Gaps in Access to Diabetes Medications

Background

There are an estimated 4 million people living with diabetes in Canada. Diabetes is a chronic, progressive disease that affects the body's ability to regulate the amount of glucose (sugar) in the blood. It has no cure, but can be managed through education, support, healthy behaviour interventions, and medications. People with type 1 diabetes require daily injections or infusions of insulin to sustain life. People with type 2 diabetes often rely on one or more diabetes medications (known as antihyperglycemic agents, or AHAs) to achieve target blood glucose levels and minimize the risk of complications associated with the condition. Diabetes management in many cases also requires the use of appropriate glucose monitoring devices to safely dose medications.

Diabetes Canada's current Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada recommend the initiation of a basal-bolus insulin regimen (background insulin + meal time insulin) upon diagnosis in people with type 1 diabetes.[1] Insulin type, dosing schedule, and other treatment details are determined based on factors like general health, lifestyle, goals, and ability to self-manage and should be tailored to each patient.[1] For those with type 2 diabetes, metformin is typically recommended at the time of diagnosis or a few months thereafter if blood glucose targets are not achieved with healthy behavior interventions alone.[2] Other AHAs, including insulin as an option, should be added until blood glucose targets are reached. The choice of agent should be made with consideration to individual patient characteristics. For those with type 2 diabetes and clinical cardiovascular disease in whom blood glucose targets are not currently achieved:

- AHAs with demonstrated cardiovascular (CV) outcome benefit, such as a GLP1-RA class medication (e.g., liraglutide) and/or an SGLT2-i class medication (e.g., empagliflozin or canagliflozin), are recommended to reduce the risk of major cardiovascular events.[2]
- An AHA with demonstrated CV outcome benefit, such as an SGLT2-i class medication (e.g., empagliflozin or canagliflozin), is recommended to reduce the risk of heart failure hospitalization.[2]
- An AHA with demonstrated CV outcome benefit, such as an SGLT2-i class medication (e.g., empagliflozin or canagliflozin), is recommended to reduce the risk of progression of nephropathy (kidney damage).[2]

Challenges

Many Canadians rely on provincial drug programs to obtain the medications they need to manage their medical conditions. Public coverage of AHAs varies across Canada, and is based on factors such as age, income, and treatment type. The availability of each of the AHAs and the prescribing rules on many of the public formularies is not in keeping with best practice guidelines (some of which are described above). This means people in certain provinces or territories cannot quickly or easily access the most appropriate medications for their condition.

Cost is also a barrier to procuring AHAs and can affect people's ability to properly manage their diabetes. The Conference Board of Canada's analysis of public and private medical insurance plans found that less than 3% of Canadians have no access to insurance to pay for their prescription medications but that over 10% of Canadians are not enrolled in either a public or private plan in 2020.[3] However, a Statistics Canada survey from 2021 found that one fifth of Canadians (21%) reported having no insurance to cover medication costs during the pandemic.[4] Even with insurance, Canadians living with diabetes can pay thousands of out-of-pocket dollars annually to pay for their medications, devices, and supplies.[5] Some provincial drug plans reimburse the entire cost of AHAs for people who are eligible, and others provide little to no reimbursement. Private group plans offer different levels of reimbursement, but not all employers provide prescription drug coverage, and it can be otherwise expensive or challenging for individuals with

pre-existing health conditions to get. Co-pays and deductibles applied to medications on public and private plans may prohibit access if a person cannot afford to pay them. Many must choose between paying for food/rent/utilities and obtaining medication. Some regularly cannot fill their prescriptions. Others take their AHAs less frequently and/or at a lower dose than indicated to extend their prescription and save money.

Policy Implications

Several provincial governments either do not cover certain AHAs, or medications are restricted and require special permission to obtain, which can represent a significant access barrier for health-care providers and patients. Those who cannot afford their medications, are unable to take them as directed due to cost or cannot get the most appropriate options in a timely way often have difficulty managing their disease. This can have very serious short and long-term health impacts and represents a burden to individuals, families, and Canadian society at large. High and unnecessary costs are incurred from lost productivity and elevated health-care system use due to diabetes and its many complications, including heart attack, stroke, kidney failure, blindness, and amputation.

Recommendations

Diabetes Canada strongly advises the alignment of public and private drug plan policies with evidence-based guidelines to provide high quality treatment and optimize patient care in every jurisdiction across the country. Where they are a barrier to access, co-pays, deductibles, and policies allowing only partial reimbursement of AHAs should be changed or eliminated. Additionally, people living with diabetes across Canada must have access to the education and supports they require that allow them to effectively self-manage their disease.

