

This supplement captures highlights from a roundtable discussion that took place on June 20, 2024, at **Optometry's Meeting®** in Nashville, Tennessee.

## PARTICIPANTS



**Marc Bloomenstein, OD**  
Schwartz Laser Eye Center  
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**Nora Lee Cothran, OD**  
The Eye Institute of West  
Florida  
Largo, FL



**James Deom, OD**  
Hazleton, Stroudsburg,  
Pottsville, Nanticoke  
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**Andrew Royer, OD**  
Ophthalmology Associates  
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*Participants of this roundtable are paid consultants of Bausch + Lomb.*

## Introduction

Primary open-angle glaucoma (POAG) is a subtype of glaucoma with an open angle at the junction of the iris and cornea and no other underlying disease present.<sup>1</sup> POAG is a chronic and progressive optic neuropathy characterized by acquired atrophy of the optic nerve head and loss of retinal ganglion cells and their axons, which cannot be explained by other causes.<sup>1</sup> Elevated intraocular pressure (IOP), or ocular hypertension, is a strong risk factor for glaucoma progression and represents the only clinical attribute that can be modified by topical pharmacologic treatment, laser therapy, and/or surgery.<sup>1</sup> Numerous randomized clinical trials have demonstrated the clinical benefit of IOP lowering, either by an absolute amount or as a percentage from baseline.<sup>1</sup>

## INDICATION

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

## IMPORTANT SAFETY INFORMATION

- Increased pigmentation of the iris and periorbital tissue (eyelid) can occur. Iris pigmentation is likely to be permanent

**Please see additional Important Safety Information throughout and full Prescribing Information for VYZULTA [here](#).**



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solution), 0.024%

## Introduction (Continued)

According to practice guidelines from the American Optometric Association, prostaglandin analogs (PGAs) should be considered as an initial therapy in patients with ocular hypertension or POAG unless contraindicated.<sup>1</sup> In fact, PGAs have been found to provide the strongest IOP-lowering among all the topical monotherapy agents.<sup>1</sup> VYZULTA® (latanoprostene bunod ophthalmic solution) 0.024% is a prostaglandin analog indicated for the reduction of IOP in patients with open-angle glaucoma or ocular hypertension.<sup>2</sup> The efficacy and safety of VYZULTA have been evaluated in numerous clinical studies, inclusive of both prospective randomized controlled trials as well as real-world retrospective analyses.<sup>3</sup> Across studies, VYZULTA delivered powerful and sustained IOP reduction with excellent tolerability.<sup>3</sup>

In this roundtable discussion, 4 leading optometrists with expertise in management of open-angle glaucoma and ocular hypertension shared their perspectives on the scientific data in support of VYZULTA. The faculty defined 3 distinct patient types appropriate for IOP lowering using VYZULTA and provided real-world examples of each of these patient types from their own clinical experience:

- Those who **need a powerful first-line IOP-lowering treatment** when beginning their glaucoma journey
- Those who are **not adequately responding to their current PGA treatment**, including latanoprost 0.005%
- Those with **inadequately controlled IOP following selective laser trabeculoplasty (SLT)\***

These patient cases provide real-world reinforcement of the VYZULTA clinical study findings, confirming why monotherapy with VYZULTA can empower both optometrists and affected patients to **go for IOP control...from the start**.

\*In clinical trials, patients with a history of SLT in either eye >90 days prior to study entry could be enrolled.

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## The optometrist's role in management of open-angle glaucoma and ocular hypertension

**Dr. Deom:** I work in a primary care office, and even though we are involved in all aspects of eye care, it is rare that a day goes by without me diagnosing a patient with ocular hypertension or open-angle glaucoma. I approach management of these conditions like a puzzle, where I evaluate the patient's age, family history, treatment preferences, and other factors, and then I consider all these variables when selecting an appropriate treatment. IOP lowering is not a one-size-fits-all problem. That said, I tend to treat ocular hypertension more conservatively than symptomatic open-angle glaucoma.

