Diabetes Canada: Overview of Bill C-64

Overview

On February 29, 2024, the Government of Canada introduced Bill C-64, *An Act Respecting Pharmacare*. This legislation creates a framework to implement the national pharmacare plan. As part of its overall plan, the government committed to providing coverage for diabetes medications, as well as a fund for devices. A draft formulary listing medications proposed for coverage has been released.

What does the pharmacare proposal and C-64 mean for people with diabetes?

Diabetes Canada applauds the government's intention to include diabetes medication and devices in the initial scope of its pharmacare plan. We all acknowledge that there is an urgent and pressing need to help people living in Canada with diabetes access life saving medications. With broad consultation and engagement, and careful implementation, this could represent a significant step towards reducing barriers to diabetes care. Providing improved access, comprehensive coverage, and patient choice are our key objectives.

The government has published a draft formulary outlining diabetes medications for which coverage is planned under the pharmacare program. Unfortunately, it is not aligned with our clinical practice guidelines (CPGs) nor the Non-Insured Health Benefits Plan (NIHB) and is limited in scope, excluding several key treatments while including several older and outdated products. Diabetes Canada has consulted with patients, partners, and stakeholders across the country who have voiced the same anxiety and concern.
Accordingly, we have produced a comparison document of the proposed formulary with our CPGs and the NIHB. This document demonstrates that for many uninsured individuals living with diabetes in Canada, most of the commonly prescribed medications will not be covered by the public plan. This is why there is an urgent need to fill the gaps and focus on un-and-underinsured individuals.

We also suggest the adoption of a principle in the law of continued improvement of care and access. The care and management of diabetes is very individualized and no one patient is the same. As our CPGs have shown, new data continually suggests improvements in care, services and products. A pharmacare system must incorporate this principle to ensure that as new techniques and products which are more effective become available, they become incorporated at appropriate times. This should be paired with a 'do no harm' or 'nobody left behind' principle. This would protect people with existing coverage, including private, for diabetes medications that are not covered under the public formularies that will be established in consultation with the provinces and territories.

Diabetes Canada has three primary recommendations to improve C-64 and benefit people living with diabetes therefore the law should:

1. **Emphasize Comprehensiveness and Choice**
    - Before C-64 receives Royal Assent, the government should utilize Diabetes Canada's clinical practice guidelines and develop a more comprehensive formulary, in consultation with people with lived experience of diabetes, healthcare experts, the provinces and territories, and Indigenous communities. Each person living with diabetes is unique and health care professionals need a choice of effective intervention to personalize and adapt their recommended treatment.
    - Diabetes Canada has created a very detailed comparison document that looks at our Clinical Practice Guidelines when it comes to diabetes mediations as well as the Non-Insured Health Benefits Program for First Nations and Inuit peoples that is run by the Federal Government. This document is attached as Appendix 1.
        - This document demonstrates that for many uninsured individuals living with diabetes in Canada, most of the commonly prescribed medications will not be covered by the public plan. This is why filling the gaps to focus on un-and-underinsured individuals is so critical.
        - There is an urgent need to cover people in Canada who do not have coverage; while the government explores the implementation of any model, it should free up resources immediately and work with drug plans to determine priority areas, reduce administrative burden and immediately fill the gaps. (see Provincial /Territorial Formulary listings Appendix 2)
        - Bill C64 states that the Canada Health Act should be considered in the creation of the National Pharmacare Program. One of the principles in the Canada Health Act is comprehensiveness; the background formulary is far from meeting that definition.

2. **Ensure Continued Improvement in Access and Care**
    - As outlined in our Clinical Practice Guidelines; the government should adopt a principle of 'continued improvement of care and access', reflecting the reality that new techniques and treatments will continue to become available after the pharmacare program is adopted.
    - The pharmacare system must implement this principle with a mechanism to ensure improvements in care, services and products are incorporated into the system as they emerge.
    - The system should welcome diverse approaches and creativity, including private insurance, while seeking universal coverage. Every province and territory is distinct in its approach to healthcare, and pharmacare will be no

different. Quebec's hybrid model is a good example of an approach to consider. Other approaches by the federal government (eg. NIHB) as well as provinces and territories should also be considered as they are mandated for the primary delivery of health care in Canada.

