Joshua Cronin-Lampe

Therapeutic Group Manager

PHARMAC

PO Box 10 254 | Level 9, 40 Mercer Street, Wellington

4/6/21

Dear Josh

Re: Diabetes health professional suggestions for adjustments for current Insulin Pump special authority criteria.

We are writing to you collectively as clinical leads in our five District Health Boards and in our various national and international roles, including: as the Chair South Island Alliance Paediatric Diabetes Working Group; Chair Paediatric Society NZ National Paediatric Diabetes Working Group, President of the New Zealand Society of Endocrinology; and the NZ Society for the Study of Diabetes and Australasian Paediatric Endocrinology Group councils.

Prior to any meetings of the PHARMAC diabetes sub-committee, we would like to highlight our support for the following suggested changes to the PHARMAC insulin pump special authority criteria:

1) That access be provided to people with **in target glycaemic control (i.e. HbA1c <53mmol/mol)** experiencing significant hypoglycaemia.

Since the current criteria went live in 2012, globally recommended glycaemic targets have tightened. A target HbA1c of <53mmol/mol is now recommended by major bodies such as ISPAD (International society for paediatric and adolescent diabetes), NICE [recommends below 50 mmol/mol], ADA (American diabetes association), as opposed to 58 mmol/mol when the current criteria went live. Given that reducing hypoglycaemia remains a significant proven benefit of pump therapy, allowing access to people with control with an HbA1c ≥45mmol/mol should be the new standard. Currently those achieving the exact control we are recommending are penalised for this hard work, and unable to access the hypoglycaemia reducing benefits of pump therapy.

2) Exit criteria currently particularly adversely impact adolescents, young adults, and those of non-European ethnicity (see attached papers). Given we have already shown the current criteria have led to inequity based on age, non-European ethnicity, and low socioeconomic status – the exit criteria likely perpetuates this inequity. The conditions for exiting funded pump therapy need to be relaxed – and also allow leeway for those known to experience elevations in HbA1c (in particular youth, and non-Europeans).

It is also important to note that wider access to insulin pump therapy is the stepping stone to automated insulin delivery – which has a strong evidence base demonstrating improved glycaemia, which would translate into reduced long-term complications for those at most risk (and hence directly tackles issues of inequity).

If the above requires more evidence (which we would hope it does not) we are currently conducting an in-depth evidenced base review of the current criteria, and our proposed changes, which will be provided to you and the sub-committee in the coming months.

Thank you for your time reviewing this letter and our recommendations.

Kind regards

Associate Professor Ben Wheeler

Dr Martin De Bock

Professor Esko Wiltshire

Associate Professor (Hon) Craig Jefferies

Dr Ryan Paul