Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

GLP -1 Receptor Agonists – National Shortage: Frequently Asked Questions (FAQs)

Q: How many doses of a GLP1 RA can be missed without re-uptitrating?

This all depends on individual GLP-1 RA as they have varying pharmacokinetics. Consider time missed and individual patient factors such as previous tolerability.

Dulaglutide (Trulicity) - For lower strengths (0.75mg & 1.5mg), restart at same dose when available. For 3mg dose, if 2 or more doses are missed then restart at 1.5mg weekly and titrate up (will need script for lower strength preparation).

Liraglutide (Victoza) - If dose is missed for more than 3 days, re-start with 0.6mg daily and titrate (the same pen is used for all doses – will not need a different script).

Semaglutide s/c (Ozempic) - If 2 or more doses of 0.5mg or 1.0mg are missed, likely to need re-uptitration with lower dose and titrate up as required (will need another script for lower strength preparation).

Semaglutide oral (Rybelsus) - If a patient misses medication for more than 2 weeks, likely to need re-uptitration with lower dose (will need script for lower strength preparation).

Q: Can a lower strength version of the GLP-1 RA be prescribed, and the dose doubled or higher strength of the oral GLP 1 RA prescribed, or oral GLP1 RA tablet halved?

The NPSA alert states not to switch to a lower strength and double it; note that double dose does not mean double the effectiveness. The recent national primary care bulletin [10th August (Issue 251)] also made clear that prescribers should not switch to alternative GLP-1 RAs or alternative strength preparations. (The exception would be, as above, when there is some security about ongoing supply of higher strength preparations and re-uptitration using lower strength preparations is appropriate.)

Q: During the shortage, should repeat prescriptions be limited to 28 days supply?

It is worth reducing supplies to monthly issues to manage demand for more patients. Local pharmacies have started rationing to 28 days supply per patient.

Q: Should local pharmacies be advising patients they have supply of lower doses and sending patients to ask GP for a change in prescription? There are lots of returned scripts with pharmacy saying 'get GP to give alternative/lower dose' etc. This is causing increased workload and lots of stress to patients.

There are supply issues with all the GLP-1 RA and the advice given in the NPSA alert is not to switch products at this time. Although it does not specifically mention not to switch to lower strength (it only covers doubling up), prescribers were advised against doing this in the national primary care bulletin (Issue 251) on August 10th, 2023.

We will be addressing this issue with local pharmacies and advise against switching to lower strengths based on availability as the supply chain for these products may then be affected.

Q: Is anything being done to encourage wholesalers to provide GLP-1 RAs to NHS scripts for T2DM instead of private scripts for weight loss?

This is under the remit of the Department of Health and Social Care (DHSC) – who are exploring the possibilities of various mitigations.

Q: What do I do if a patient cannot get hold of their GLP-1 RA?

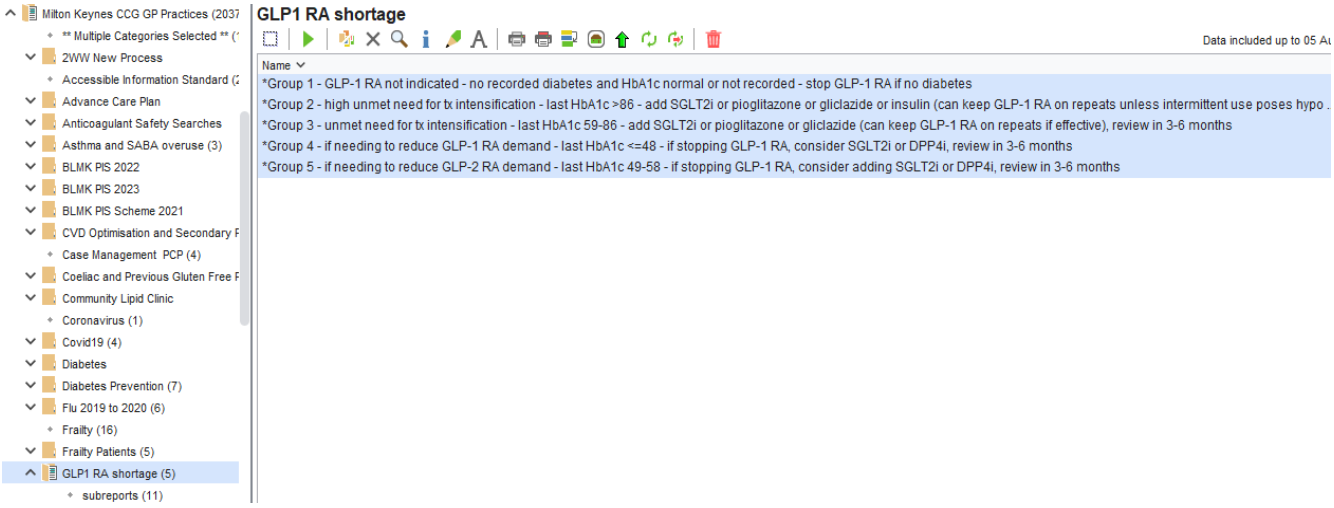
If patient has responded well on the GLP-1 RA, they should stay on it but may have a period when they cannot obtain it. The pharmacy may be able to guide them as to when it will be back in stock. If they miss multiple doses, they may need advice on re-uptitration.

Q: Can we prescribe exenatide for new initiations?

Exenatide is non-formulary across BLMK - no new initiation since 2021 and this has not changed. The current shortage impacts on supplies of all GLP-1 RAs and exenatide cannot support uplift if patients are switched to this

Q: Where can the published SystmOne searches be found if a practice wants to conduct proactive reviews?

Under GLP-1 RA shortage.



If practices would like to do pro-active reviews using the SystmOne searches, then Groups 1-3 would be a good starting point.

Group 1 is those for whom a GLP-1 RA licensed for use in type 2 diabetes is unlikely to be indicated as they have no record of diabetes or suggestive HbA1c results.

Groups 2 and 3 are people who have unmet glycaemic need and are likely to benefit from a review. It may be that intensification of treatment is needed (e.g., offering additional therapies). The GLP-1 RA could be stopped ***if it has not been sufficiently effective***.

Groups 4 and 5 are people who have less need for a review to manage glycaemia but could stop GLP-1 RA ***if it has not been sufficiently effective***.

Q: During this shortage, is the use of pioglitazone as an alternative glucose lowering agent advisable especially if patient has history of non-alcoholic fatty liver disease (NAFLD)?

Pioglitazone is an effective glucose lowering agent in patients with T2DM and has some evidence of benefit in NAFLD. It is one of many glucose-lowering medications, including SGLT2 inhibitors, which could be considered. If using pioglitazone, be aware that re-checking HbA1c at 3 months may underestimate its effect as it takes some weeks to be effective – therefore checking at 6 months after pioglitazone initiation may be more advisable.

Q: What should be done if HbA1c is running very high and patient is on maximum tolerated oral agents and GLP-1 RA as well as insulin?

There would be a proportion of people who are prescribed a GLP 1 RA who will be on insulin. This is a good opportunity to have a holistic review – diet, lifestyle, and review of CBG to determine appropriate insulin titration.

Q: Are there any resources to send to patients as/when we pause on medication to support our decisions?

Below are links to the available resources from Diabetes UK.

Our response to serious supply issues of drugs for people with type 2 diabetes

FAQs – GLP-1 RA shortages | Diabetes UK