3. **Provide for Robust and Fulsome Consultation**
    - Prior to C-64 receiving Royal Assent, there should be a robust and fulsome consultation, including persons with lived experience of diabetes, health care providers, researchers, the provinces and territories, and Indigenous communities. This consultation should include the development of real and practical scenarios regarding the impact of the proposed plan.
    - C-64 should enshrine a 'do no harm' or nobody left behind' principle in law, similar to the protections that exist under the previously passed dental care legislation, to protect the private coverage that many people living with diabetes already rely on.
    - Diabetes Canada has seen the consequences that can flow from lack of consultation.
        - Ontario's OHIP+, a single payer provincial plan introduced in 2017, led to more red tape for health-care providers and less access to treatments for people living with diabetes. The program was subsequently revised to be second payer for those with private health insurance coverage and primary payer for those without.
        - Alberta's Insulin Pump Therapy Program was set to be discontinued and moved to Alberta Blue Cross without any form of consultation. An outcry from the diabetes community compelled the government to reverse course.
    - While these programs seemed like a significant step in improving access to medications, the concerns raised highlighted the complexities involved in implementing such a policy; such as limited formularies, authorization delays, and coordination issues with private insurance. We do not want to see the same thing happen with national pharmacare.

In conclusion, Diabetes Canada believes it is paramount to emphasize the human reality that we are trying to tackle in this submission. Too many people are un-or-underinsured. Our 1-800 Banting info team receives many calls and emails from people in Canada living with diabetes who have difficulty obtaining the medications they need. For example:

- A couple who both have T2 diabetes are waiting for approval for government support to pay for their medication, so while they wait they are either rationing or going without their medication.
- People are not taking the right amount of medication as they can't afford them – because of the cost per month.
- People are concerned their private insurance will be adversely affected.

The people living with diabetes who are struggling to pay for their medications or get access to these drugs should remain the critical focus. This legislation has the opportunity to ensure that no one gets left behind. Diabetes Canada continues to advocate for appropriate, comprehensive and timely access to diabetes care throughout Canada. Our goal is to improve the quality of life for people living in Canada with diabetes by connecting patients with healthcare providers, providing expert guidance and information, and assisting with research. We look forward to working with all provincial/territorial governments to achieve these goals.

DIABETES CANADA

BILL C-64

Comparision of Non-Insured Health Benefits (NIHB) and Diabetes Canada Clinical Practice Guidelines with Bill C-64

MAY 2024

Comparision of Non-Insured Health Benefits (NIHB) and Diabetes Canada Clinical Practice Guidelines with Bill C-64

Diabetes Canada's evidence-based clinical practice guidelines are rigorously developed to inform general patterns of care; reduce inappropriate variation in practice; promote efficient use of health-care resources; identify gaps in knowledge; and inform public policy to improve the quality of care and health-care outcomes for people in Canada who live with diabetes.

Based on values that respect the individuality of people living with diabetes and their clinical and social context, Diabetes Canada's clinical practice guidelines also empower people living with diabetes and promote the importance of individualized care through the principles of inclusion, diversity, equity, and accessibility.

All people living with diabetes in Canada should have the opportunity to manage their diabetes to the best of their ability and achieve their optimal health through equal access to person-centered care and support. Every person is unique, and their diabetes management should be tailored to meet their specific needs, including collaborative care that addresses gender identity, sexual orientation, ethnicity, geographical location, culture, and social class. The clinical practice guidelines respect and welcome patient autonomy, and recognize that optimal care for the population (by addressing social determinants of health and inequities in access to care) is as important as defining optimal care for individuals living with diabetes.

While Bill C-64 shows a commitment to helping people live well with diabetes and to reducing risk and/or delaying complications of the condition, its limited drug formulary is lacking several pharmacological treatments that should be offered for consideration to individuals living with diabetes. The limited list opposes the main principles of the clinical practice guidelines which advocates for people to have access to individualized care that is determined through shared decision-making between the individual affected by diabetes and the diabetes health-care team. Not having access to a comprehensive medication formulary that is fulsome and inclusive is detrimental to individuals who cannot tolerate certain therapies and those who need to choose medications and therapies not included in the proposed list.

Unlike the NIHB plan, which offers coverage of all diabetes medications (including cardiorenal protective and prioritized glucose-lowering therapies which support weight-management and are not, on their own, affiliated with hypoglycemia), as well as supplies and technology, Bill C-64 includes only a small number of pharmacologic therapies. This is inconsistent with the clinical practice guidelines which recommend use of the agent/therapy that is best suited to an individual's unique circumstances. The list is also glycemic-centric and neglects to include key medications for cardiorenal protection that are recommended in the clinical practice guidelines, including statins, ACE/ARBs, anti-platelet agents (when indicated), and medications to manage hypertension. The clinical practice guidelines look beyond the glucocentric approach and seek to support each person based on their current health status, including recommending preventative therapies when appropriate according to an individual's level of risk of health outcomes, and supporting the person's desired health-care goals.

