

iDose TR

Travoprost intracameral implant

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The problem drops don't solve

iDose TR is a pillar of "interventional glaucoma" — moving from drops to procedures earlier

- ◆ **Adherence.** Roughly half of glaucoma patients aren't taking drops as prescribed within a year.
- ◆ **Preservative toxicity & ocular surface disease.** Chronic BAK exposure drives redness, burning, and unstable tear film.
- ◆ **Prostaglandin-associated periorbitopathy (PAP).** Orbital fat atrophy, deepened sulcus, lash changes.
- ◆ **The pitch:** a one-time, in-office implant that removes the daily-drop burden while it works.

What it is

- ◆ **Titanium implant, 1.8×0.5 mm** — smaller than a grain of rice.
- ◆ **75 mcg of preservative-free travoprost** held in a reservoir.
- ◆ Elutes **continuously into the anterior chamber** by membrane-controlled diffusion — steady drug level, no daily dosing.
- ◆ Implanted through the trabecular meshwork and back wall of Schlemm's canal, anchored in scleral tissue.

1.8×0.5 mm

Titanium reservoir implant

75 mcg

Preservative-free travoprost

Continuous

Membrane-controlled elution

Travoprost & the prostaglandin analogs

- ◆ **Travoprost is a prostaglandin F2 α analog** — same class as latanoprost, bimatoprost, tafluprost, and the most potent topical IOP-lowering class (~25–33%).
- ◆ **Prodrug → FP-receptor agonist.** Corneal esterases convert it to travoprost free acid, which lowers IOP mainly by increasing **uveoscleral outflow**.
- ◆ **Delivery is the differentiator, not the molecule** — efficacy across PGAs is broadly similar; iDose changes *how* the drug is delivered.
- ◆ **Preservative-free, intracameral, negligible systemic exposure** — plasma travoprost stays below the assay limit (<10 pg/mL); it bypasses the ocular surface.

Fewer surface & cosmetic effects than drops: much less hyperemia, and trials saw none of the iris / periorbital pigmentation typical of topical PGAs — though the label still lists possible, likely-permanent iris pigmentation.

How it goes in

- ◆ Clear corneal incision, aseptic conditions — **in-office or OR.**
- ◆ Delivered across the angle and **anchored at the iridocorneal angle.**
- ◆ **Gonioscopy-visible** — confirm position at the slit lamp.
- ◆ Standalone or **combined with cataract surgery.**



Implantation across the angle (video clip)

Who it's for

- ◆ **Mild-to-moderate open-angle glaucoma or ocular hypertension** needing better IOP control.
- ◆ Patients with **poor adherence or intolerance** to topical drops.
- ◆ Ocular surface disease, dexterity limits, or cost barriers to daily drops.
- ◆ Can be performed **with or without cataract surgery**.

Contraindications & cautions

Contraindicated

- Active or suspected ocular / periocular infection
- Corneal endothelial dystrophy — **Fuchs, guttata**
- Prior corneal transplant or DSAEK
- Hypersensitivity to travoprost

Use caution / counsel

- Narrow angles or angle abnormalities
- Monitor routinely to confirm implant position
- **Iris pigmentation** can occur — likely permanent
- **MRI conditional** — a handy practical pearl

Why the corneal ones: the implant sits by the corneal endothelium — Fuchs/guttata and prior grafts have too little endothelial reserve to absorb further cell loss.

Re-administration is now approved

- ◆ FDA approved a labeling supplement allowing **re-administration in the same eye** — the old label said don't re-dose.
- ◆ **Requires specular microscopy:** the eye must meet an **age-based minimum endothelial cell density**; re-dosing is withheld if there's $\geq 10\%$ ECD loss or prior device dislocation.
- ◆ **No more than once per year.**
- ◆ Backed by **no clinically significant endothelial cell loss through 3 years** across the phase 3 / 2b studies.
- ◆ Exchange study: **place the new implant first, then remove the old one** — safe and tolerated over 12 months.

