



**CALL FOR STAKEHOLDER COMMENTS ON THE PRELIMINARY  
RECOMMENDATION OF THE HEALTH TECHNOLOGY ASSESSMENT (HTA)  
COUNCIL ON AFLIBERCEPT, RANIBIZUMAB, AND DEXAMETHASONE IMPLANT  
FOR THE TREATMENT OF RETINAL DISEASES**

*Published as of 27 January 2026*

As of 27 January 2026, the HTA Council has completed the evidence appraisal on the assessment of the following drugs for their respective indications, for possible government financing:

- first-line treatment of **Diabetic Macular Edema (DME)**
  - **Aflibercept** [40mg/mL solution for intravitreal injection]
  - **Ranibizumab** [10 mg/mL solution for intravitreal injection]
  - **Dexamethasone implant** [700 mcg intravitreal implant]
- first-line treatment of **Macular Edema secondary to Retinal Vein Occlusion (ME-RVO)**
  - Aflibercept [40mg/mL solution for intravitreal injection]
  - Ranibizumab [10 mg/mL solution for intravitreal injection]
  - Dexamethasone [700 mcg intravitreal implant]
- first-line treatment of **wet Age-Related Macular Degeneration (wAMD)**
  - Aflibercept [40mg/mL solution for intravitreal injection]
  - Ranibizumab [10 mg/mL solution for intravitreal injection]

The HTA Council hereby releases its **preliminary recommendation** on the said health technologies **for stakeholder feedback and comments from 27 January to 10 February 2026.**

The population, interventions, and comparators set by the HTA Council for the said evaluation are shown in the table below, for your reference:

<b>Population</b>	<p><b>DME:</b> Centrally-involving diabetic macular edema</p> <p><b>ME-RVO:</b> Macular edema secondary to retinal vein occlusion (regardless if central or branched)</p> <p><b>wAMD:</b> Wet or neovascular age-related macular degeneration</p>
<b>Intervention/Comparator</b>	<p><b>DME and ME-RVO:</b> Ranibizumab vs. Aflibercept vs. Dexamethasone implant as first-line</p> <p><b>wAMD:</b> Ranibizumab vs. Aflibercept as first-line</p>

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These health technologies were reviewed against requirements for marketing authorization of the Philippine Food and Drug Administration (FDA), existing recommendations by the World Health Organization (WHO), clinical practice guidelines (CPGs) *[developed by relevant local medical societies; and/or international CPGs adopted by the relevant local medical society]*. Further, a costing analysis of the use of the health technologies was performed.

As a preliminary recommendation, **the HTA Council recommends the following for government financing:**

- **Aflibercept [40mg/mL solution for intravitreal injection]** as first-line treatment of DME, ME-RVO and wAMD;
- **Dexamethasone [700 mcg intravitreal implant]** as alternative treatment for DME and ME-RVO for patients contraindicated or non-responsive to anti-vascular endothelial growth factor (VEGF) drugs; and
- **Ranibizumab [10 mg/mL solution for intravitreal injection]** as first-line treatment of DME, ME-RVO and wAMD.

This recommendation considers the role of anti-VEGF drugs as first-line therapy for DME, ME-RVO, and wAMD based on consultation with the relevant local medical society, current local and international CPGs, and the overall cost implications of using the treatment options. The recommendations on these health technologies and their indication/s are aligned with current local **standards of care for first-line therapy** and the **alternative treatment for those contraindicated or non-responsive to first-line anti-VEGF drugs.**

Overall, current guidelines on DME indicate that anti-VEGF drugs (i.e., Aflibercept and Ranibizumab) are the first-line treatment for center-involved DME with vision loss, while corticosteroids (i.e., Dexamethasone implant) are reserved for patients with suboptimal response to anti-VEGFs or with chronic disease. Similarly for ME-RVO, anti-VEGF drugs (i.e., Aflibercept and Ranibizumab) are the first-line treatment of choice, while intravitreal corticosteroids (i.e., Dexamethasone implant) should be considered when patients have a failure to respond or have an inadequate response to anti-VEGF. For wAMD, Aflibercept and Ranibizumab are the preferred first-line treatment, with intravitreal anti-VEGF therapy considered the most effective approach.