Concerns and inconsistencies with Diabetes Canada Clinical Practice Guidelines

Drug	Concerns and inconsistencies
SGLT2 Inhibitors	• Forxiga (dapagliflozin) is included in the proposed list, but canagliflozin and empagliflozin (single entity agents) are not included. • Synjardy (empagliflozin/metformin) is included in the proposed list, but combination Invokamet (canagliflozin/metformin) and Xigduo (dapagliflozin/metformin) are not included. • This limited list is contrary to Diabetes Canada's clinical practice guidelines which support the appropriate use of cardiorenal protective agents when indicated. Further, this discordance is impractical from a clinical care perspective in that it would require a clinician to change a person's medication within a class, i.e. change from empafliflozin to dapafliflozin, in the event that that clinician is simply aiming to adjust the dose of metformin. • The following is a list of the SGLT2 inhibitors that are indicated in the recommendations of the Diabetes Canada clinical practice guidelines: canagliflozin, dapagliflozin, and empagliflozin.* **Note: *See Appendix A*** for the recommendations from the 2020 update of the *Pharmacologic Glycemic Management of Type 2 Diabetes* in *Adults* chapter. The level of evidence is listed for each.
DPP4 Inhibitors	• Saxagliptin is included in the proposed list in the form of Komboglyze (saxagliptin/metformin), but sitagliptin (neither single entity nor combination product) is not included. • Linagliptin is included in the proposed list in the form of Jentadueto (linagliptin/metformin), but linagliptin (single entity) is not included. • This limited list is very restrictive to the clinician who would be able to use a DPP4 inhibitor only in combination with metformin. Metformin is contraindicated, and/or not tolerated, in a number of individuals with diabetes, requiring that the DPP4 inhibitor be available as a single entity product. • The following is a list of the DPP4 inhibitors that are indicated in the recommendations of the Diabetes Canada clinical practice guidelines: saxagliptin.* Of note, due to a higher risk of heart failure, saxagliptin is not recommended in people with a history of heart failure, a recognized complication of diabetes. **Note: *See Appendix A*** for the recommendations from the 2020 update of the *Pharmacologic Glycemic Management of Type 2 Diabetes* in *Adults* chapter. The level of evidence is listed for each.

Drug	Concerns and inconsistencies
GLP1-RA/dual GIP/GLP-1 RA	• No incretin mimetics (neither GLP-1 RA nor dual GIP/GLP-1 RA) are included in the proposed list. • Again, this is contrary to the guidelines. Access and equity in diabetes care need to look beyond the glucocentric approach and follow the guidelines for GLP1-RA, at least for those with cardiorenal complications. In clinical practice, not everyone is a candidate for SGLT2 inhibitors or can tolerate these medications. These options are not only important, but necessary. • The following is a list of the GLP1-RAs that are indicated in the recommendations of the Diabetes Canada clinical practice guidelines: liraglutide, dulaglutide, and semaglutide.* **Note: *See Appendix A*** for the recommendations from the 2020 update of the *Pharmacologic Glycemic Management of Type 2 Diabetes* in *Adults* chapter. The level of evidence is listed for each.
Insulins	• Biosimilar insulin glargine u100 and detemir are included in the proposed list, but neither insulin degludec nor insulin glargine U300 are included. • There are concerns that many of the insulins on this list would not be "commonly used" (i.e. Entuzity, Hypurin Regular Insulin Pure, Hypurin NPH Insulin Isophane Pork, and even Humulin R and Novolin ge Toronto). According to a 2007 CADTH report, a very small percentage - approximately 0.1% of the Canadian insulin market - uses animal products, which represents 400 people using animal insulin out of approximately 382,000 insulin-dependent Canadians[1]. Access to these particular insulins is important to this small population, however, the majority of insulin users in Canada use synthetic insulins, the majority of which are not included in the proposed list. • With respect to the premixed insulins, Novolin ge 30/70 and Humulin 30/70 are included in the proposed list, but the premixed insulins that are affiliated with comparably less hypoglycemia (i.e. NovoMix 30, Humalog 25, and Humalog 50) are not included. • The following is a list of insulins that are indicated in the recommendations of the Diabetes Canada clinical practice guidelines: glargine U-100, glargine U-300, detemir, degludec, and aspart.* For a complete list of insulins listed in the Diabetes Canada clinical practice guidelines, please see Table 1, available at: https://guidelines.diabetes.ca/GuideLines/media/Images/cpg/Ch13-2020-Tbl1b-Antihyperglycemic-agents-for-use-in-type-2-diabetes.png **Note: *See Appendix B*** for the insulin-related recommendations from the 2020 update of the *Pharmacologic Glycemic Management of Type 2 Diabetes* in *Adults* chapter. The level of evidence is listed for each.

* These are the pharmacologic therapies indicated in the recommendations of the 2020 update of the *Pharmacologic Glycemic Management of Type 2 Diabetes in Adults* chapter.