References

1. McGibbon A, Adams L, Ingersoll K et al. Diabetes Canada 2018 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada: Glycemic Management in Adults with Type 1 Diabetes. Can J Diabetes 2018; 42 (Suppl. 1): S80-S87.
2. Lipscombe L, Booth G, Butalia S et al. Diabetes Canada 2018 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada: Pharmacologic Glycemic Management of Type 2 Diabetes in Adults. Can J Diabetes 2018; 42 (Suppl. 1): S88-S103.
3. Gagnon-Arpin, Isabelle, Wanlin Chen, and Chad Leaver. *Understanding the Gap 2.0: A Pan-Canadian Analysis of Prescription Drug Insurance Coverage*. Ottawa: The Conference Board of Canada, 2022.
4. Cortes, Kassandra and Leah Smith. *Insights on Canadian Society: Pharmaceutical access and use during the pandemic*. Ottawa: Statistics Canada, 2022.
5. Diabetes Canada. *Diabetes and Diabetes-Related Out-of-Pocket Costs: 2022 Update.* Ottawa: Diabetes Canada; 2022.

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Provinces	Gaps in Coverage for Those Covered Under a Public Plan		
	Insulin	AHAs for CV/Nephropathy Risk Reduction	Other AHAs
British Columbia	• partial reimbursement for rapid-acting and certain pre- mixed insulins • long-acting insulin covered for those who meet eligibility criteria and receive prior special authorization (SA) • insulin glargine U-300, originator biologic insulin glargine and insulin degludec not listed • insulin aspart and insulin lispro delisted • biphasic insulin aspart, insulin lispro 25%/lispro protamine 75% and insulin lispro 50%/lispro protamine 50% not listed	• liraglutide not listed • canagliflozin not listed • empagliflozin covered with preapproval SA only after treatment with metformin and a sulfonylurea	• linagliptin and saxagliptin covered for those who meet eligibility criteria and receive approval under SA rules of Pharmacare • sitagliptin not listed • gliclazide covered (generic available) for those who meet eligibility criteria under SA rules • many combination medications not listed/
Alberta	• insulin glargine U-300 and originator biologic insulin glargine delisted (Jan 2021) • insulin degludec regular benefit (Dec 2018) • biphasic insulin aspart not listed • Insulin aspart delisted (April 2022) • Insulin lispro delisted (Feb 2022)	• liraglutide not listed • empaglifozin and canaglifozin covered under SA for those who meet eligibility criteria as an add-on therapy when treatment with metformin and a sulfonylurea have provided inadequate glycemic control and for whom insulin is not an option	• linagliptin, sitagliptin and saxagliptin covered for those who meet eligibility criteria under SA rules • many combination medications not listed or are restricted
Saskatchewan	• insulin aspart covered for those who meet eligibility criteria under Exception Drug Status (EDS) • insulin glargine U-300 not listed • biphasic insulin aspart, insulin lispro 25%/lispro protamine 75% and insulin lispro 50%/lispro protamine 50% not listed	• liraglutide not listed • empaglifozin and canaglifozin covered for those who meet eligibility criteria under EDS as an add-on therapy for those who are not adequately controlled on or are intolerant to metformin and a sulfonylurea	• linagliptin, sitagliptin and saxagliptin covered for those who meet eligibility criteria under EDS • many combination medications not listed or are restricted
Manitoba	• insulin glargine U-300 not listed • insulin aspart and insulin lispro 50%/lispro protamine 50% not listed	• liraglutide not listed • empaglifozin and canaglifozin covered for those who meet eligibility criteria under EDS as an add-on therapy for those who are not adequately controlled on or are intolerant to metformin and a sulfonylurea	• linagliptin, sitagliptin and saxagliptin covered for those who meet eligibility criteria under EDS • many combination medications not listed or are restricted
Ontario	• insulin aspart covered for those who meet eligibility criteria under special authorization rules	• liraglutide not listed	