All treatments, however, incur significant costs. Hence, the DOH should strongly consider conducting price negotiation to ensure affordability and sustainable access to these treatments. Notably, considering the maximum number of injections required for each drug in patients with DME, Aflibercept shows considerably lower cost compared to Ranibizumab among the anti-VEGF drugs, whereas Dexamethasone implant shows the lowest cost overall for this indication. Meanwhile, assuming the use of the maximum number of injections for patients with ME-RVO, and comparing the anti-VEGF drugs, Aflibercept incurs lower costs than Ranibizumab, whereas Dexamethasone implant incurs the least cost overall. For wAMD, assuming the same number of injections, Aflibercept shows higher total annual treatment costs per patient and annual treatment cost for all patients compared to Ranibizumab.

This HTA Council Core Committee and Subcommittee preliminary recommendation is based on the following evidence:

### **Disease Magnitude and Severity**

- **Diabetic Macular Edema (DME)**

Globally, an estimated 5% (29.4 million) of the 588.7 million individuals with diabetes mellitus are affected by DME ([International Diabetes Federation, 2025](#)). Furthermore, a systematic review and meta-analysis (SR-MA) by [Im et al. \(2022\)](#) reported a DME prevalence of 5.47%. Based on calculations supported by the Vitreo-Retina Society of the Philippines (VRSP), using the prevalence by Im et al. (2022), approximately 258,528 of the 4,726,300 adult Filipinos with diabetes are estimated to have DME.

- **Macular Edema secondary to Retinal Vein Occlusion (ME-RVO)**

According to a SR-MA by [Wu, et al. in 2024](#), the global prevalence of central retinal vein occlusion (CRVO) is 0.80 per 1,000 persons, while branch retinal vein occlusion (BRVO) is 4.4 per 1,000 persons. Applying this prevalence, the VRSP estimated 166,920 patients with RVO in the Philippines.

- **Wet Age-Related Macular Degeneration (wAMD)**

Globally, AMD is the third most common cause of loss in eyesight with 170 million being affected ([Xu, et al., 2020](#)). wAMD is the less common form which comprises only 10-15% of AMD patients but accounts for more than 80% of severe visual loss or legal blindness (i.e., visual acuity of 20/200 or worse) in AMD patients ([Jager, et al., 2008](#)). Locally, using prevalence from Asian studies ([Angiogenesis Foundation, 2013](#); [Kawasaki, 2010](#)), the VRSP estimated 272,850 patients with wAMD in the Philippines.

### **Review of Clinical Practice Guidelines Certifying the Health Technologies as Standard of Care**

- **DME**

- In the Philippines, intravitreal injections and implants are neither listed nor mentioned in DOH Omnibus Health Guidelines, and there are no DOH-approved CPGs specifically addressing DME. Nonetheless, the [Diabetic Retinopathy \(DR\) Preferred Practice Patterns \(PPP\) Philippines, 2016](#) identifies anti-VEGF drugs (i.e., **Aflibercept and Ranibizumab**) as the preferred treatment for DME while **Dexamethasone implant** is an option or a possible agent.
- As to the [WHO Essential Medicines List \(EML\)](#), Aflibercept is not included in the list. Meanwhile, Ranibizumab's application for inclusion for DME was rejected in 2015. Dexamethasone, on the other hand, is listed in the [WHO EML](#) but for different dosage forms and routes of administration (i.e., *oral and parenteral*), and indications (i.e., *for 1] respiratory distress syndrome of the newborn, altered by maternal corticosteroid therapy, 2] plasma cell myeloma, 3] Lymphoid leukemia, 4] Burkitt lymphoma, 5]*

*Anaplastic large cell lymphoma, 6] Allergic or hypersensitivity conditions of unspecified type, 7] palliative care, and 8] nausea and vomiting).*