Where iDose sits in sustained-release glaucoma

System	Drug & format	Duration	Status
iDose TR	Travoprost — titanium, non-biodegradable, re-dosable	Label ~3 yr	FDA approved 2023
Durysta	Bimatoprost — biodegradable intracameral	~3–4 mo	FDA approved 2020
OTX-TIC	Travoprost — biodegradable hydrogel	4–6 mo	Phase 3 (missed endpoint)
ENV515	Travoprost XR — biodegradable	~6 mo	Phase 2a
SpyGlass	Bimatoprost — drug-eluting IOL pads (at cataract)	Up to 3 yr	Phase 1/2

Takeaway: iDose & Durysta are the only FDA-approved intracameral implants — iDose is the only **non-biodegradable, re-administrable** one, giving it by far the longest duration.

How iDose fits our MIGS toolkit

Option	Indication	On a med?	IOP drop	Notes
iDose TR	Mild–moderate OAG + ocular HTN	Not required	~20–25%	Continuous travoprost; can get OHT / one-med patients off drops
iStent Infinite (3 stents)	Mild–moderate OAG	Required — must be on a med	~15–20% (if lucky)	Not for ocular HTN; best when noncompliant or poor ocular surface
OMNI	Ocular HTN + mild–moderate	Not required	Largest drop	Usually 2+ meds / more moderate disease; ↑ hyphema & cyclodialysis-cleft risk → historically after iStent
ECP	Closed-angle cases	—	—	For closed angles; also driven by insurance coverage

What we see in clinic

- ◆ **iDose** — for ocular hypertension or a one-med patient, we can often get them **off drops entirely**. Labeling supports ~3 years; in our hands we typically see **~2 years** of effect.
- ◆ **iStent** — anecdotally a temporary drop holiday, but many are back on a drop within **1–2 years**.
- ◆ **OMNI** gives the biggest IOP reduction — we reserve it for 2+ meds / more moderate disease, and historically place it **after iStent** given higher hyphema and cyclodialysis-cleft risk.
- ◆ **ECP** — we use in **closed-angle** eyes, and where **insurance coverage** favors it.

Our iDose + iStent study

The study

- All qualifying patients receive **iDose TR**; **20% randomized** to also get **3 iStent infinite** stents
- One eye · **12-month** follow-up
- Goal: safety & IOP-lowering efficacy of iDose TR + **iStent infinite**
- Patients **reimbursed \$1,050**

Who qualifies — refer if...

- Age **18+**, any sex
- Glaucoma or **ocular hypertension**
- On **0–2** IOP-lowering medications
- **No prior incisional** glaucoma surgery

Have a patient who fits? Send them to Parkhurst NuVision for screening.

Managing the postop patient

- ◆ Postop course resembles other trabecular MIGS — minimal inflammation, quick recovery.
- ◆ Expect **gradual** IOP lowering as travoprost releases; effect may not be immediate.
- ◆ Continue preop drops initially, then **taper based on IOP response** and your discretion.
- ◆ Monitor IOP, inflammation, corneal status at routine intervals (POD1 if combined, then 1–4 wks).
- ◆ Gonioscopy confirms implant position if IOP response is suboptimal.
- ◆ Reinforce this is **not a cure** — ongoing glaucoma monitoring is still required.

Coverage & coding

- ◆ **Medicare + true supplemental insurance cover iDose** — minimal out-of-pocket for most patients.
- ◆ Available **buy-and-bill** or via **specialty pharmacy** (physician isn't paid for the drug if via specialty pharmacy).

Who to send us

Great candidates

- Mild-to-moderate OAG / ocular hypertension
- Poor compliance / drop-intolerant
- Uncomfortable eyes — poor or damaged ocular surface
- Dexterity or cost barriers
- Anyone heading to cataract surgery — combine it

Not for

- Fuchs / guttata
- Prior corneal graft
- Narrow angles
- Advanced disease needing a low target

Thank you

Let's connect — Gurpal Virdi, MD · scan to follow or reach out



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