**Dr. Cothran:** I also routinely diagnose ocular hypertension and open-angle glaucoma. I have an open and honest conversation with the patient to address what their fears and concerns are, and then I discuss the benefits and risks of treatment and the possible risks of undertreatment or delayed treatment with all my patients. I specifically tell my patients with ocular hypertension, "Imagine a fork in the road, and your choice is to actively take control of your eye pressure or potentially risk progressing to open-angle glaucoma. We'll make the best choice together." When my patients understand their disease in those terms, they usually choose to be treated.

**Dr. Bloomenstein:** When I initially diagnose a patient with ocular hypertension or open-angle glaucoma, my immediate thought is, "I only have one workable strategy for this patient—lowering their IOP—and I need to do it right away." However, how I go about doing it will vary from patient to patient. When treating these conditions, I don't make decisions in a vacuum. It's important to examine the totality of the patient's attributes. I think about how much I need to lower their IOP and how quickly. I also have to confront the challenge of communicating my treatment decision to the patient. The patient may be on this treatment for the rest of their life, so I need their buy-in.

### IMPORTANT SAFETY INFORMATION (CONTINUED)

- Gradual changes to eyelashes, including increased length, increased thickness, and number of eyelashes, may occur. These changes are usually reversible upon treatment discontinuation

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## The optometrist's role in management of open-angle glaucoma and ocular hypertension (Continued)

**Dr. Royer:** I echo the sentiment that open communication between the optometrist and the patient is key. It's important that the patient understand their diagnosis and treatment options. I'm always looking for the path of least resistance for them. For example, many of my patients are noncompliant—not because they want to be difficult but because they forget or because they have busy lifestyles. I don't want to prescribe anything they find uncomfortable or burdensome. The two of us have to be on the same page.

## VYZULTA—an IOP-lowering monotherapy for diverse patient types

**Dr. Bloomenstein:** Oftentimes we talk about which patient demographics or subpopulations are most appropriate for a particular therapy. In the case of VYZULTA, I don't have any particular demographic in mind. VYZULTA is my first-line treatment for my patients with ocular hypertension or open-angle glaucoma. There are many reasons for this, but my main reason to recommend VYZULTA is its favorable adverse event profile. The most common ocular adverse reactions with incidence  $\geq 2\%$  associated with VYZULTA are conjunctival hyperemia (6%), eye irritation (4%), eye pain (3%), and instillation site pain (2%).<sup>2</sup> Approximately 0.6% of patients discontinued therapy due to ocular adverse reactions including ocular hyperemia, conjunctival irritation, eye irritation, eye pain, conjunctival edema, vision blurred, punctate keratitis, and foreign body sensation.<sup>2</sup> In my practice, my patients find it reassuring that there is low probability that they will encounter unwanted adverse secondary sequelae with VYZULTA.

“ VYZULTA is my first-line treatment for my patients with ocular hypertension or open-angle glaucoma. ”

—Dr. Bloomenstein

**Dr. Royer:** In my experience, the safety profile of VYZULTA is a manageable one. Many of my patients with ocular hypertension or open-angle glaucoma have ocular comorbidities such as dry eye disease. I've observed that these types of patients are accustomed to the adverse events known to be associated with VYZULTA and know how to mitigate their potential impacts.

“ In my experience, the safety profile of VYZULTA is a manageable one. ”

—Dr. Royer

**Dr. Cothran:** When talking to patients, I tend to focus on VYZULTA's mechanism of action. Latanoprostene bunod, the active ingredient in VYZULTA, is thought to lower IOP by increasing outflow of aqueous humor through both the trabecular meshwork and uveoscleral routes.<sup>2</sup> Consequently, reduction of IOP starts approximately 1 to 3 hours after the first administration with the maximum effect reached after 11 to 13 hours in eyes with elevated IOP.<sup>2</sup> I explain to patients that glaucoma is a complex disease, and there is no cure. Treatments with unique mechanisms of action, like VYZULTA, give us the power to help control the trajectory of the disease.