- The [American Academy of Ophthalmology \(AAO\) Preferred Practice Pattern \(PPP\) for Diabetic Retinopathy \(2024\)](#) which serves as the locally adopted CPG of VRSP, notes that anti-VEGF agents are effective in the treatment of center-involved diabetic macular edema (CI-DME) with vision loss, while corticosteroids (e.g., **Dexamethasone implant**) are generally used as second-line treatment and may be recommended for patients with suboptimal response or no response to anti-VEGF therapy especially for those with chronic macular edema.
    - Anti-VEGF agents showed sustainable improved vision and reduced the risk of further vision loss ([AAO DR PPP 2024](#) citing [RISE and RIDE trial](#); [VIVID and VISTA study](#)).
    - Dexamethasone may improve visual and anatomic outcomes among DME patients with suboptimal response or no response to anti-VEGF therapy ([AAO DR PPP, 2024](#))
  - **Aflibercept** is preferred for patients with a baseline visual acuity of more than or equal to 20/50, as it demonstrates greater visual acuity gain, particularly after one year of treatment. It also allows for longer treatment intervals, administered every 8 weeks after loading phase ([Diabetic Retinopathy Clinical Research Network \(DRCR.net\) Protocol T-1 Year, 2015](#); [European Society of Retina Specialists \[EURETINA\] Guidelines for the Management of Diabetic Macular Edema, 2017](#)).
  - **Ranibizumab** is preferred for patients with baseline visual acuity of 20/40 or better, as well as for those with a history of recent stroke or myocardial infarction since it has better systemic safety profile, specifically shorter systemic half life and minimal systemic VEGF suppression ([DRCR.net Protocol T-1 Year, 2015](#); [EURETINA Guidelines for the Management of Diabetic Macular Edema 2017](#); [Kim et al., 2020](#); [Kaiser, et al., 2019](#)).
  - **Dexamethasone implant** is preferred in patients who are contraindicated for anti-VEGF agents, those with long-standing or chronic inflammatory DME, and in cases of poor compliance or limited access, as it provides 3-4 months effect and reduces the burden of frequent clinic visits ([DRCR.net Protocol T-1 Year, 2015](#); [EURETINA Guidelines for the Management of Diabetic Macular Edema 2017](#)).
- **ME-RVO**
    - Locally, intravitreal injections and implants are not listed or mentioned in DOH Omnibus Health Guidelines, and there are no DOH-approved CPGs on ME-RVO. Meanwhile, according to the 2016 [Retinal Vein Occlusion Preferred Practice Pattern Philippines](#), anti-VEGF drugs (i.e., **Aflibercept and Ranibizumab**) are the preferred treatment for ME-RVO while **Dexamethasone implant** is an option or a possible agent.
    - As to the [WHO Essential Medicines List \(EML\)](#), **Aflibercept** is not included in the list. Meanwhile, the application of **Ranibizumab** for [ME-RVO](#) was rejected in 2015. **Dexamethasone**, on the other hand, is

listed in the WHO EML as an essential medicine, but as different dosage forms and routes of administration, and for different indications as mentioned in the previous section.

- According to the American Academy of Ophthalmology (AAO) [Retinal Vein Occlusions Preferred Practice Pattern](#) [Age-Related Macular Degeneration Preferred Practice Pattern, 2024](#), a locally adopted CPG of VRSP, **anti-VEGF drugs (i.e., Aflibercept and Ranibizumab)** are the first-line treatment for macular edema associated with RVO (ME-RVO). Further, AAO ([Retinal Vein Occlusions Preferred Practice Pattern, 2024](#)) recommends that **intravitreal corticosteroids like Dexamethasone implant** should be considered when patients have a failure to respond or have an inadequate response to anti-VEGF.
    - Studies have demonstrated that anti-VEGF injections improve efficacy in terms of visual acuity in the treatment of ME-RVO, with minimal adverse effects ([AAO RVO PPP, 2024](#) citing [Regnier et al 2015](#) and [Shalchi et al., 2020](#); [Song et al., 2015](#) and [HORIZON Trial](#); [VIBRANT Trial](#)).
    - Dexamethasone significantly improves visual acuity on DME and ME-RVO patients but with increased risk of ocular side effects such as secondary glaucoma and cataract formation ([AAO RVO PPP, 2024](#) citing [GENEVA study](#); [COBALT study](#), and [AAO DR PPP, 2024](#) citing [MEAD trial](#))
  - **Aflibercept** is preferred in clinical scenarios requiring longer treatment intervals, or in patients with higher disease burden, treatment resistant edema, or ischemic retinal vein occlusion with high VEGF drive, due to its broader binding spectrum (VEGF-A; VEGF-B, PlGF) ([Copernicus/Galileo Trial, 2017](#); [EURETINA Guideline 2019](#); [AAO PPP for Retinal Vein Occlusion 2024](#); [Papadopoulos, 2012](#)).
  - **Ranibizumab** is preferred for patients in whom systemic exposure is a major concern, such as elderly patients or those with a history of cardiovascular disease ([Kaiser et al., 2019](#); [Avery et al., 2017](#)).
  - **Dexamethasone implant** may be preferred in patients with contraindications to anti-VEGF therapy such as recent stroke or myocardial infarction; in those with chronic or long standing inflammatory macular edema; or in settings of poor treatment adherence or limited access to care where its longer duration of effect of approximately three to four months can reduce visit and injection burden ([EURETINA Guideline 2019](#); [AAO PPP for Retinal Vein Occlusion 2024](#); [Tadayoni et al., 2017](#)).
- **wAMD**
    - Locally, intravitreal injections and implants are not listed or mentioned in DOH Omnibus Health Guidelines, and there are no DOH-approved CPGs on wAMD. However, according to the [Age Related Macular Degeneration \(AMD\) Preferred Practice Patterns \(PPP\) Philippines \(2016\)](#), anti-VEGF

