DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Dry eye prescribing – position statement

Introduction
Derby and Derbyshire Integrated Care Board (DDICB) currently spends approximately £1m on prescribing for dry eye preparations. Simple dry eye is an uncomplicated condition which can be managed without medical intervention. Patients should be directed to self-care.

DDICB recommends:

"Simple dry eye can be managed by directing the patient to self-care and to purchase dry eye lubricants over–the-counter."

This includes for tired eyes, hay fever symptoms, contact lens wearers, visual display screen users, and age-related dry eyes. See table 1 - dry eye lubricant options for self-care.

DDICB support the prescribing of dry eye lubrications for **new patients ONLY** where the use of dry eye lubrication is **essential to preserve sight function** for following patients:

- Severe ocular surface disease (OSD) caused by the following conditions: Sjögren's syndrome, auto immune disease (e.g. Rheumatoid arthritis, ulcerative keratitis), neurotrophic cornea
- Previous corneal conditions, recurrent corneal erosions, corneal injury
- Lid abnormalities (ectropion, entropion or reduced lid laxity where corrective surgery is not undertaken)
- Other causes ocular surface inflammation such as atopic keratoconjunctivitis and severe Meibomian gland dysfunction.

See tables 2 and 3 for formulary options when prescribing is necessary.

For **existing patients** discuss ongoing prescribing at the next clinical review

General Management advice for all patients

- Dry eye syndrome or dry eye disease is a common condition characterised by inflammation of the ocular surface that occurs when the eyes don't make enough tears, or the tears evaporate too quickly.
- Symptoms of dry eye syndrome include dryness, irritation or discomfort, excessive reflex watering, and intermittent blurring of vision. Symptoms typically worsen with prolonged visual tasks, exposure to wind and air conditioning.
- The aims of treatment are to restore the ocular surface and improve ocular comfort.
- Many cases of sore tired eyes resolve to an acceptable level of comfort with minimal intervention. Dry eye, however, is a chronic and often relapsing condition.
- Patients should be encouraged to manage both dry eyes and sore eyes by implementing some self-care measures such as good eyelid hygiene and avoidance of environmental factors alongside treatment.

Non-pharmacological management of dry eyes

- keep your eyelids clean
- take breaks to rest your eyes when using a computer screen
- make sure computer screen is at or below eye level so you do not strain your eyes
- use a humidifier to stop the air getting dry
- get plenty of sleep to rest your eyes
- if you wear contact lenses, take them out and wear glasses to rest your eyes
- do not smoke or drink too much alcohol
- do not spend too long in smoky, dry or dusty places
- do not spend too long in air conditioned or heated rooms

Refer to the self-care section of the Joined Up Care Derbyshire website, where condition specific patient information leaflets can also be found.

Primary care management & Referral –
Mild & Mild/moderate dry eye:

- For treatments of minor conditions such as dry eyes/ sore tired eyes, patients are encouraged to self-care by measures such as good eyelid hygiene and avoidance of environmental factors.
- Mild & Mild-Moderate symptoms of dry eye can be treated with simple eye lubricants (drops, gels and ointments). These can be easily purchased over-the-counter. **See table 1** for treatment options.
- Monitor response to treatment- if ineffective at 8 weeks, consider purchasing another agent

If a recommendation to prescribe comes from an ophthalmologist:

- For simple dry eye – advise the patient to purchase the recommended product.
- Prescribe where the patient has a diagnosis as stated on p1 and if the recommended product is on the formulary.

Review existing patients prescribed dye eye products.

- For new patients with simple dry eye advise to purchase dry eye products over the counter
- Continue prescribing if they have a diagnosis as stated on p1. Follow the dry eye formulary.

Mild/moderate dry eyes:
Referral to the corneal/ocular surface clinic can be made for any patients who GPs are not happy managing (patients with persistent, unresolving symptoms).

For non-emergency/urgent patients GPs may want to refer into the Minor Eye Conditions Service (MECS) delivered by community optometrists. Optometrists will examine and treat the patients appropriately or make an onward referral to the corneal/ocular surface clinic if necessary.

Derbyshire MECS practice list https://primaryeyecare.co.uk/find-a-practice/
A postcode can be used to locate the MECS practices closest to a patient's postcode. Using the service filter for 'Urgent or Minor Eye Services' will identify a list of closest MECS practices

Severe dry eyes:
Patients with severe symptoms who are not managed on preservative-free (PF) lubricants alone should also be referred to the hospital eye service.

Table 1: Dry eye lubricant options for self-care (purchase OTC)

Ensure patients are appropriately sign-posted to self-care resources/ leaflets
The majority of patients in primary care can be managed with 1st line agents.

<table>
<tr><th></th><th>Active ingredient</th></tr>
<tr><td rowspan="3">1st line treatment options

• Hypromellose should be appropriate for the majority of patients presenting with mild dry eye syndrome. Hypromellose eye drops may need to be instilled frequently initially until symptoms improve, then applied at a decreased frequency. Once symptoms are controlled, if the patient's maintenance regimen is greater than 4–6 times a day, a review may be needed with consideration of alternative or additional options.