“ Treatments with unique mechanisms of action, like VYZULTA, give us the power to control the trajectory of the disease. ”

—Dr. Cothran

**Dr. Bloomenstein:** I find it helpful to explain to patients that VYZULTA's mechanism of action can be explained by the fact that the drug is metabolized into 2 molecules—latanoprost acid and nitric oxide—that work on the eye in their own distinct ways. Specifically, after topical ocular administration, latanoprostene bunod is rapidly metabolized in the eye to latanoprost acid (active moiety), an F2a prostaglandin analog, and butanediol mononitrate.<sup>2</sup> Butanediol mononitrate is then metabolized to 1,4-butanediol and nitric oxide.<sup>2</sup> Given these biochemical properties, I find it helpful to describe VYZULTA as “a prostaglandin analog with something more.”

### IMPORTANT SAFETY INFORMATION (CONTINUED)

- 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

Please see additional Important Safety Information throughout and full Prescribing Information for VYZULTA [here](#).



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## VYZULTA® (latanoprostene bunod ophthalmic solution)—an IOP-lowering monotherapy for diverse patient types (Continued)

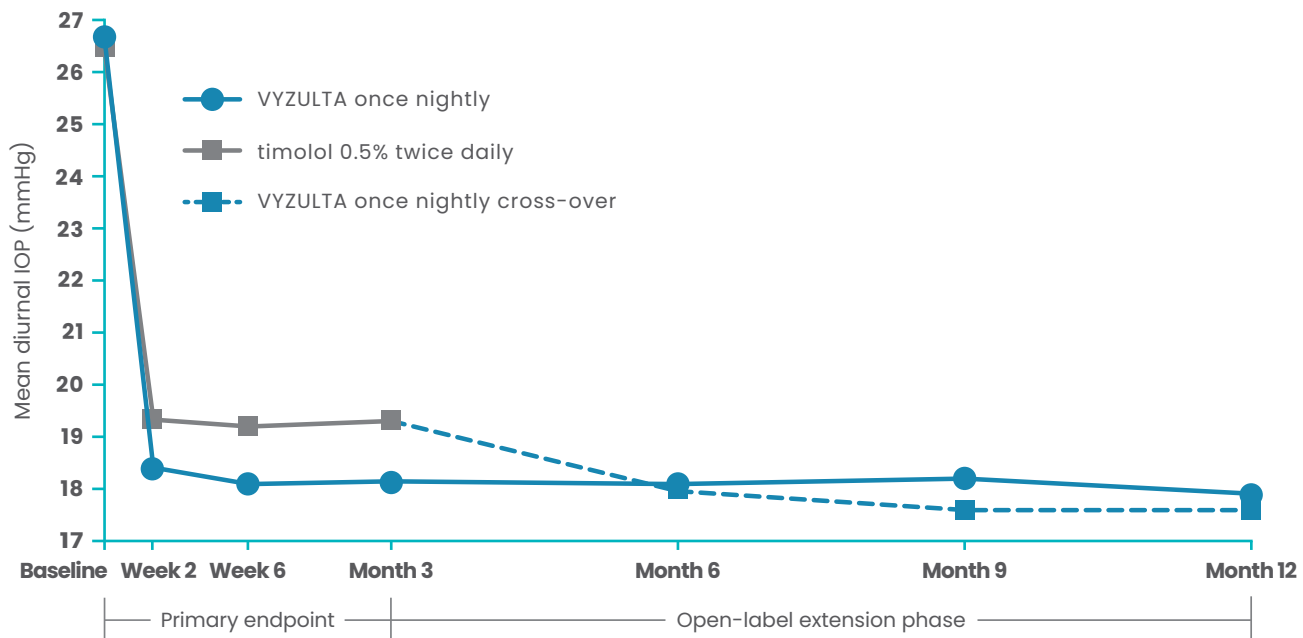
**Dr. Deom:** VYZULTA is a useful tool in my toolbox of IOP-lowering therapies.