- drugs (i.e., **Aflibercept and Ranibizumab**) are the preferred treatment for wAMD.
- **Aflibercept** is not listed in WHO EML, while **Ranibizumab**'s application for inclusion was rejected in 2015 as the WHO noted that it has similar effectiveness and safety but has higher cost compared to the available treatment for wAMD (i.e., Bevacizumab). WHO also noted that the inclusion of Ranibizumab for the treatment of wAMD might divert relevant resources from other interventions or result in considerable additional expenditure at country level if listed as a pharmaceutical alternative to the currently WHO-listed anti-VEGF drug (i.e., Bevacizumab). However, in the Philippines, Bevacizumab's approved indication does not include wAMD.
  - The [Age-Related Macular Degeneration Preferred Practice Pattern \(2024\)](#) of the American Academy of Ophthalmology, a locally adopted CPG of VRSP, states that intravitreal injection therapy using anti-VEGF agents, which may or may not target other factors such as placental growth factor or angiopoietin-2, are the most effective way to manage wAMD and is the first-line treatment.
    - Anti-VEGF agents have shown to be safe and effective in maintaining visual acuity in patients with wet AMD ([AAO AMD PPP, 2024](#) citing [Bakri et al., 2019](#); [Solomon et al., 2019](#); [VIEW 1 and 2 Trials](#)).
  - **Aflibercept** may be preferred for patients in the maintenance phase of intravitreal anti-VEGF therapy following completion of the loading doses, based on evidence from the VIEW 1 and VIEW 2 trials demonstrating maintained efficacy with dosing every eight weeks ([Heier et al., 2012](#)).
  - **Ranibizumab** is preferred for patients with high cardiovascular risk, based on evidence demonstrating a favorable safety profile in this population ([Kaiser et al., 2019](#); [Avery et al., 2017](#); [Avery et al., 2014](#)).

## Costing Analysis

- **DME**

- The estimated annual treatment cost per patient using the drugs below for this indication are as follows:
  - **Aflibercept (7 to 8 injections)**
    - Unilateral treatment: Php 251,184.08 to Php 287,067.52
    - Bilateral treatment: Php 475,866.30 to Php 543,847.20
  - **Ranibizumab (7 to 9 injections)**
    - Unilateral treatment: Php 238,619.08 to Php 306,795.96
    - Bilateral treatment: Php 450,736.30 to Php 579,518.10
  - **Dexamethasone implant (1 to 2 implants)**
    - Unilateral treatment: Php 39,622.64 to Php 79,245.28
    - Bilateral treatment: Php 75,459.30 to Php 150,918.60
- The estimated annual treatment cost for all patients using the drugs below for this indication are as follows:
  - **Aflibercept**: Php 82 billion to Php 93 billion

- **Ranibizumab:** Php 77 billion to Php 99 billion
    - **Dexamethasone implant:** Php 13 billion to Php 26 billion
  - The total estimated annual treatment cost for DME patients with history of stroke or myocardial infarction using **Dexamethasone implant** is Php 3 billion to Php 6 billion.
  - Overall for DME, the treatment option with the lowest estimated cost is Dexamethasone implant and the highest estimated cost is with Ranibizumab.
- **ME-RVO**
  - The estimated annual treatment cost per patient using the drugs below for this indication are as follows:
    - **Aflibercept (7 injections)**
      - Unilateral treatment: Php 251,184.08
      - Bilateral treatment: Php 475,866.30
    - **Ranibizumab (9 to 11 injections)**
      - Unilateral treatment: Php 306,795.96 to Php 374,972.84
      - Bilateral treatment: Php 579,518.10 to Php 708,299.90
    - **Dexamethasone implant (1 to 2 implants)**
      - Unilateral treatment: Php 39,622.64 to Php 79,245.28
      - Bilateral treatment: Php 75,459.30 to Php 150,918.60
  - The estimated annual treatment cost for all patients using the drugs below for this indication are as follows:
    - **Aflibercept:** Php 45 billion
    - **Ranibizumab:** Php 55 billion to Php 67 billion
    - **Dexamethasone implant:** Php 7 billion to Php 14 billion
  - The total estimated annual treatment cost for ME-RVO patients with history of stroke or myocardial infarction using **Dexamethasone implant** is Php 214 million to Php 429 million.
  - Overall for ME-RVO, the treatment option with the lowest estimated cost is Dexamethasone implant and the highest estimated cost is with Ranibizumab.
- **wAMD**
  - The estimated annual treatment cost per patient using the drugs below for this indication are as follows:
    - **Aflibercept (7 to 8 injections)**
      - Unilateral treatment: Php 251,184.08 to Php 287,067.52
      - Bilateral treatment: Php 475,866.30 to Php 543,847.20
    - **Ranibizumab (7 to 8 injections)**
      - Unilateral treatment: Php 238,619.08 to Php 272,707.52
      - Bilateral treatment: Php 450,736.30 to Php 515,127.20
  - The estimated annual treatment cost for all patients using the drugs below for this indication are as follows:
    - **Aflibercept (7 to 8 injections):** Php 91 billion to Php 104 billion
    - **Ranibizumab (7 to 8 injections):** Php 86 billion to Php 98 billion

