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Royal Australian College of General Practitioners

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Via email: PBSpostmarket@health.gov.au

Dear Dr Bartlett,

Thank you for your letter regarding the proposed changes to Pharmaceutical Benefits Scheme (PBS) listings for type 2 diabetes mellitus (T2DM) medicines following the Pharmaceutical Benefits Advisory Committee (PBAC) meeting in March 2023.

The RACGP does not support PBAC's recommendation for glucagon-like peptide-1 receptor agonists (GLP1 RAs) to be changed from Authority Required (streamlined) to Authority Required (telephone/electronic). The RACGP strongly recommends they remain as Authority Required (streamlined).

The PBS Authorities system is onerous. It is a complex administrative process that takes time away from GPs delivering care to patients. Overall, the restrictions that have been proposed for dual therapy with insulin and triple combinations across the SGLT2 inhibitors, DPP4 inhibitor combinations and GLP1 RAs therapy, will make this authority listing difficult to negotiate for busy and already burdened GPs.

Our response to your specific consultation questions are detailed below.

Question 1: Do you have any suggestions on how the restrictions could be made clearer or more concise?

Feedback on the clinical criteria in the restriction summaries (detailed in *Attachment C - Proposed PBS listing changes for SGLT2 inhibitors, DPP4 inhibitors, GLP-1 RAs and pioglitazone – March 2023)* is detailed in the tables below in reference to the PBS criteria it pertains to.

1.1 SGLT2 Inhibitors

1.1.1 Dapagliflozin and Empagliflozin (page 8)

	Clinical criteria:	**RACGP feedback**
New CC	The treatment must be used in combination with at least one of: metformin, a sulfonylurea, insulin.	The updated clinical criteria appear for straight forward however there may be prescriber confusion when it comes to dual combination (fixed dose) recommendations for SGLT2, outlined below in 1.1.2.
	AND	
	Clinical criteria:	

	The condition must be inadequately responsive to at least one of: metformin, a sulfonylurea, insulin.	
	AND	
	Clinical criteria:	
New CC	The treatment must not be prescribed in combination with each of: a GLP-1 receptor agonist, another SGLT2 inhibitor.	

1.1.2 Dapagliflozin/empagliflozin and metformin combinations (page 8-9)

	Clinical criteria:	**RACGP feedback**
New CC	The condition must be inadequately responsive to metformin	The updated PBS criteria may lead to GP prescriber confusion. There is less restrictive wording as part of this PBS criteria, in comparison to the single agents which are used independently, but in combination with metformin alone (detailed under Dapagliflozin and Empagliflozin page 8). It may cause GPs to utilise a fixed dose combinations before utilising each of the single agents. The RACGP recommends that a similar format is used to describe the combinations, as per Dapagliflozin and Empagliflozin (page 8) and include what medications must not be prescribed in combination, with these fixed dose combinations. It may also be improved using the words Fixed dose combination in brackets after the initial clinical criteria to assist GP prescribers to identify this quickly.
	AND	
	Clinical criteria:	
New CC	The treatment must not be prescribed in combination with each of: a GLP-1 receptor agonist, another SGLT2 inhibitor.	

1.1.3 DPP4 inhibitor combinations with SGLT2 inhibitors (page 10)

	Clinical criteria:	**RACGP feedback**
New CC	The treatment must be triple combination therapy limited to this drug with metformin	The updated PBS criteria may lead to confusion. The updated criteria imply that GP prescribers may not be able to utilise a fixed dose combination DPP4 inhibitor and SGLT2 inhibitor, with insulin. This is
	AND	
	Clinical criteria:	

New CC	The condition must be inadequately responsive to dual therapy consisting of metformin with either: a DDP-4 inhibitor, an SGLT2 inhibitor	currently possible under current PBS listings for some of these combinations. The RACGP recommends that the clinical criteria clarify, omit or alter information, about utilising fixed dose DPP4 inhibitors with SGLT2 inhibitor combinations with insulin.
	AND	
	Clinical criteria:	
New CC	The treatment must not be prescribed in combination with each of: a GLP-1 receptor agonist, insulin, another SGLT2 inhibitor, another DPP4 inhibitor	

1.2 DPP4 inhibitors

1.2.1 Linagliptin/sitagliptin in combination with metformin (page 12)

	Clinical criteria:	**RACGP feedback**
New CC	The condition must be inadequately responsive to metformin	The updated PBS criteria may lead to GP prescriber confusion as wording of this PBS criteria is less restrictive, in comparison to using single agents in combination with metformin alone. The RACGP recommends that a similar format is used to describe what treatment must not be prescribed in combination with fixed dose combinations (detailed under Linagliptin/Sitagliptin page 11), as essentially, they are the same therapies in different forms. It may also be improved using the words Fixed dose combination in brackets after the initial PBS criteria to assist GP prescribers to identify this quickly.
	AND	
	Clinical criteria:	
New CC	The treatment must not be prescribed in combination with each of: a GLP-1 receptor agonist, another DPP4 inhibitor	

1.3 GLP1 RAs (page 17)

The GLP1 RA's restrictions need to be clearly presented. As a comparison, the new PBS criteria detailed for SGLT2 inhibitors, Dapagliflozin and Empagliflozin (page 8) are clearer than the current wording for GLP1RA's restrictions.