Optometrists may have different IOP targets for their patients, depending on the patient's baseline IOP and other clinical features. In my view, VYZULTA provides a means to lower IOP across a full spectrum of patients with ocular hypertension or open-angle glaucoma. In fact, in clinical studies of up to 12 months duration evaluating patients with open-angle glaucoma or ocular hypertension and an average baseline IOP of 26.7 mmHg, the IOP-lowering effect of VYZULTA was up to 7 to 9 mmHg.<sup>2</sup> Moreover, in a pooled analysis of the APOLLO and LUNAR studies evaluating VYZULTA vs timolol 0.5% for the treatment of ocular hypertension or open-angle glaucoma, mean IOP was lower in the VYZULTA treatment arm through Month 3 and stayed low through Month 12 (FIGURE 1).<sup>4</sup>

“VYZULTA is a useful tool in my toolbox of IOP-lowering therapies.”

—Dr. Deom

**FIGURE 1. Mean diurnal IOP over 52 weeks in a pooled analysis of the APOLLO and LUNAR studies.** The mean (standard deviation) diurnal IOP at baseline was 26.7 (2.43) mmHg in subjects randomized to VYZULTA and 26.5 (2.35) mmHg in subjects randomized to timolol 0.5%. Adapted from Weinreb et al, 2018.<sup>4</sup>



**Dr. Bloomenstein:** What I appreciate about VYZULTA is that it only needs to be administered once per day in the evening.<sup>2</sup> VYZULTA can easily fit into my patients' busy lifestyles, especially working professionals and those who travel often.

**Dr. Cothran:** When managing patients with open-angle glaucoma or ocular hypertension, I try to develop a treatment plan that will work for the long term. I tell them, “We’re on a journey together. I’m in the driver’s seat, and you’re in the passenger seat.” VYZULTA is like a seatbelt. It’s a critical part of the journey.

### IMPORTANT SAFETY INFORMATION (CONTINUED)



- 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

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## Case #1: A patient who needed a powerful first-line IOP-lowering treatment when beginning their glaucoma journey

### Dr. Cothran // Patient Case 1

<b>Background</b>	<p><b>56-year-old Black male</b></p> <ul style="list-style-type: none"><li>• Social drinking and nightly use of cannabis (vaping)</li><li>• Family history of glaucoma<ul style="list-style-type: none"><li>• Father experienced vision loss due to glaucoma, which required surgical intervention</li></ul></li></ul>
<b>Medical history</b>	<ul style="list-style-type: none"><li>• Medical history includes asthma, hypophosphatemia, and migraine<ul style="list-style-type: none"><li>• Medications include albuterol sulfate inhaler, ergocalciferol 1250 µg, and sumatriptan 50 mg</li></ul></li><li>• Ocular history includes trace nuclear sclerotic cataract in both eyes</li><li>• BCVA 20/20 OD and 20/20 OS</li></ul>
<b>Prior IOP-lowering treatment</b>	None
<b>Baseline IOP</b>	<ul style="list-style-type: none"><li>• 22 mmHg OD; 23 mmHg OS</li></ul>
<b>Diagnostic workup with imaging</b>	<ul style="list-style-type: none"><li>• Central corneal thickness of 588 µm OD and 599 µm OS</li><li>• Fundus photographs</li></ul> <div style="display: flex; justify-content: space-around;"></div>