It is important to note, however, that ALL antihyperglycemic agents are listed in the chapter preamble, along with their class, mechanism of action, cost, their effect on primary CVD outcomes, risk of hypoglycemia, and other therapeutic considerations. It is also specifically stated that the choice of agent should be individualized as per the unique circumstances of the individual living with diabetes.

1 Canadian Agency for Drugs and Technologies in Canada. Efficacy and Safety of Human versus Animal Insulins. August 3, 2007

Conclusion

While a significant step forward for diabetes health-care support in Canada, Bill C-64 needs to expand its formulary to not only ensure more diverse coverage, but to support collaborative and individualized care which is the cornerstone of the clinical practice guidelines. The limited formulary makes individualized care nearly impossible and may negatively impact our health-care system and the health of people living with diabetes by offering sub-optimal therapies (i.e. prioritizing management options that increase a person's risk of hypoglycemia and weight gain). Also, a national pharmacare program with a limited formulary has the potential to impact choice; health-care providers may look to the formulary as a definitive list without collaborating with the person living with diabetes and discussing all theraputic options.

Diabetes is a complicated condition with a constantly expanding compendium of new therapies and new technologies, and they should all be available and covered as options for care.

Appendix A: Recommendations for the advancement or adjustment of treatment in people with type 2 diabetes*

* Taken from the 2020 update to the *Pharmacologic Glycemic Management of Type 2 Diabetes* in *Adults* chapter. This chapter is currently being revised based on newly published evidence, so the recommendations may change.

1. In adults with type 2 diabetes **with ASCVD, HF and/or CKD, treatment should include agents from the following classes with** demonstrated **CV or renal benefits** (see Figures 2A, 2B and Table 2).
   - **a.** In adults with **type 2 diabetes and ASCVD**, a GLP1-RA or SGLT2i with CV or renal benefit should be used to reduce the risk of:
     - **i.** MACE [Grade A, Level 1A (6,10) for liraglutide and dulaglutide; Grade B, Level 2 for subcutaneous semaglutide (7); Grade A, Level 1A (12) for empagliflozin; Grade B, Level 2 (15) for canagliflozin].
     - **ii.** HHF [Grade B, Level 2 (12,15,17) for empagliflozin, canagliflozin and dapagliflozin].
     - **iii.** Progression of nephropathy [Grade B, Level 2 (44,15,17) for empagliflozin, canagliflozin and dapagliflozin].
   - **b.** In adults with type 2 diabetes and **a history of HF** (reduced ejection fraction ≤40%):
     - **i.** An SGLT2i should be used to reduce the risk of HHF or CV death, if the eGFR is >30 mL/min/1.73m^2 [Grade A, Level 1A (19) for dapagliflozin; Grade A, Level 1 (18) for empagliflozin and canagliflozin].
     - **ii.** TZD and saxagliptin should be avoided due to their higher risk of HF [Grade A, Level 1A (21,45,46)].
   - **c.** In adults with type 2 diabetes and **CKD and an estimated eGFR >30 mL/min/1.73m^2**:
     - **i.** An SGLT2i should be used to reduce the risk of:
       1. Progression of nephropathy [Grade A, Level 1A (16) for canagliflozin; Grade A, Level 1 (18) for empagliflozin and dapagliflozin].
       2. HHF [Grade A, Level 1 (18) for canagliflozin, dapagliflozin and empagliflozin].
       3. MACE [Grade B, Level 2 for canagliflozin (16), Grade C, Level 3 (12) for empagliflozin].
     - **ii.** A GLP1-RA may be considered to reduce the risk of MACE (Grade B, Level 2 (6,7) for liraglutide and semaglutide).
2. In adults with type 2 diabetes requiring treatment advancement or adjustment to improve glycemic control, the choice of antihyperglycemic medication should be individualized according to clinical priorities (see Figure 2A and Table 1 for therapeutic considerations and cautions) [Grade B, Level 2 (26)].
   - **a.** In adults with type 2 diabetes **aged 60 years or older with at least 2 CV risk factors** (see Table 3), inclusion of the following classes in glycemic management should be considered:
     - **i.** A GLP1-RA with proven CV outcome benefit to reduce the risk of MACE [Grade A, Level 1A (10) for dulaglutide; Grade B, Level 2 (6) for liraglutide and Grade C, Level 2 (7) subcutaneous semaglutide]; OR
     - **ii.** An SGLT2i with proven cardiorenal outcome benefit if estimated GFR is >30 mL/min/1.73m^2 to reduce the risk of
       1. HHF [Grade B Level 2 (15,17) for dapagliflozin and canagliflozin].
       2. Progression of nephropathy [Grade C, Level 3 (15,17) for canagliflozin and dapagliflozin].
   - **b.** If reducing risk of hypoglycemia is a priority: Incretin agents (DPP4i or GLP1-RA), SGLT2i, acarbose and/or pioglitazone should be considered as add-on medication to improve glycemic control with a lower risk of hypoglycemia than other agents [Grade A, Level 1A (26,28,29,47,48,49,74)]. (See Table 1.)
   - **c.** If weight loss is a priority: A GLP1-RA and/or SGLT2i should be considered as add-on medication to improve glycemic control with more weight loss than other agents [Grade A, Level 1A (26,28,29,30,47,48,49]. (See Table 1.)