• Dry eye syndrome treatments containing carbomers or polyvinyl alcohol require less frequent administration but may be less well tolerated than hypromellose.

• Within the 1st line regimen, using both hypromellose and carbomers may be appropriate to try before progressing to 2nd line treatment options.

If failure to improve symptoms after 6-8 weeks, progress to second-line treatment options.</td><td>Hypromellose 0.3%</td></tr>
<tr><td>Polyvinyl alcohol 1.4%</td></tr>
<tr><td>Carbomer 0.2%</td></tr>
<tr><td rowspan="2">Alternative treatment options

• There is no evidence to support any differences in efficacy between the different strengths available for sodium hyaluronate, although the different delivery systems of the products may affect patient acceptability.
• Some sodium hyaluronate delivery systems give longer in-use expiry dates. If required, these should be considered on an individual patient basis.

If failure to improve symptoms after 6-8 weeks, refer for specialist input.</td><td>Carmellose 0.5%</td></tr>
<tr><td>Sodium hyaluronate e.g. 0.2%</td></tr>
</table>

Table 2: Dry eye lubricant options to aid selection when prescribing is necessary

Active ingredient	Preferred brand	Pack size	Expiry once opened	Cost per pack (Drug tariff November 2025)	Suggested maximum price for alternative brands if preferred brands out of stock
Preparations containing preservatives					
Hypromellose 0.3%	AaproMel	10ml	28 days	£0.61	£0.70
Carbomer 0.2%	*AaCarb eye gel*	10g	28 days	£1.29	£1.40
Carmellose 0.5%*	Aqualube	10ml	28 days	£1.68	£1.75
Polyvinyl alcohol 1.4%	Liquifilm Tears	15ml	28 days	£1.93	No equivalent
Sodium hyaluronate 0.2%	Blink Intensive Tears	10ml	3 months	£2.97	£3.50
Hydroxypropyl Guar	Systane	10ml	3-6 months (check box)	£4.85	£7.00
Sodium hyaluronate 0.1%, carmellose 0.5%, Glycerol 0.9%	Optive Fusion	10ml	6 months	£7.49	No equivalent
Carmellose 0.5%, Caster oil 0.25%, glycerine 1%	Optive Plus	10ml	6 months	£7.49	No equivalent

Preservative-free eye lubricants

Preservative intolerance should usually be diagnosed by an ophthalmologist, however if patients require drops more than six times per day consider switching to preservative-free drops (taken from Dry eye diagnosis and treatment - Moorfields Eye Hospital). If PF formulation is warranted, proprietary preservative-free formulations (often available as unit dose preparations) should be bought as self-care items if possible.

Manufactured “specials” are unlicensed and almost invariably cost significantly more and should not be prescribed.

Table 3: Preservative-free lubricant options to aid selection when prescribing is necessary

Active ingredient	Preferred brand	Pack size	Expiry once opened	Cost per pack (Drug tariff November 2025)	Suggested Maximum price for alternative brands if preferred brands out of stock
Preservative-free preparations					
Carmellose 1%	Eyeaze **$**	10ml	3 months	£1.81	£1.85
White soft paraffin-based* ointment	Hydramed Night ophthalmic ointment	5g	3 months	£2.38	£2.75
Carmellose 0.5%	Ocufresh Comfort carmellose **$**	10ml	3 months	£2.29	£2.88
Carbomer 0.2%	Evolve Carbomer 980	10g	3 months	£2.92	No equivalent
Hypromellose 0.3%	AddTear **$**	10ml	3 months	£2.99	£3.00
Sodium hyaluronate 0.2%	Aactive HA PF 0.2%	10ml	60 days	£3.46	£4.15
Carmellose 1%	Cellusan	30 **UDVs**	Single use	£3.07	£3.10
Hypromellose 0.3%	AddTear **$**	30 **UDVs**	Single use	£3.99	£4.00
Carmellose 0.5%	Xailin Fresh	30 **UDVs**	Single use	£4.23	£4.92
Polyvinyl alcohol 1.4%	Liquifilm Tears	30 **UDVs**	Single use	£5.35	No equivalent

***** The active ingredients in paraffin-based products varies between brands

$ contains borax/ boric acid (buffer)

Reference

- Prescqipp Bulletin 202 Eye Preparations March 2018 https://www.prescqipp.info/our-resources/bulletins/bulletin-202-eye-preparations/
- All Wales Medicines Strategy Group Dry Eye Syndrome Guidance Dec 2016
- Mid Essex CCG policy statement: prescribing of dry eye lubrication
- MIMS Dry Eye Treatments table https://www.mims.co.uk/dry-eye-treatments/ophthalmology/article/1596602 (November 2025)
- Moorfields Eye Hospital, Dry eye diagnosis and treatment (November 2025)

Document control	Date