### IMPORTANT SAFETY INFORMATION (CONTINUED)

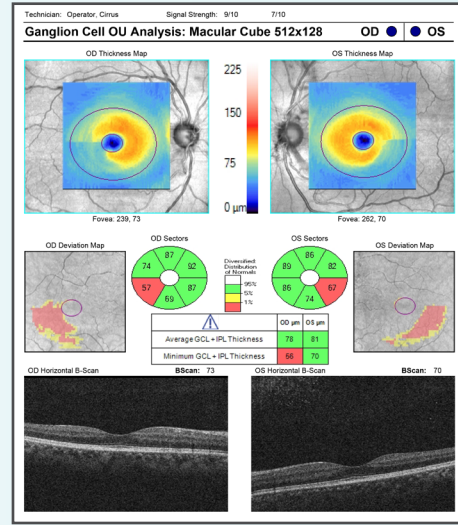
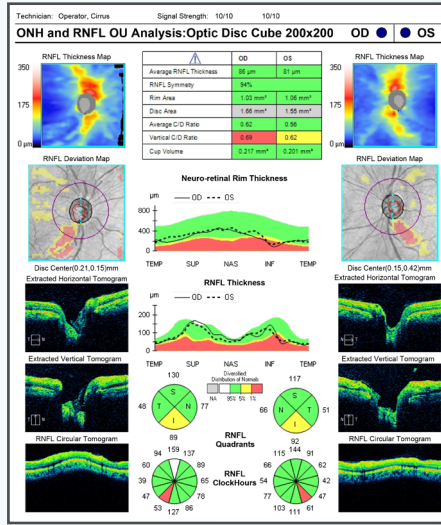
- There have been reports of bacterial keratitis associated with the use of multiple-dose containers of topical ophthalmic products that were inadvertently contaminated by patients

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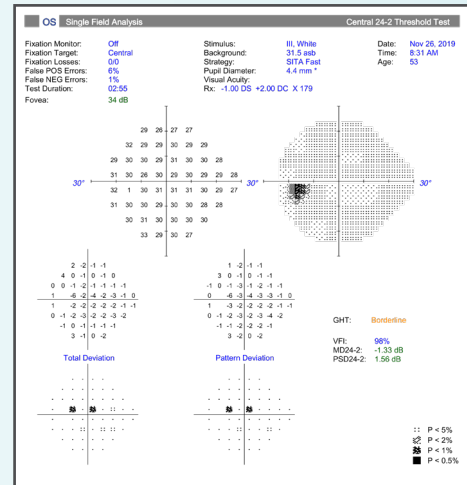
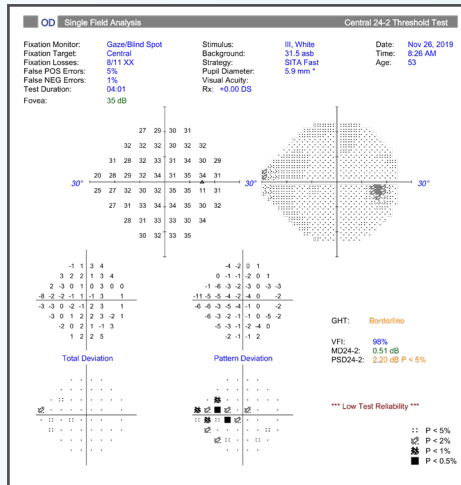
Dr. Cothran // Patient Case 1 (Continued)

- Optic nerve head, retinal nerve fiber layer, and ganglion cell analysis



Diagnostic workup with imaging

- Humphrey visual field 24-2



**Patient Case #1** recounts a patient undergoing treatment for open-angle glaucoma for the first time. Because of the patient's moderate baseline IOP and **Dr. Cothran's** clinical judgement, a standard PGA was inappropriate for reducing IOP to the desired target of 15 mmHg in both eyes, and VYZULTA was selected as this patient's first-line IOP-lowering therapy.

The patient returned to **Dr. Cothran's** office 3-4 weeks later, at which time his IOP was 13 mmHg OU. He was recommended for quarterly monitoring for 2 years, with 4- to 6-month follow-ups thereafter. The patient has been on VYZULTA for over 5 years with stable IOP and no significant change in clinical tests for glaucoma. A candid discussion with the patient revealed that, due to the severe vision loss experienced by his father, he had a "deep fear of going blind" from glaucoma. This drove long-term compliance with topical therapy and all follow-up appointments. The patient noted, "I watched my father struggle for years with so many bottles of eye drops. I'm happy I only have to be on one bottle."