Appendix B: Recommendations for initiating insulin treatment in individuals with type 2 diabetes*

* Taken from the 2020 update to the *Pharmacologic Glycemic Management of Type 2 Diabetes* in *Adults* chapter. This chapter is currently being revised based on newly published evidence, so the recommendations may change.

1. In people not achieving glycemic targets on existing noninsulin antihyperglycemic medication(s), the addition of a basal insulin regimen should be considered over premixed insulin or bolus-only regimens, if lower risk of hypoglycemia and/or preventing weight gain are priorities [Grade B, Level 2 (50)].

2. In adults with type 2 diabetes treated with basal insulin therapy, if minimizing risk of hypoglycemia is a priority:

- **a.** Long-acting insulin analogues (insulin glargine U-100, glargine U-300, detemir, degludec) should be considered over NPH insulin to reduce the risk of nocturnal and symptomatic hypoglycemia [Grade A, Level 1A (51-56)].
- **b.** Insulin degludec or insulin glargine U-300 (57) may be considered over insulin glargine U-100 to reduce overall and nocturnal hypoglycemia [Grade B, Level 2 for individuals with ≥1 risk factor for hypoglycemia (58,59)]; [Grade C, Level 3 for other individuals without risk factors for hypoglycemia (56)]; and severe hypoglycemia in patients at high CV risk [Grade C, Level 3 (60)]

Treatment Advancement or Adjustment for People With Type 2 Diabetes Treated With Insulin

1. In adults with type 2 diabetes receiving insulin, doses should be adjusted and/or additional antihyperglycemic medication(s) should be added if glycemic targets are not achieved [Grade D, Consensus].

- **a.** A GLP1-RA should be considered as add-on therapy [Grade A, Level 1A (61,62)], before initiating bolus insulin or intensifying insulin to improve glycemic control with potential benefits of weight loss and lower hypoglycemia risk compared to single or multiple bolus insulin injections [Grade A, Level 1A (63-71)].
- **b.** An SGLT2i should be considered as add-on therapy to improve glycemic control with potential benefits of weight loss and lower hypoglycemia risk compared to additional insulin [Grade A, Level 1A (72-74)].
- **c.** A DPP4i may be considered as add-on therapy to improve glycemic control with potential benefits of less weight gain and lower hypoglycemia risk compared to additional insulin [Grade B, Level 2 (72,75-77)].

2. When bolus insulin is added to antihyperglycemic agents, rapid-acting analogues may be considered over short-acting (regular) insulin for greater improvement in glycemic control [Grade B, Level 2 (78,79) for aspart].

3. Bolus insulin may be initiated using a stepwise approach (starting with 1 injection at 1 meal and additional mealtime injections as needed) to achieve similar A1C reduction with lower hypoglycemia risk compared to initiating bolus injections at every meal [Grade B, Level 2 (80)].

Appendix C: Comparison of Diabetes Canada Clinical Practice Guidelines (CPG), NIHB, and Bill C-64 Formulary Listings

SGLT2 Inhibitors			
Drug (brand name)	**Bill C-64**	**NIHB**	**Diabetes Canada CPG**
canagliflozin **(Invokana)**		Limited use benefit (prior approval required)	✓
dapagliflozin **(Forxiga)**	✓	✓	✓
dapagliflozin and metformin **(Xigduo)**		✓	✓
empagliflozin **(Jardiance)**		✓	✓
empagliflozin and metformin **(Synjardy)**	✓	✓	✓
ertugliflozin **(Steglatro)**			✓

DPP4 Inhibitors			
Drug (brand name)	**Bill C-64**	**NIHB**	**Diabetes Canada CPG**
alogliptin **(Nesina)**			✓
linagliptin **(Trajenta)**		✓	✓
linagliptin and metformin **(Jentadueto)**	✓	✓	✓
saxagliptin **(Onglyza)**		✓	✓
saxagliptin and metformin **(Komboglyze)**	✓	✓	✓

