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Educating Providers and Patients About Insulin Biosimilars

Dr. Cheeley:
Welcome to *Diabetes Discourse* on ReachMD. I'm Dr. Mary Katherine Cheeley, and joining me to discuss insulin biosimilars is Dr. Lizzie Cook. Dr. Cook is a clinical pharmacist in the primary care clinics at Robert J. Dole Veteran Affairs Medical Center in Wichita, Kansas.

Dr. Cook, thanks for joining me today.

Dr. Cook:
Yeah. Thank you for having me.

Dr. Cheeley:
Let's jump right in on a topic that I think is really interesting, insulin biosimilars. Can you start us at the beginning and tell us which biosimilars for insulin are on the market currently?

Dr. Cook:
Sure. So in the US we currently have two biosimilar insulins on the market. They're both basal insulins. The first one that came out in July of 2021 is Semglee, or insulin glargine-yfgn. And then the second one that followed in December 2021 is Rezvoglar, and that's the insulin glargine-aglr. And the reason why I'm saying the random assortment of letters after the name is it's important to know that a biosimilar can't carry the same proprietary name brand as the reference product. This is something that the FDA wanted to make sure that there was a designated suffix that includes four random letters that are completely devoid of meaning so we can clearly identify and distinguish between those biologic products and their reference product, Lantus.

Dr. Cheeley:
Can we take that a little bit further for me? So these are not what we would consider AB-rated in the pharmacy world. You can't have a reference product glargine and substitute it for one of these biosimilars, correct?

Dr. Cook:
Yeah. So one good reference that we can always use, it's called the *Purple Book,* that's been put out by the FDA, and that allows us to know what's interchangeable and what's not. When we talk about these two different biosimilar products, Semglee, or the glargine-yfgn product, it's considered an interchangeable product with insulin glargine, or Lantus, so that was a special designation that it was given. So Semglee is interchangeable with insulin glargine, or Lantus, and there are some specifics depending on the state laws, in terms of how that interchange can occur. Rezvoglar, however, is considered a biosimilar to Lantus but is not considered interchangeable.

Dr. Cheeley:

That's really interesting that there's one that is and one that isn't, and I know in our world, in the retail pharmacy world, it makes it very difficult to make sure that your patient actually gets their insulin. So with the advent of these biosimilars and given the current shortage of insulin and the difficulty in patients getting there, do you think having these options has made things easier or harder for our patients?

Dr. Cook:
Yeah. So I think that it will definitely make things easier, especially with that special interchangeability that Semglee has been given with Lantus. So with that interchangeable designation, we can substitute for a less expensive option at a pharmacy level in certain states. And like I mentioned, with these savings that we have, there are some intricacies as to whether this change needs to be communicated between the pharmacist and the prescriber, the pharmacist and the patient, what is that mode of communication, the time frame that it needs to occur. So while it is making things more accessible, there may be additional steps in order to grant that accessibility.

But when we talk about Semglee, there have been some people who have investigated, and they found that if somebody has no insurance but has a discount card, the cash price of Semglee can be about 63 percent lower for some patients versus insulin glargine. So we're already seeing that payout, so to speak, in terms of helping people where cost may be prohibitive in getting these basal insulin products. So these biosimilars can be made more quickly and at a lower cost because we already have that research invested in making the reference product, so we're taking a couple steps out of the process where we can have additional product on the market, but without that time investment and research upfront.

Dr. Cheeley:
Have you prescribed any of these?

Dr. Cook:
Yeah. So the VA has been a very early adopter of biosimilar insulins. We want to make sure that we're providing quality care but still being efficient with our funds, and so back when Semglee was approved as interchangeable, our VA actually converted all of our patients who are on the Lantus insulin glargine reference product at a one-to-one ratio over to Semglee, so this was something that we were very efficient in doing once it became available.

Dr. Cheeley:
For those just tuning in, you're listening to *Diabetes Discourse* on ReachMD. I'm Dr. Mary Katherine Cheeley, and I'm speaking with Dr. Lizzie Cook about insulin biosimilars.

