UVEITIS CLINICAL STUDY GROUP

Route to National Uveitis Pathways

An introduction to commissioning for Uveitis CSG members — how uveitis biologics get funded, who makes the decisions, and how to get recognised to prescribe locally.

Contents

1. Funding across the four nations — in brief

In one line: the biologic is the same everywhere, but the appraisal body, the committees and the payment route differ by nation — England appraises via NICE and is moving biologics into local trust tariffs (postcode-lottery risk), while Scotland (SMC), Wales (AWMSG / NICE) and Northern Ireland (endorses NICE) fund through their own health boards.

Detail per nation — the specific appraisal bodies, committees and funding routes — is in Appendix (v).

2. Funding in England — more complex than the devolved nations, and changing

Two things move independently. First, who runs the service: NHS England is delegating specialised commissioning (including adult uveitis) to the 42 Integrated Care Boards, with seven Offices for Pan-ICB Commissioning taking over at scale from April 2027. Second, who pays for the biologic: a drug is funded either nationally (on the NHS high-cost drugs list, paid pass-through) or in tariff (off that list — the cost sits in the activity tariff the Trust receives).

From 2026/27, adalimumab, infliximab and rituximab were removed from the national high-cost list and moved into tariff (Trust-funded) on 1 April 2026; only tocilizumab (to 31 August 2027) and abatacept remain national. Crucially, NICE TA460 still mandates adalimumab for non-infectious uveitis — so ICBs must fund eligible patients. What changed is who pays and who approves, not whether the drug is available. For a locally-funded drug, your key contact is the Trust pharmacy team. (See Appendix (ii) for the full structure.)

3. The Uveitis CSG project — UK consensus treatment pathways

UK consensus treatment pathways for ocular inflammatory diseases.

This is a Uveitis CSG-facilitated initiative, open to all specialty doctors and consultants treating uveitis, and to patients with uveitis, from all four nations. All CSG members — particularly pharmacists — are invited to view proceedings, contribute and feed back, to make sure the pathways are most representative of our populations.

If and when published, the names of all contributors will be collected and indexed as part of the Uveitis CSG consortium for publication. Finalised pathways will be posted for national reference at www.uveitisstudygroup.org.

4. Route to consensus — the surveys and timeline

We will send surveys to your inbox via your regional representative, following your explicit consent. Regional representatives record the number of people to whom each survey has been sent.

- **Please** complete Consensus Survey 1 by Sunday 9 August 2026.
- **Please** complete Survey 2 (data) by Saturday 6 September 2026.

For Survey 2 we will send an Excel sheet to work from, as well as an online form for your final national-data responses. Please discuss the data with your regional representative to avoid double-counting with your referring networks, and how gaps or uncertainties might be resolved. Your Excel spreadsheet stays with you and informs your local pathway applications.

The two surveys — two different jobs

Survey 1 — Ocular Inflammatory Disease Treatment Pathways. Part 1 of the Delphi consensus method to agree a UK-wide treatment pathway: it asks whether you agree with each step of the pathway. (see Appendix (i) — the Delphi method)

Survey 2 — Uveitis CSG Prescribing Survey (deadline 6 September). A data-collection tool: it asks each clinic a simple question — how many of your patients are on, or need, each named medication (a conventional immunomodulatory agent / DMARD, or a named biologic). Added up across each nation, this shows how many people we are talking about — which is what convinces the people who hold the money. Data are collated at regional level so we are clear about our denominator (our populations, the group on DMARDs, the population who need biologics and of what type, and the size of population in each pathway).

Survey 3 & Focus Group — Uveitis CSG Patient Engagement Consensus. Runs in parallel with Surveys 1 and 2.

5. Helping centres prescribe biologics locally

A key aim of this project: help uveitis centres across the country prescribe biologics locally.

Now that adalimumab, infliximab and rituximab are locally commissioned, recognition to prescribe is a local governance step, not a national designation. This is especially achievable for units that already have the skills and local set-up to prescribe and monitor conventional immunomodulatory therapy (IMT / DMARDs) — for them, adding a biologic pathway is a small extension of existing governance, not a new capability. We want to support these centres to start, so that patients are treated where they are seen rather than referred away.