**IMPORTANT SAFETY INFORMATION (CONTINUED)**

- Contact lenses should be removed prior to the administration of VYZULTA and may be reinserted 15 minutes after administration

Please see additional Important Safety Information throughout and full Prescribing Information for VYZULTA [here](#).



## Case #1: A patient who needed a powerful first-line IOP-lowering treatment when beginning their glaucoma journey (Continued)

After this patient's diagnosis of open-angle glaucoma, he contacted his 3 siblings, all of whom were subsequently diagnosed with open-angle glaucoma as well. This underscores that glaucoma shows a high genetic disposition, especially in mothers and siblings of individuals with glaucoma.<sup>1</sup> Clinicians should obtain an in-depth family history of glaucoma, which should be continually updated during follow-up visits.<sup>1</sup>

## Case #2: A patient with inadequate response to their current PGA treatment, including latanoprost 0.005%

Dr. Bloomenstein // Patient Case 2	
<b>Background</b>	<b>48-year-old White Hispanic male</b> <ul style="list-style-type: none"><li>• Family history of glaucoma</li></ul>
<b>Medical history</b>	<ul style="list-style-type: none"><li>• No systemic comorbidities</li><li>• Best uncorrected visual acuity of 20/20</li></ul>
<b>Prior IOP-lowering treatment</b>	<ul style="list-style-type: none"><li>• Goldmann-correlated IOP of 27 mmHg OD and 29 mmHg OS prior to treatment</li><li>• Started on timolol 0.5% BID, which was discontinued due to complaints of shortness of breath</li><li>• Switched to latanoprost 0.005% qHS</li></ul>
<b>Current IOP</b>	<ul style="list-style-type: none"><li>• Goldmann-correlated IOP of 17 mmHg OD and 19 mmHg OS</li></ul>
<b>Diagnostic workup</b>	<ul style="list-style-type: none"><li>• Central corneal thickness of 490 <math>\mu</math>m OD and 503 <math>\mu</math>m OS</li><li>• Central corneal hysteresis of 7.3 mmHg OD and 6.9 mmHg OS</li><li>• Both Humphrey visual fields demonstrated progression from baseline</li><li>• Fundus photograph of the left eye showed a superotemporal Drance hemorrhage</li></ul>

**Patient Case #2** describes an individual who was able to obtain some IOP control with generic latanoprost 0.005%, but not enough. This patient was then switched to VYZULTA with the goal of achieving further IOP control with a single branded medication. **Dr. Bloomenstein** described the importance of communicating the rationale for treatment switch to the patient: "When a patient is properly educated about their condition and actively involved in their treatment plan, they will do what the doctor feels is in their best interest and are more apt to adhere to treatment."

For this patient, changes in IOP from baseline were measured using an ocular response analyzer (ORA). Two weeks after switching to VYZULTA, his corneal-compensated IOP was 12 mmHg OD and 13 mmHg OS. Three months after switching, his corneal-compensated IOP was 14 mmHg OD and 11 mmHg OS. The patient leveraged Bausch + Lomb's Access Program for VYZULTA and was able to receive the medication after prior authorization. The patient is still on VYZULTA, and his optic nerve head and visual field remain subject to continued monitoring.

### IMPORTANT SAFETY INFORMATION (CONTINUED)

- Most common ocular adverse reactions with incidence  $\geq$ 2% are conjunctival hyperemia (6%), eye irritation (4%), eye pain (3%), and instillation site pain (2%)



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## Case #3: A patient with inadequately controlled IOP following SLT