DPP4 Inhibitors (continued)			
Drug (brand name)	**Bill C-64**	**NIHB**	**Diabetes Canada CPG**
sitagliptin **(Januvia)**		Limited use benefit (prior approval required)	✓
sitagliptin and metformin **(Janumet)**		Limited use benefit (prior approval required)	✓
GLP1-RAs			
Drug (brand name)	**Bill C-64**	**NIHB**	**Diabetes Canada CPG**
dulaglutide **(Trulicity)**			✓
exenatide **(Bydureon)**			✓
exenatide XR **(Byetta)**			✓
liraglutide **(Victoza)**			✓
lixisenatide **(Adlyxine)**		✓	✓
semaglutide **(Ozempic; Rybelsus)**		✓	✓
Insulins			
Drug (brand name)	**Bill C-64**	**NIHB**	**Diabetes Canada CPG**
aspart **(NovoRapid)**		✓	✓
aspart (biosimilar) **(Trurapi; Kirsty)**	✓	✓	✓
biphasic insulin aspart **(NovoMix 30)**	✓		✓
concentrated Humulin R **(Entuzity)**	✓	✓	
degludec U100; U200 **(Tresiba)**		✓	✓

Insulins (continued)			
Drug (brand name)	**Bill C-64**	**NIHB**	**Diabetes Canada CPG**
detemir **(Levemir)**	✓	✓	✓
Glargine U100; U300 **(Lantus; Toujeo)**		✓	✓
glargine (biosimilar) **(Basaglar; Semglee)**	✓	✓	✓
glargine and lixisenatide **(Soliqua)**		✓	✓
glulisine **(Apidra)**	✓	✓	✓
isophane, pork pure **(Hypurin NPH)**	✓		Due to lack of published evidence regarding animal-sourced insulins, the guidelines do not offer recommendations for their use. However, it is also specifically stated that the choice of agent should be individualized as per the unique circumstances of the individual living with diabetes.
Lispro U100; U200 **(Humalog)**		✓	✓
lispro (biosimilar) **(Admelog)**	✓	✓	✓
lispro/lispro protamine suspension **(Humalog Mix)**		✓	✓

Insulins (continued)			
Drug (brand name)	**Bill C-64**	**NIHB**	**Diabetes Canada CPG**
pork regular **(Hypurin R)**	✓		Due to lack of published evidence regarding animal-sourced insulins, the guidelines do not offer recommendations for their use. However, it is also specifically stated that the choice of agent should be individualized as per the unique circumstances of the individual living with diabetes.
premixed regular NPH **(Humulin 30/70; Novolin 30/70)**	✓	✓	✓
regular, human **(Humulin R; Novolin ge Toronto)**	✓	✓	✓
Biguanides			
Drug (brand name)	**Bill C-64**	**NIHB**	**Diabetes Canada CPG**
metformin **(Glucophage; Glumetza)**	✓	✓	✓
metformin XR **(Glucophage; Glumetza)**	✓	✓	✓
Insulin Secretagogues (Sulfonylureas)			
Drug (brand name)	**Bill C-64**	**NIHB**	**Diabetes Canada CPG**
gliclazide **(Diamicron; Diamicron MR)**	✓	✓	✓
glimepiride **(Amaryl)**			✓
glyburide **(Diabeta; Euglucon)**	✓	✓	✓

Insulin Secretagogues (Meglitinides)			
Drug (brand name)	**Bill C-64**	**NIHB**	**Diabetes Canada CPG**
repaglinide **(GlucoNorm)**		✓	✓

Alpha-glucosidase Inhibitors			
Drug (brand name)	**Bill C-64**	**NIHB**	**Diabetes Canada CPG**
acarbose **(Glucobay)**		✓	✓

DIABETES CANADA

Formulary Listings for Diabetes Medications in Canada

This information demonstrates that access to diabetes medication varies across the provinces and territories. Specific listings should be verified with provincial and territorial formularies (accessible online). **Please send notification of amendments or errors to info@diabetes.ca**

January 2024

Class	Drug (brand name)	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	NIHB NU/NT	YK
Alpha-glucosidase inhibitor	acarbose (***Glucobay***)	NL	L	L	L	R	L	L	L	L	L	L	L
Combined formulations	alogliptin & metformin (***Kazano***)	NL	NL	NL	NL	NL	R	NL	NL	NL	NL	NL	NL
	canagliflozin & metformin (***Invokamet***)	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL
	dapagliflozin & metformin (***Xigduo***)	NL	L	R	R	L	R	R	R	R	R	L	R
	empagliflozin & metformin (***Synjardy***)	R	R	R	R	L	R	R	R	R	R	L	R
	ertugliflozin & metformin (***Segluromet***)	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL
	linagliptin & metformin (***Jentadueto***)	R	R	R	R	L	R	R	R	R	R	L	R
	rosiglitazone & metformin (***Avandamet***)	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL
	rosiglitazone & glimepiride (***Avandaryl***)	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL
	saxagliptin & metformin (***Komboglyze***)	R	R	R	R	L	R	R	R	R	R	L	R
	sitagliptin & metformin (***Janumet***)	NL	R	R	R	L	R	L	R	R	R	R	R
	sitagliptin & ertugliflozin (***Steglujan***)	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL
	insulin degludec & liraglutide injection (***Xultophy***)	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL
	insulin glargine & lixsenatide injection (***Soliqua***)	NL	NL	R	R	L	NL	NL	NL	NL	R	L	NL
DPP-4 inhibitor	alogliptin (***Nesina***)	NL	NL	NL	NL	NL	R	NL	NL	NL	NL	NL	NL
	linagliptin (**Trajenta**)	R	R	R	R	L	R	L	R	R	R	L	R
	sitagliptin (***Januvia***)	NL	R	R	R	L	R	L	R	R	R	R	R
	saxagliptin (***Onglyza***)	R	R	R	R	L	R	R	R	R	R	L	R