Uveitis CSG mentorship is available to anyone who wants it — contact Srilakshmi.Sharma@ouh.nhs.uk. A step-by-step route is in Appendix (iii).

Appendix (i) — How we agree the pathway: the Delphi method

Why a method? If we just talk it through, the loudest voice tends to win and quiet disagreement disappears. Instead we vote on each step of the pathway privately. Anyone who disagrees has their view written down, not overruled — and that view is discussed at the moderation meeting, held about two weeks after the surveys are in. A formal consensus method underpinning our chosen best-practice pathways also strengthens the case to NHS England and other bodies for treatment pathways in rare disease.

The method has two rounds: a private first-round survey (about 15 minutes; you can pause and finish later), then a moderation meeting where we set aside the steps most people agreed on and spend our time only on the steps we did not — rewording and re-voting until settled. We vote first and discuss second, so the first person to speak does not sway the room.

The voting rules (agreed before we vote)

Result	What it takes	What happens next
It's in	7 of 10 choose “agree” (and hardly anyone disagrees)	The step goes into the shared pathway
It's out	7 of 10 choose “disagree”	The step is dropped
Not settled	Neither — or many want it changed	Reworded and re-voted at the moderation meeting
Enough to count	At least 6 of 10 asked reply	If fewer reply, the result is a steer, not a final decision

Private and fair. No one sees who voted which way — only the totals — so seniority does not decide it. If a fair number (say one in five or more) disagree with a step, we write their view into the final pathway rather than pretend everyone agreed. Nobody gets steam-rollered.

Appendix (ii) — England: commissioning structure & who's who

There are two approval routes. Follow the LOCAL route for the in-tariff biologics (adalimumab, infliximab, rituximab); the NATIONAL route applies only to the pass-through drug, tocilizumab.

Local route (in-tariff biologics: adalimumab · infliximab · rituximab)

Local route: Consultant → Trust Chief Pharmacist / Medicines Optimisation → Trust MMTC / D&TC → Area Prescribing Committee → ICB IMOC (with RMOC / OPIC for regional consistency).

Who	What they do — and when you need them
Consultant (you)	Write the clinical business case: patient numbers, evidence, cost. You start the process.
Trust Chief Pharmacist / Medicines Optimisation	THE interface with the ICB. Packages your case, confirms the funding route, submits to committees. Your first stop.
Trust MMTC / D&TC	Medicines Management & Therapeutics / Drug & Therapeutics Committee. Approves the drug +

	indication for your trust formulary.
Area Prescribing Committee (APC)	Joint trust + ICB formulary decision — what is routinely prescribable across the patch.
ICB Chief Pharmacist / IMOC	Integrated Medicines Optimisation Committee. Holds commissioning + budget for locally-funded drugs.
RMOC (4, advisory)	Regional Medicines Optimisation Committees. Publish high-cost-drug initiation/maintenance pathways ICBs adopt — the model to copy for a consistent regional pathway.
OPIC	Office for Pan-ICB Commissioning. 7 from April 2027 (one per region) — pan-ICB consistency as NHSE winds down.

National route (pass-through drug: tocilizumab)

National (tocilizumab) route: CRG → CET → CPAG → DCG.

Who	What they do — and when you need them
CRG / CET	Specialised Ophthalmology Clinical Reference Group endorses a national policy; the Clinical Effectiveness Team (england.CET@nhs.net) receives the proposal.
CPAG / DCG	Clinical Priorities Advisory Group (9-box scoring) → Delegated Commissioning Group (final decision) for a national Clinical Commissioning Policy.

Appendix (iii) — Getting recognised to prescribe adalimumab locally

Under the previous national arrangements, adalimumab for uveitis was prior-approved through NHSE specialised commissioning, and some clinicians or units could not initiate it. With delisting to local commissioning, that national barrier falls away — recognition to prescribe is now a local governance step. Uveitis CSG mentorship is available to anyone who wants it (Srilakshmi.Sharma@ouh.nhs.uk).