### Dr. Royer // Patient Case 3

<b>Background</b>	<p><b>58-year-old White female</b></p> <ul style="list-style-type: none"> <li>• Works in sales</li> <li>• Frequent traveler (on the road nearly 50% of the time)</li> <li>• Father and paternal grandfather had open-angle glaucoma</li> </ul>
<b>Medical history</b>	<ul style="list-style-type: none"> <li>• Medical history includes seasonal allergies and depressive disorder</li> <li>• Ocular history includes dry eye disease and trace nuclear sclerotic cataract in both eyes</li> <li>• Visual status:             <ul style="list-style-type: none"> <li>• Eyeglass prescription of sphere -3.25, cylinder +1.00, axis x085, add +2.00 OD and sphere -2.00, cylinder +0.75, axis x150, add +2.00 OS</li> <li>• Dynamic visual acuity of 20/20 OU</li> <li>• Near visual acuity of J1+ OU</li> </ul> </li> <li>• Goldmann IOP of 32 mmHg OD and 31 mmHg OS prior to any treatment</li> </ul>
<b>Prior IOP-lowering treatment</b>	<ul style="list-style-type: none"> <li>• Bimatoprost 0.01% provided effective IOP lowering to 18 mmHg OD and 17 mmHg OS, corresponding to a ~44%-45% reduction in IOP             <ul style="list-style-type: none"> <li>• Discontinued due to compliance issues associated with cost, inconvenience, and forgetfulness when traveling</li> </ul> </li> <li>• VYZULTA provided effective IOP lowering to 18 mmHg OD and 17 mmHg OS, corresponding to a ~50% reduction in IOP             <ul style="list-style-type: none"> <li>• Stopped therapy with VYZULTA due to compliance issues associated with inconvenience and forgetfulness when traveling</li> </ul> </li> <li>• Bilateral SLT*             <ul style="list-style-type: none"> <li>• IOP of 19 mmHg OD and 17 mmHg OS 1 month post-SLT</li> <li>• IOP of 22 mmHg OD and 21 mmHg OS 3 months post-SLT</li> </ul> </li> </ul>
<b>Current IOP</b>	<ul style="list-style-type: none"> <li>• 24 mmHg OD and 25 mmHg OS 9 months post-SLT</li> </ul>
<b>Diagnostic workup with imaging</b>	<ul style="list-style-type: none"> <li>• Target IOP of <math>\leq 22</math> mmHg (<math>\geq 30\%</math> IOP reduction; both eyes)</li> <li>• Central corneal thickness of 551 <math>\mu\text{m}</math> OD and 550 <math>\mu\text{m}</math> OS</li> <li>• Cup-to-disc ratio of 0.55/0.45 OD and 0.6/0.6 OS</li> <li>• Fundus photographs</li> </ul> <div style="display: flex; justify-content: space-around;">   </div>

\*In clinical trials, patients with a history of SLT in either eye >90 days prior to study entry could be enrolled.

### IMPORTANT SAFETY INFORMATION (CONTINUED)

- Increased pigmentation of the iris and periorbital tissue (eyelid) can occur. Iris pigmentation is likely to be permanent

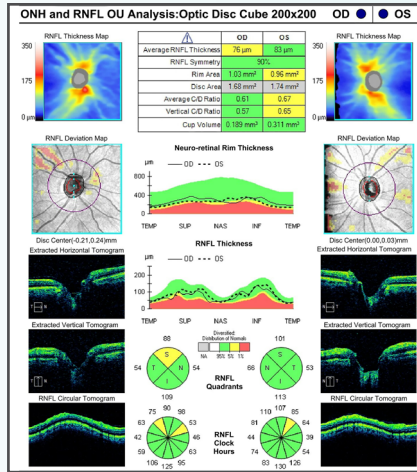
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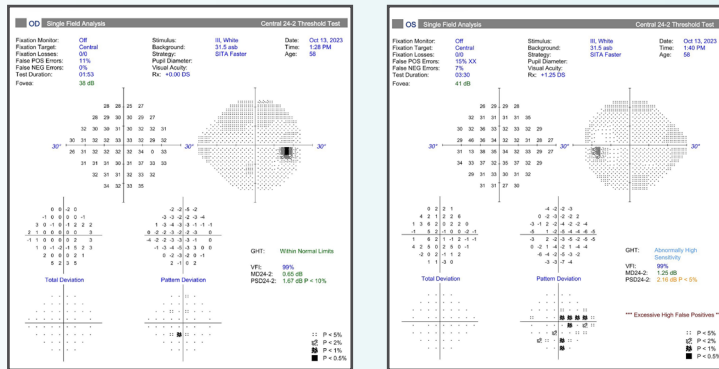
## Case #3: A patient with inadequately controlled IOP following SLT (Continued)