Class	Drug (brand name)	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	NIHB NU/ NT	YK
GLP-1 receptor agonist	albiglutide (***Eperzan***)	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL
	dulaglutide (***Trulicity***)	R	NL	NL	NL	NL	R	NL	Nle	NL	NL	NL	NL
	exenatide injection (***Byetta***) / extended release (***Bydureon***)	NL	NL	NL	NL	NL	NL	NL	NLd	NL	NL	NL	NL
	liraglutide injection (***Victoza***)	NL	NL	NL	NL	NL	R	NL	NL	NL	NL	NL	NL
	lixisenatide injection (***Adlyxine***)	NL	R	R	R	L	NL	R	R	NL	R	L	NL
	semaglutide injection (***Ozempic***)	R	R	R	R	L	R	R	R	R	R	L	R
	semaglutide tablet (oral) (***Rybelsus***)	NL	NL	NL	NL	R	NL	NL	NL	NL	NL	NL	NL
Insulin	**Bolus (prandial) Insulins: Rapid-acting** aspart (***NovoRapid***)	NL except pumps	NL	NL Feb 1, 2024	L	R	L	L	NL except pumps	L ending June 30, 2024	L ending April 1, 2024	L	L
	aspart (biosimilar) (**Trurapi**)	L	L	L	L	L	L	L	L	L	L	L	L
	aspart (***Fiasp***)	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL
	glulisine (***Apidra***)	L	L	L	L	L	L	L	L	L	L	L	L
	lispro (***Humalog***)	NL except pumps	NL	NL Mar.31, 2024	L	R	L	NL	NL except pumps	L Ending June 30, 2024	NL	L	L
	lispro (biosimilar) (***Admelog***)	L	L	L	L	L	L	L	L	L	L	L	L
	Short-acting Regular ***Humulin-R, Novolin ge Toronto***	L	L	L	L	L	L	L	L	L	L	L	L
	Concentrated Humulin R (***Entuzity***)	L	R	L	L	L	L	L	R	R	R	L	NL
	Pork regular insulin (***Hypurin Regular***)	R	NL	L	NL	NL	NL	NL	NL	NL	NL	NL	L
	Basal Insulins Intermediate acting – regular NPH ***Humulin-N, Novolin GE NPH***	L	L	L	L	L	L	L	L	L	L	L	L
	Long-acting basal analogues detemir (***Levemir***)	R	L	L	L	L	L	R	R	R	R	L	R
	glargine (***Lantus***)	NL	NL	R Peds only	L	R	L	NL	NL except peds	R until June 30,2024	NL	L	R
	glargine U300 (***Toujeo***)	NL	NL	NL	NL	L	L	NL	NL	R	NL	L	NL

