glaucoma solutions. Philosophically, we are thinking about glaucoma more intervisionally, with an emphasis on laser

treatment, MIGS, and sustained drug delivery. But if you call 100 glaucoma patients and ask how their glaucoma is treated, 99 of them will say with eye drops. I find that patients who receive a bimatoprost implant and experience either a full drop holiday or at least a reduction in their medication burden ask, “Can we do something else?” when the effect of treatment wears off.

I have many patients who were on one topical medication, usually a prostaglandin analogue, that was replaced with a bimatoprost implant. I then became more aggressive about patient selection and began offering the implant to patients who were also on adjunctive drops beyond the primary prostaglandin analogue. I told them to stop using both of their drops and see how they did with the bimatoprost implant. I found that 75% of these patients met their IOP goal with just the bimatoprost implant. This highlighted the true impact of drop noncompliance. The 25% of patients whose pressures decreased but not to target were outspoken about not wanting to resume drop therapy when discussing the need for an additional treatment.

As we think more intervisionally about glaucoma, we want our patients to do the same. If the indication for the bimatoprost implant ultimately changes, great; if not, I find that its use helps my patients to remain receptive to alternative interventional approaches.

5. GT: What type of learning curve can ophthalmologists generally expect for implantation of the device?

S.T.: Ophthalmologists who perform cataract surgery or glaucoma surgery will likely find the learning curve to be short. The first five to 10 cases give the user a feel for implantation. After about 10 to 20 cases, the technique should feel comfortable and, after about 20 to 100 cases, should be optimized. At that point, it is all about enhancing the patient experience. The more efficient the process is, the less

likely the patient is to realize that they are getting the injection—that is when it gets good.

6. GT: What are some practice-based considerations that ophthalmologists may need to take into account before adopting the bimatoprost implant?

S.T.: The key consideration is whether the procedure will be performed at the slit lamp in their office or at the surgery center. Each setting presents unique considerations. I have found it easier to perform the procedure in a surgery center because I think the patient experience is better in this setting. The environment is completely sterile, and I can move patients in and out of the rooms quickly, which makes the process easier. For some physicians, taking patients to the surgery center is more difficult. Regardless of the setting, it is important to have easy access to everything needed for the procedure, ensure that the patient’s eyes are numb, and have staff well trained on the approach. Over time, the setup and workflow become more efficient, and the patient experience improves as a result.

Retina specialists regularly administer injections in the office. When I first started using the bimatoprost implant, I considered what my retina colleagues were doing and what I could learn from their approach. I figured that, if they can maintain efficiency with how many injections they perform, they must have pearls. Ophthalmologists in a practice with a retina service that offers injections or in a setting where any injections are administered may find the implementation of the bimatoprost implant to be streamlined. ■

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