Pharmac

26 April 2024

Re: Proposal to fund continuous glucose monitors, insulin pumps, and insulin pump consumables.

Thank you for the opportunity to provide feedback on the above proposal. The Aotearoa College of Diabetes Nurses represents 411 nurses across Aotearoa, with a large portion of our membership working within specialist diabetes teams, or with a focus on diabetes care within their clinical practice.

We are in support of the following aspects:

- Continuous glucose monitors (CGM) being available for all people with type 1 diabetes in Aotearoa. This aligns with evidence-based practice models of CGM use being standard care.
- Increased allocation of insulin pump consumables from 13 boxes per year to 19 boxes per year. This change will enable insulin pump infusion set site changes every 1.9 days if using the full allocation of supplies, which is required when users have a total daily dose of insulin above 100 units. There are likely to continue to be people with type 1 diabetes, who require exemptions for additional supplies when their total daily dose of insulin is high due to severe insulin resistance, specifically whilst prescribed corticosteroids or during the third trimester of pregnancy.
- Continued funding of the Tandem insulin pump.
- Addition of funding the mylife YpsoPump. When paired with CGM, the CamAPS algorithm appears to have good evidence to support improved glycaemia and quality of life.
- The inclusion of a 10% alternative brand allowance to allow flexibility for people who do not find suitable solutions with the brands proposed, although elaboration on criteria is required.

We have concerns about the following aspects:

- We are concerned that the proposal does not include people with type 2 diabetes having access to CGM. Emerging evidence both internationally and nationally supports the use of CGM in specific type 2 diabetes populations to improve health outcomes. We strongly support funding being available for CGM use for people with type 2 diabetes.
- Discontinuation of funding for Medtronic insulin pumps. Many patients are manually pumping (no use of CGM) using a Medtronic 640G or 770G insulin pump, along with several people that currently self-fund Medtronic CGM and utilise the SmartGuard hybrid-closed loop software. The SmartGuard hybrid-closed loop software supports users to achieve exceptional time in range, whilst also being largely “hands-free” for the user with the learning algorithm. Deterioration in glycaemic control is likely to be experienced by SmartGuard users having to switch to an alternate hybrid-closed loop system. SmartGuard is also the only hybrid-closed loop system demonstrating evidence in lowering HbA1c in people with high risk HbA1c results above 80 mmol/mol. We propose that current users of Medtronic pumps receive ongoing funding for Medtronic pumps and consumables, along with funding of Medtronic CGM, as well as consideration of funding for people with persistently elevated high risk HbA1c results.
- Although the mylife YpsoPump and CamAPS software is sound, there are issues with it being reliant on a cellphone being present continuously, as well as only working with Android devices. Being bound to a cellphone is not likely to be acceptable or appropriate for some users; specifically those with vulnerabilities including the elderly in care facilities. Children and young adults in schools have restrictions for cell phone use in schools, which will impact this population group to uptake the funded

care. Many Medtronic SmartGuard users would likely elect to transition to the mylife YpsoPump and CamAPS software given its similarities to SmartGuard, and will be impacted and inconvenienced by the use of cellphone.

- The mylife YpsoPump also has smaller insulin reservoirs, so will require more frequent loading of cartridges which will be inconvenient.
- The delay in the mylife YpsoPump being brought to market (October 2024) versus the Tandem pump (July 2024) is likely to influence people with type 1 diabetes to choose the Tandem pump due to earlier availability, rather than selecting a pump based on its merits and clinical appropriateness.
- Special authority criteria for CGM initial applications appear reasonable, however, the renewal requirement for "objective evidence of maintained improvement in glycaemic control" is problematic and must not be bound to HbA1c or CGM time in range improvements alone. Glycaemia varies across the lifespan, with expected periods of change during adolescence, at times of illness, during times of diabetes distress, and during significant life events such as new employment or education. It is not reasonable to expect "objective evidence of maintained improvement in glycaemic control" during all stages of life. Furthermore, use of CGM is known to improve quality of life, and reduce hypoglycaemia frequency and severity, occasionally resulting in a rise in HbA1c, which in some cases would still be associated with a clinical improvement for the individual. Patients commenced on CGM and/or insulin pumps during times of tight glycaemic control such as pregnancy should also not be expected to maintain such tight glycaemic control long-term to continue to access funding. There is also concern around how those already self-funding CGM (+/- an insulin pump) would meet renewal criteria, as they are unlikely to have any improvement in glycaemia when accessing funded CGM given their existing use.
- We are concerned about the lack of detail around the rollout process for CGMs. Primary care providers, as well as secondary care diabetes services, will be overwhelmed with requests for CGM special authorities and prescriptions. Completing special authority applications and providing prescriptions for CGM alone will require significant resourcing, but the required education, support, and glycaemic review following the initiation of CGM devices should also be acknowledged. We would support a planned rollout process that targets high-risk population groups first i.e. Māori and Pasifika people, pregnant women, children and youth, those with frequent and severe hypoglycaemia resulting in hospitalisation, those with significantly elevated HbA1c results, and those with diabetic ketoacidosis hospitalisations. Given the variation in access to specialist diabetes services across Aotearoa, it would be of benefit for Pharmac to measure and report on the uptake of CGM to ensure the rollout is equitable for Māori and Pasifika people, those living in areas with high social deprivation, and those living in remote and rural areas.
- Specialist diabetes services must be provided with access to technology and devices required for uploading insulin pump and CGM data within outpatient settings. Currently, the Tandem pump uploader technology comes at a cost for individual services to purchase, resulting in some specialist diabetes services being unable to review Tandem pump and CGM data at clinic appointments.
- National guidance should be made available on the use of CGM within inpatient settings. Currently, international guidance is limited on the use of CGM and hybrid-closed loop within acute care settings and will result in clinical risk if appropriate national recommendations are not made.

Signed on behalf of the Aotearoa College of Diabetes Nurses.

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