- Overall for wAMD, the treatment option with the lowest estimated cost is Ranibizumab and the highest estimated cost is with Aflibercept.

## Other Evidence Considered

- **Review of Guidelines**

Guidelines from Ministries of Health (MOH) and HTA Agencies of eleven (11) countries, representative of different income categories, representative of different income categories [i.e., six (6) high income countries (HIC): United States of America (USA), United Kingdom (UK), Australia, Canada, Singapore, Taiwan; three (3) upper middle income countries (UMIC): Malaysia, Thailand, Indonesia; two (2) lower middle income countries (LMIC): Vietnam, Cambodia] were reviewed.

- **DME**

- **Ranibizumab** is recommended or reimbursed in all six (6) HICs (i.e., USA, UK, Australia, Canada, Singapore, Taiwan), three (3) UMICs (i.e., Malaysia, Thailand, Indonesia), and one (1) LMIC (i.e., Vietnam), while there were no recommendation or evidence of national health insurance coverage found for Cambodia.
- **Aflibercept** is recommended or reimbursed in six (6) HICs (i.e., USA, UK, Australia, Canada, Singapore, Taiwan), while there were no recommendation or evidence of national health insurance coverage found for three (3) UMICs (i.e., Malaysia, Thailand, Indonesia) and two (2) LMICs (i.e., Vietnam, Cambodia).
- **Dexamethasone implant** is recommended or reimbursed in three (3) HICs (i.e., UK, Australia, Taiwan), but not recommended in two (2) HICs (i.e., Canada, Singapore) due to insufficient evidence to demonstrate benefit over other available treatment options (i.e., anti-VEGF injections such as ranibizumab and aflibercept) ([Canadian Agency for Drugs and Technologies in Health \[CADTH\], 2022](#)), and unfavourable clinical and cost-effectiveness compared with current treatment interventions (i.e., anti-VEGF agents such as ranibizumab and bevacizumab) ([Singapore Agency for Care Effectiveness \[ACE\], 2023](#)). There were no recommendation or evidence of national health insurance coverage found for one (1) HIC (i.e., USA), three (3) UMICs (i.e., Malaysia, Thailand, Indonesia), and two (2) LMICs (i.e., Vietnam, Cambodia).

- **ME-RVO**

- **Ranibizumab** is recommended or reimbursed for treatment of ME-RVO in six (6) HICs (i.e. USA, UK, Australia, Canada, Singapore, Taiwan); one (1) UMIC (Malaysia) and one (1) LMIC (Vietnam). Meanwhile, no recommendation or evidence of national health insurance coverage was found for Thailand, Indonesia and Cambodia.



For the supporting evidence reviewed and discussed by the HTA Council Core Committee and Subcommittee in coming up with this preliminary recommendation, please refer to: <https://tinyurl.com/IntravitrealDrugsEvidence>. All comments, inputs, and/or appeals on the above preliminary recommendation may be submitted until **27 January to 10 February 2026**, for the consideration of the HTA Council Core Committee and Subcommittee, through email at [hta@dost.gov.ph](mailto:hta@dost.gov.ph). Please use the prescribed form for appeals indicated on the official HTA Council website [<https://hta.dost.gov.ph/appeals-2/>]. **Appeals not following the prescribed format and those submitted beyond the deadline, shall not be entertained.**

Should you have any questions or concerns regarding the preliminary recommendation, please do not hesitate to contact us through the same email address.

Thank you very much and best regards.

On behalf of the HTA Philippines,

  
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