The route

1. **Confirm the funding basis.** Adalimumab is now locally commissioned but remains a TA460 mandate — your ICB must fund eligible patients. Ask your Chief Pharmacist whether your trust has a local funding route yet, or is still using the legacy NHSE Blueteq proforma during transition.
2. **Get the drug + indication on your trust formulary.** Submit (or confirm) adalimumab for non-infectious uveitis at your MMTC / D&TC, citing TA460. If already listed for other indications, request the uveitis indication be added.
3. **Confirm the prior-approval route.** Most systems keep an electronic proforma (Blueteq or local equivalent) encoding TA460 eligibility. Ensure your service and you as prescriber are registered on it.
4. **Set up supply.** With the specialty pharmacist, arrange homecare delivery and the best-value biosimilar (e.g. Yuflyma) per the NHSE biosimilar framework.

5. **Complete prescriber credentialing.** Finish any trust biologics-prescribing sign-off and agree shared-care / monitoring arrangements where required.

6. **If no local pathway exists yet.** Propose a locally-agreed pathway via your ICB Medicines Optimisation Committee (IMOC) / Area Prescribing Committee — ideally adopting a SERMOG-style high-cost-drug pathway — and use an Individual Funding Request as an interim bridge for individual patients.

7. **Use the CSG lever.** Adopt the CSG-endorsed national reference pathway and model Blueteq criteria so your trust's approval mirrors every other member's. This turns 42 separate local decisions into one consistent national pathway.

Local variation flag: whether Blueteq persists locally, the exact transition timing, and whether your ICB has yet received the delegated budget all vary and are still settling through 2026/27 — confirm locally.

Appendix (iv) — Glossary

Blueteq	Electronic prior-approval proforma encoding eligibility (e.g. TA460 for adalimumab). No approved form = no reimbursement route.
IFR	Individual Funding Request — case-by-case route where no local pathway exists yet.
IMT / DMARD	Immunomodulatory therapy / disease-modifying antirheumatic drug (e.g. methotrexate, mycophenolate).
TA460	NICE Technology Appraisal 460 — adalimumab (and dexamethasone) for non-infectious posterior-segment uveitis.
OPIC	Office for Pan-ICB Commissioning (7 from April 2027).

Appendix (v) — Funding across the four nations (detail)

England

Appraisal by NICE (Technology Appraisals carry mandatory funding). High-cost drugs sit on Annex A of the NHS Payment Scheme — pass-through (commissioner-funded, e.g. tocilizumab) vs in-tariff (trust-funded, e.g. adalimumab / infliximab / rituximab from Apr 2026). Commissioned via ICBs (moving to 7 OPICs in 2027); local use through the trust MMTC / formulary; national drugs via the CCP / CET route.[1]

Scotland

Appraisal by the Scottish Medicines Consortium (SMC), not NICE. No Annex A / tariff split — funded by the 14 NHS Boards from their allocations, with national risk-share and a separate ultra-orphan route. Individual or off-label access via the Peer Approved Clinical System (PACS) — Tier 1 (ultra-orphan), Tier 2 — and local Area Drug & Therapeutics Committees.[2]

Wales

NICE Technology Appraisals apply; medicines NICE has not appraised are assessed by the All Wales Medicines Strategy Group (AWMSG). Funded through the 7 Local Health Boards; formularies via the All Wales Therapeutics & Toxicology Centre. Exceptional

Northern Ireland

No separate appraisal body — the Department of Health (NI) formally endorses NICE Technology Appraisals (and considers SMC advice), often with a lag. Commissioning sits in the DoH Strategic Planning & Performance Group (the HSC Board closed in

/ individual cases go through the Individual Patient Funding Request (IPFR) process.	2022); delivered by HSC Trusts. Specialist high-cost medicines run through the Regional Group on Specialist Medicines and the NI Formulary; exceptional cases via Individual Funding Request.[3]

References: [1] NHS England 2026/27 Payment Scheme (Annex A) & specialised-commissioning delegation. [2] SMC / PACS — gov.scot review of access to new medicines; NHS NSS ultra-orphan route. [3] DoH (NI) NICE-endorsed Technology Appraisals; NI Formulary.