Class	Drug (brand name)	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	NIHB /NU/ NT	YK
Insulin *(cont'd)*	glargine (biosimilar) ***(Basaglar)***	R	L	L	L	L	L	L	L	L	L	L	L
	Glargine (biosimilar) (***Semglee***)	R	L	L	L	L	L	L	L	L	L	L	L
	degludec ***(Tresiba)***	NL	L	L	L	L	L	L	L	L	L	L	L
	pork isophane insulin ***(Hypurin NPH)***	R	NL	L	NL	NL	NL	NL	NL	NL	NL	NL	L
	Pre-Mixed Insulins Premixed Regular-NPH ***(Humulin 30/70, Novolin 30/70-40/60)***	L	L	L	L	L	L	L	L	L	L	L	L
	Biphasic Insulin Aspart ***(NovoMix 30)***	NL	NL	NL	NL	L	R	NL	NL	NL	NL	NL	L
	Insuin Lispro/lispro protamine suspension ***(Humalog Mix25)***	NL	L	NL	L	L	R	NL	NL	L	NL	L	L
	Humalog Mix50	NL	L	NL	NL	L	NL	NL	NL	NL	NL	L	L
Insulin Secretagogues	**Sulfonylureas** gliclazide (***Diamicron, DiamicronMR***)	R	L	L	L	L	L	L	L	L	L	L	L
	glimepiride (***Amaryl***)	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL
	glyburide (***Diabeta, Euglucon***)	L	L	L	L	L	L	L	L	L	L	L	L
	Meglitinides repaglinide (***GlucoNorm***)	L	L	; L	R	L	L	L	NL	NL	L	L	L
Metformin	(***Glucophage, Glumetza***)	L	L	L	L	L	L	L	L	L	L	L	L
Sodium glucose co-transporter 2 inhibitors (SGLT2)	canagliflozin (***Invokana***)	NL	R	R	R	L	R	R	R	R	R	R	R
	dapagliflozin ***(Forxiga)***	L	L	R	L	L	R	L	L	L	L	L	L
	empagliflozin ***(Jardiance)***	R	R	R	R	L	R	R	R	R	R	L	R
	ertugliflozin ***(Steglatro)***	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL	NL
Thiazolidinedione (TZD)	**pioglitazone** *generic (Actos discontinued)*	R	R	R	R	L	R	L	L	L	L	L	R
	rosiglitazone *generic (Avandia discontinued)*	NL	R	R	L	L	R	NL	NL	NL	NL	NL	R

Class	Drug (brand name)	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	NIHB /NU/ NT	YK
Anti-hypoglycemic	Glucagon injection	L	L	L	L	L	L	L	L	L	L	L	L
	Nasal glucagon *(**Baqsimi**)*	L	R	L	R	R	L	R	**L**	L	R	L	L

(L) Listed: Can be prescribed by any doctor. Cost will be fully or partially covered according to the terms of the public drug plan.
(R) Restricted: Only available to those who meet eligibility criteria and receive prior approval from the drug benefit plan. Cost will be fully or partially covered according to the terms of the public drug plan.
(NL) Not Listed: Not available through the public drug plan.

Out-of-Pocket Costs

Out-of-pocket costs for people living with **type 1 diabetes** can be as high as

$18,306 per year

in certain areas of Canada.

Highest costs occur in New Brunswick for young people with family income of $150,000 using insulin pumps and real-time continuous glucose monitoring.

Out-of-pocket costs for people living with **type 2 diabetes** can be as high as

$10,014 per year

in certain areas of Canada.

Highest costs occur in New Brunswick for adults with family income of $150,000 and using oral medications that help manage blood glucose, multiple antihypertensive medications (AHT), insulin, and real-time continuous glucose monitoring.

For people living with **type 2 diabetes** in Canada,

government plans cover less than 20% of total costs for nearly half of the provincial and territorial scenarios.

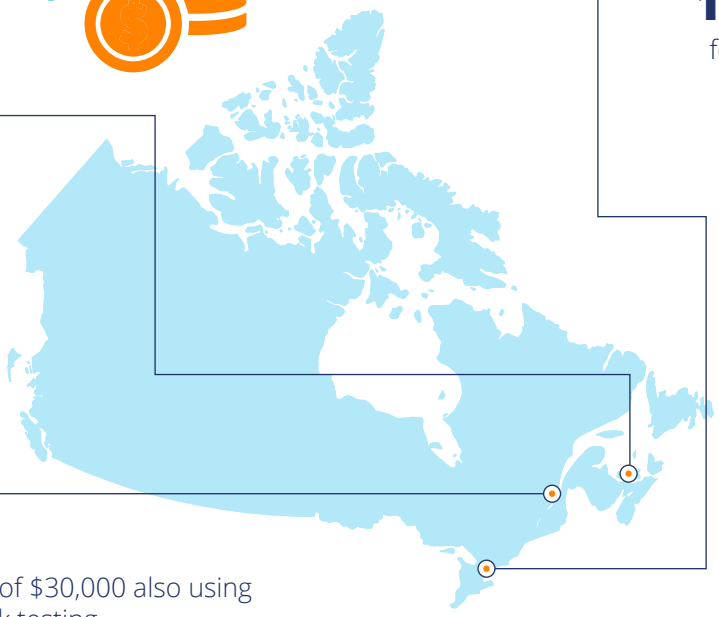
For people living with **type 1 diabetes**, out-of-pocket costs as a share of family income are highest in:

Prince Edward Island where they can account for up to

20% of income

for adults and seniors with family income of $30,000 using an insulin pump and finger prick testing.

Quebec for adults with income of $30,000 also using an insulin pump and finger prick testing.



For people living with **type 2 diabetes**, out-of-pocket costs as a share of family income are highest in Ontario, where they can account for up to

17% of income

for adults with family income of $30,000 using oral medications that help manage blood glucose, insulin, multiple AHT medications and real-time continuous glucose monitoring.

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