I am so fascinated by the fact that you guys swapped from one to the other. Being a clinical pharmacist myself, we always think of is it the same way that patients use these? So does the pen work the same? How did you guys manage that process? Because to the patient, it is still this "same product" if it's interchangeable and the reference product, but when the devices work differently, that can be a game-changer.

Dr. Cook:
Yes. And so definitely, communication is key. I am a big proponent of the most effective medication is the one that the patient is willing to take, so making sure that you're collaborating and communicating clearly, that the patient is on board with the device itself, as well as educating them on what a biosimilar is. I feel like we have similar pushback when we talk with patients about generic products and brand products. And while biosimilars and generics are not equivalent to each other, the philosophy that some patients have that the brand product is better, discussing with them that these are very similar medications, they have undergone very rigorous testing, and there aren't any clinically significant differences between products, allows for them to understand this medication was invented to reduce cost and make medication more accessible. This is something that's being done in order to better patient access to medication as a whole.

Dr. Cheeley:
Did you guys lean on your retail colleagues? Did you do that at the clinic level with your clinical pharmacist? How did you get that information out?

Dr. Cook:
So I am very lucky to have a lot of different pharmacists who assisted us in making sure that those who were prescribing the product had a very good base in terms of educating patients on how we were going to transition. So our particular facility, we have a dedicated pharmacoeconomics pharmacist who was essential in making sure that letters were mailed to patients, in-services were given at provider meetings, so that we had a good background, and people knew before the change occurred why it was occurring and what exactly was happening, as well as our retail colleagues, those who work in the operations area at our facility, them being on the frontlines, and providing those patients who are picking up their scripts with the information. "Hey, this is why the vial looks different." "This is why the pen looks different." We made sure that there was education being done every step of the way.

Dr. Cheeley:
If you had to give a nugget of advice to anyone, be it a retail pharmacist or another clinical pharmacist that has to explain this to a provider, how would you have them explain that? Because I feel like sometimes our providers are even more skeptical than our patients.

Dr. Cook:
I like to use the toddler method—where if you're able to ask yourself three follow-up questions and come up with an answer, then you truly have a mastery of the material. So I like to try and give information in chunks of three. "This is what a biosimilar is." "How is a biosimilar different than the reference product?" "How is a biosimilar developed?" And "What is the reason behind developing a biosimilar?" Then generally, having that background information makes providers and other healthcare professionals a little bit more comfortable with that material and maybe a little bit more open to utilizing these products.

Dr. Cheeley:
I love that. I'm going to use the toddler method, not just with my toddlers but with my providers too. That's a good one. Before we close, are there any barriers that you see to insulin biosimilars?

Dr. Cook:
I think the biggest barrier to us using biosimilars in clinical practice is we need more of them. Right now, we just have those basal insulin products for Lantus, the Rezvoglar, and the Semglee, but I know that they're currently in the process of getting insulin aspart and insulin lispro biosimilars in the pipeline, and so I think having more of these on the market will benefit our patients in terms of cost. It will benefit them in terms of accessibility. This is cutting-edge technology, and it will give us a little bit more resistance when it comes to drug shortages if we have more product on the market, and with these new products coming out, we can see people being a little bit more hesitant to adopt, and so having resources that are easily accessible, in a very digestible format, like ReachMD, can allow for people to have easier access to this information, introduce it earlier, and make them a little bit more comfortable with giving their patients a biosimilar product for use.

Dr. Cheeley:
This has been such a great discussion on insulin biosimilars, expanding access through a biosimilar pathway, especially for our patients with diabetes. I would like to thank my guest, Dr. Lizzie Cook, for joining me and providing her amazing insights on this topic.

Dr. Cook, it was a pleasure speaking with you.

Dr. Cook:
Hey, absolutely. Pleasure talking with you too, and thank you for having me.

Dr. Cheeley:
For ReachMD, I'm Dr. Mary Katherine Cheeley. To access this and other episodes in this series, visit Diabetes Discourse on

ReachMD.com where you can Be Part of the Knowledge. Thanks for listening.