North East London GLP-1 RA Shortage Protocol (for T2DM patients)

NHS North East London

Due to a continuing national shortage of glucagon like peptide-1 receptor agonists (GLP-1 RAs) supplies of some GLP-1 RA preparations' may be intermittent or exhausted. Normal supply is expected end of 2024. **Immediate Actions to be taken:**

- **GLP-1 RAs should only be prescribed for their licensed indications.**
- **Prescribe Rybelsus® tablets or Mounjaro® KwikPens for new initiations of GLP-1 RAs (in line with NICE NG28)**
- **Identify patients prescribed Byetta® and Victoza® injection (in line with NICE NG28) or patients unable to obtain Ozempic® or Trulicity® for 2 weeks or more and switch to Rybelsus® tablets or Mounjaro® KwikPens.**
- **Counsel patients on any changes in drug formulation, and dose regimen where appropriate.**

Proactively identify patients established on affected GLP-1 RAs and consider prioritising for review based on the criteria set out in the clinical guidance and discuss stopping treatment with patients who have not achieved treatment targets as per NICE NG28. An adequate metabolic response is defined as:

- a reduction of at least 11 mmol/mol [1.0%] in HbA1c and weight loss of at least 3% of initial body weight in 6 months
  - **Do not double up a lower dose preparation where a higher dose preparation of GLP-1 RA is not available.**
  - **Do not switch between strengths of a GLP-1 RA solely based on availability.**
  - **Do not prescribe excessive quantities; limit prescribing to one-month supply to minimise risk to the supply chain whilst acknowledging the needs of the patient.**
    Work with pharmacies to source supply before patient runs out. Refer to the SPS website for stock availability.
  - **For children and young people prescribed GLP-1 RAs, refer to specialist services**
  - **Refer to the national patient safety alert on GLP-1 RAs shortages, Medicine Supply Notification, joint ACBD/PCDS guidance and NEL T2DM guidelines for further prescribing information**

Clinical Review of Patients Guide

Insulin patients:
Optimise insulin dose(s)
Ensure that combination therapy with a GLP-1 RA and insulin comes with specialist care advice and ongoing support from specialists.

Non-Insulin patients:
If the HbA1c is >86: consider gliclazide or Insulin as rescue treatment (do not stop GLP-1 RA until insulin started – this is particularly important if referring into specialist community providers for initiation).

For HbA1c between 58 and 86: optimise current treatment or add an extra therapy as per the NEL T2DM guideline. If established on maximum tolerated treatment and doses, consider insulin.

For HbA1c <58: optimise doses or add additional treatment as per NEL T2DM guideline. For insulin initiation please follow the NICE NG28 guideline (do not stop GLP-1 RA until insulin started – this is particularly important if referring into specialist community providers for initiation. Refer to SPS guidance for availability).

Alternative Treatment Options

If not already taking, add metformin. If eGFR < 45ml/min/1.73m^2 then reduce and STOP if eGFR falls below 30ml/min/1.73m^2. Please advise on sick day rules.

For patients with established CVD risk or at high risk of CVD (e.g. QRISK2 >10%, or CKD with uACR >3 mg/mmol (on maximum tolerated ACEi/ARB) add SGLT2i: review dose of concomitant sulphonylurea treatment and insulin. A reduction of up to 25% should be considered. Ensure adequate counselling on side effects such as UTI, thrush and balanitis. Serious side effects such as euglycaemic ketoacidosis and Fournier Gangrene should be discussed and urgent action to seek medical attention. Please advise on sick day rules.

For non-CVD risk patients or where SGLT2i are contra-indicated consider a DPP4i. Ensure GLP-1 RA has stopped before initiating. Advise on risk of pancreatitis. Check eGFR for appropriate dosing (except Linagliptin).

Consider pioglitazone in dyslipideamia, CKD up to ESRD and fatty liver. Check for contra-indications such as heart failure, unexplained haematuria, history of bladder cancer, osteopenia/osteoporosis or low mineral bone density (including post-menopausal women) and deranged LFT: ALT above 2.5 x ULN (ALT above 3 x ULN if already taking).

Consider gliclazide (gliclazide MR): especially if requiring rescue treatment. Allow for SMBG and advise on risk for hypoglycaemia. Advise on DVLA if driving- especially professional drivers.

Switching Between GLP-1 RAs

Patients prescribed Byetta® and Victoza® injection (in line with NICE NG28) or patients who are unable to obtain Ozempic® or Trulicity® for 2 weeks or more are to be switched to **Rybelsus® tablets** or **Mounjaro® KwikPens (prescribe formulary 4mm insulin pen needles)**. Discuss the decision to switch with the patient and refer to the product SPC for dosage and administration information and to ensure the patient is not intolerant to any of the excipients.

Do NOT switch patients who have not achieved a metabolic response.

There is limited data for switching between different GLP-1 RA or switching to a GIP/GLP-1 RA, therefore follow the licenced dose initiation for each product given the need for them all to gradually reach steady state. The exception is converting from Ozempic® (semaglutide) to Rybelsus® (oral semaglutide) with less than two doses missed, where an approximate equivalent dose can be given.

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