New Brunswick	• insulin lispro, insulin glargine and insulin glargine U-300 not listed • insulin detemir covered for those who meet eligibility criteria and receive SA • biphasic insulin aspart, insulin lispro 25%/lispro protamine 75% and insulin lispro 50%/lispro protamine 50% not listed	• liraglutide not listed • empaglifozin and canaglifozin covered under special authorization for those who meet eligibility criteria as an add-on therapy when treatment with metformin and a sulfonylurea have provided inadequate glycemic control and for whom insulin is not an option	• linagliptin, sitagliptin and saxagliptin covered for those who meet eligibility criteria under SA rules • many combination medications not listed or are restricted
Nova Scotia	• insulin detemir covered for those who meet eligibility criteria under EDS • insulin glargine delisted • insulin glargine U-300 not listed • biphasic insulin aspart, insulin lispro, insulin lispro 25%/lispro protamine 75% and insulin lispro 50%/lispro protamine 50% not listed	• liraglutide not listed • empaglifozin and canaglifozin covered under EDS for those who meet eligibility criteria as an add-on therapy when treatment with metformin and a sulfonylurea have provided inadequate glycemic control and for whom insulin is not an option	• linagliptin, sitagliptin and saxagliptin covered for those who meet eligibility criteria under EDS • many combination medications not listed or are restricted
Prince Edward Island	• insulin detemir, insulin glargine U-300 and insulin glargine covered for those who meet eligibility criteria under SA • biphasic insulin aspart and insulin lispro 50%/lispro protamine 50% not listed	• liraglutide not listed • empagliflozin and canagliflozin covered for those who meet eligibility criteria under SA as a third drug added on to metformin and a sulfonylurea for patients with inadequate glycemic control on optimal doses of metformin	• linagliptin, sitagliptin and saxagliptin covered for those who meet eligibility criteria under SA • many combination medications not listed or are restricted
Newfoundland & Labrador	• insulin detemir covered for those who meet eligibility criteria with SA • insulin lispro, insulin glargine not listed • insulin glargine U-300 not listed • biphasic insulin aspart, insulin lispro 25%/lispro protamine 75% and insulin lispro 50%/lispro protamine 50% not listed	• liraglutide not listed • empaglifozin and canaglifozin covered under SA for those who meet eligibility criteria as an add-on therapy when treatment with metformin and a sulfonylurea have provided inadequate glycemic control and for whom insulin is not an option	• linagliptin, sitagliptin and saxagliptin covered for those who meet eligibility criteria under SA • many combination medications not listed or are restricted
Yukon	• insulin detemir covered for those who meet eligibility criteria with EDS • insulin glargine U-300 not listed • insulin glargine covered for those who meet eligibility criteria with EDS	• liraglutide not listed • empagliflozin and canagliflozin covered under EDS for those who meet eligibility criteria for persons with inadequate glycemic control on metformin and a sulfonylurea and for whom insulin is not an option	• linagliptin, sitagliptin and saxagliptin covered for those who meet eligibility criteria under EDS • many combination medications not listed or are restricted
Northwest Territories	• biphasic insulin aspart not listed	• liraglutide not listed • canaglifozin covered under EDS for those who meet eligibility criteria for those who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin and a sulfonylurea	• linagliptin, sitagliptin and saxagliptin covered for those who meet eligibility criteria under EDS • many combination medications not listed or are restricted

Nunavut	• biphasic insulin aspart not listed	• liraglutide not listed • canaglifozin covered under EDS for those who meet eligibility criteria for those who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin and a sulfonylurea	• linagliptin, sitagliptin and saxagliptin covered for those who meet eligibility criteria under EDS • many combination medications not listed or are restricted
NIHB	• biphasic insulin aspart not listed	• liraglutide not listed • canaglifozin covered under EDS for those who meet eligibility criteria for those who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin and a sulfonylurea	• linagliptin, sitagliptin and saxagliptin covered for those who meet eligibility criteria under EDS • many combination medications not listed or are restricted

NOTE: Cost of medications is a significant barrier to access. Though a medication may theoretically be available to a patient through a public plan, any co-pays and/or deductibles charged to the patient can prohibit access. Additionally, accessibility is limited for many patients when medications are only partially reimbursed by a public plan.

BC: NovoRapid, Humalog are non-benefits but insulin pump users have extended coverage to 30 Nov 2022
AB: Humalog KWIKPEN 200 UNIT / ML INJECTION remains a regular benefit
ON: Lantus 100U/mL Inj Sol-10mL Vial Pk is a General Benefit; Lantus SoloStar or cartridge 100U/mL Inj Sol-5x3mL Pk are Limited Use; Humalog ODB funding remains for established users [eff January 29, 2021 RFU Code 599]
NS: Insulin glargine is covered in other formats such as insulin glargine hum.rec.anlog BASAGLAR 100 UNIT/ML (3ML) INSULIN PEN; Lantus Feb 4, 2022, no longer eligible for New Exception status approvals, biosimilar versions covered
NL: Insulin glargine is covered in other formats such as insulin glargine hum.rec.anlog BASAGLAR 100 UNIT/ML (3ML) INSULIN PEN

Legend	
AHA	Single-Source Brand Name
empagliflozin	Jardiance
liraglutide	Victoza
canagliflozin	Invokana
insulin glargine U-300	Toujeo
insulin degludec	Tresiba
biphasic insulin aspart	NovoMix 30
insulin aspart	NovoRapid
insulin lispro 25%/lispro protamine 75%	Humalog Mix25
insulin lispro 50%/lispro protamine 50%	Humalog Mix50
insulin lispro	Humalog
insulin detemir	Levemir
insulin glargine	Lantus
linagliptin	Trajenta
saxagliptin	Onglyza
sitagliptin	Januvia *
gliclazide	Diamicron *

* Generic versions available. Pharmacare plans cover cost of lowest priced generic available.