### Dr. Royer || Patient Case 3 (Continued)

- Disc cube report OU



- Humphrey visual field 24-2



Diagnostic workup with imaging

**Patient Case #3** explores a patient who struggled to remain compliant to IOP-lowering drops because of her busy lifestyle and was treated with SLT\*. Generally, SLT is a desirable initial or alternative therapy or adjunct to topical medication for achieving IOP control in patients with ocular hypertension or POAG.<sup>1</sup> However, this patient's IOP rebounded post-SLT, which necessitated additional IOP-lowering therapy. VYZULTA was chosen due to the patient's history of adequate response to PGA therapy (including VYZULTA itself), as well as **Dr. Royer's** desire to administer a consistent branded IOP-lowering medication. **Dr. Royer** noted, "I consider VYZULTA to be well tolerated and efficacious. It has quickly become a top choice as my preferred IOP-lowering therapy for open-angle glaucoma."

Four months after starting VYZULTA, the patient's IOP was stable at 18 mmHg bilaterally. She reported adequate compliance but admitted to occasionally missing her prescribed doses. After a thorough conversation on the importance of medication compliance, she redoubled her commitment to following through on her IOP-lowering therapy as prescribed. This aligned with clinical guidelines, which support the idea that eye care professionals should be persistent in providing education and training to patients with POAG to improve adherence/compliance with recommended therapy.<sup>1</sup> **Dr. Royer** pointed out, "Medication compliance can vary from patient to patient for a multitude of reasons, including cost, convenience, side effects, understanding of the disease, and drug availability."

\*In clinical trials, patients with a history of SLT in either eye >90 days prior to study entry could be enrolled.

### IMPORTANT SAFETY INFORMATION (CONTINUED)

- Gradual changes to eyelashes, including increased length, increased thickness, and number of eyelashes, may occur. These changes are usually reversible upon treatment discontinuation

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## CHOOSE MONOTHERAPY WITH VYZULTA IN APPROPRIATE PATIENTS WHO<sup>2</sup>:

- ✓ Need a powerful first-line IOP-lowering treatment when beginning their glaucoma journey
- ✓ Are not adequately responding to their current PGA treatment, including latanoprost 0.005%
- ✓ Have inadequately controlled IOP following SLT\*

\*In clinical trials, patients with a history of SLT in either eye >90 days prior to study entry could be enrolled.

## GO FOR IOP CONTROL FROM THE START



### IMPORTANT SAFETY INFORMATION (CONTINUED)

- 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  $\geq 2\%$  are conjunctival hyperemia (6%), eye irritation (4%), eye pain (3%), and instillation site pain (2%)

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit [www.fda.gov/medwatch](http://www.fda.gov/medwatch) or call 1-800-FDA-1088.

**Please see additional Important Safety Information throughout and full Prescribing Information for VYZULTA [here](#).**

**References:** **1.** American Optometric Association. Evidence-based clinical practice guideline: care of the patient with primary open-angle glaucoma. Published February 27, 2024. **2.** VYZULTA. Prescribing Information. Bausch & Lomb Inc. **3.** Lo TC, Chen YY, Hung MC, Chou P. Latanoprostene bunod 0.024% in the treatment of open-angle glaucoma and ocular hypertension: a meta-analysis. *J Clin Med.* 2022;11(15):4325. **4.** Weinreb RN, Liebmann JM, Martin KR, Kaufman PL, Vittitow JL. Latanoprostene bunod 0.024% in subjects with open-angle glaucoma or ocular hypertension: pooled phase 3 study findings. *J Glaucoma.* 2018;27(1):7-15.

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