1.3.1 Dulaglutide and Semaglutide (page 17)

	Clinical criteria:	**RACGP feedback**
	The treatment must be used in combination with at least one of: metformin, a sulfonylurea, insulin.	No comments

	Clinical criteria:	**RACGP feedback**
	AND	
	Clinical criteria:	
	The condition must be inadequately responsive to at least one of: metformin, a sulfonylurea, insulin.	
	AND	
	Clinical criteria:	
	The patient must have a contraindication/intolerance requiring permanent treatment discontinuation to an SGLT2 inhibitor; OR	The updated PBS criteria for Dulaglutide and Semaglutide is open for clinical misinterpretation. While the intent of the criteria "The patient must have a contraindication/intolerance requiring permanent treatment discontinuation to an SGLT2 inhibitor", is clear, it may lead to problematic clinical situations when 'switching' therapeutic approaches may be required. Examples include: - inadequate glycaemic responses to SGLT2 inhibitor use in that patient - significant metabolic disorders requiring intervention such as metabolic syndrome where diabetes goals require greater attention to factors affected by elevated body mass index. To suitably address prevention and management goals in individual patients with diabetes, we recommend the first three PBS criteria be combined, or include 'OR' between the criteria as illustrated below: "The patient must have a contraindication/intolerance requiring permanent treatment discontinuation to an SGLT2 inhibitor; OR The condition must be inadequately responsive to treatment with an SGLT2 inhibitor; OR The patient must not have achieved a clinically meaningful glycaemic response with an SGLT2 inhibitor." The RACGP strongly recommends that the term "*clinically meaningful glycaemic response*" be removed from the alternative
	The condition must be inadequately responsive to treatment with an SGLT2 inhibitor. **Alternative:** The patient must not have achieved a clinically meaningful glycaemic response with an SGLT2 inhibitor.	
	AND	
	Clinical criteria:	
	The treatment must not be prescribed in combination with each of: an SGLT2 inhibitor, a DPP4 inhibitor, another GLP-1 receptor agonist	

	Clinical criteria:	RACGP feedback
		PBS criteria. If utilised, it needs to be defined by the PBS so that it is clear to all prescribers how to implement this criteria and what is meant by this term. Alternatively, the terminology used in the preceding statement "*The condition must be inadequately responsive to treatment with an SGLT2 inhibitor", (as per above)* aligns across wording used in other PBS restriction definitions in diabetes, and would be easier for GP understanding and implementation. Furthermore, the clinical criteria "*The treatment must not be prescribed in combination with each of: an SGLT2 inhibitor, a DPP4 inhibitor, another GLP-1 receptor agonist"* is too broad and in contrast to the national and international diabetes management guidelines [1,2]: The RACGP recommends that it would be less confusing to GPs and other prescribers, if the statement was aligned to other wording used to describe diabetes in the PBS. For example*, "This drug is not PBS-subsidised for use in combination ……"* aligns with other PBS requirements related to cost subsidisation, the basis of the DUSC report.

Question 2: If the PBS restrictions were to include a definition of inadequate response to an SGLT2 inhibitor, do you have any suggestions on how this should be defined?

The Australian Diabetes Society has emphasised the evidence for non-glycaemic related benefits of both the SGLT2 inhibitor and the GLP1 RA classes. Examples of other possible alternative statements, informed by the RACGP Management of type 2 diabetes: A handbook for general practice[3], are suggested below:

- The patient must have a documented inadequate response towards improved diabetes management goals* with an SGLT2 inhibitor. * [3]
- The patient must have a documented failure to improve clinical diabetes glycaemic goals* with an SGLT2 inhibitor. * [3]

Question 3: Noting the low cost and use of pioglitazone through the PBS, and its place in therapy in *clinical guidelines, do you consider it appropriate for pioglitazone to be changed to a Restricted Benefit listing for T2DM?*

The RACGP agrees that it is appropriate for Pioglitazone to be changed to a Restricted Benefit listing for T2DM.

Question 4: Should the restrictions for DPP4 inhibitors be aligned, noting that under the proposed restrictions this would involve not specifically excluding the use of some DPP4 inhibitors (alogliptin, vildagliptin and saxaglitpin) with insulin and/or SGLT2 inhibitors?

Aligning all these agents with proposed wording across their prescribing (PBS) restrictions would provide clear workflow pathways for GPs and other prescribers who utilise these medicines.

Further to feedback above, any clashes between the proposed new or reworded clinical criteria with current PBS restrictions, such as the possibility of combinations with insulin, need to be carefully considered.

For any enquiries regarding this letter, please contact Stephan Groombridge, National Manager, Practice Management, Standards & Quality Care on 03 8699 0544 or stephan.groombridge@racgp.org.au.

Yours sincerely

Dr Nicole Higgins
President

References

1. Australian Diabetes Society, Australian Type 2 Diabetes Glycaemic Management Algorithm. Sydney, NSW: Australian Diabetes Society, 2022. Available at https://diabetessociety.com.au/downloads/20220908%20T2D%20Algorithm%2006.09.2022.pdf [Accessed 17 May 2023].

2. American Diabetes Association. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes Diabetes Care 2023; 46(Supplement_1):S147.

3. The Royal Australian College of General Practitioners. Type 2 Diabetes goals for optimum management. In: Management of type 2 diabetes: A handbook for general practice. East Melbourne, Vic: RACGPand Diabetes Australia, 2020. Available at: https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/diabetes/type-2-diabetes-goals-for-optimum-management [Accessed 17 May 2023].