



Hypoglycemics, Insulins and Related Agents Therapeutic Class Review (TCR)

March 4, 2020

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MagellanRx
MANAGEMENTSM

FDA-APPROVED INDICATIONS

Drug	Manufacturer	Indication(s)
Rapid-Acting Insulins		
human insulin inhalation powder (Afrezza®) ¹	Mannkind	To improve glycemic control in adults with diabetes mellitus
insulin aspart (Fiasp®) ²	Novo Nordisk	To improve glycemic control in adults and pediatric patients with diabetes mellitus
insulin aspart (Novolog®) ³	generic†, Novo Nordisk	To improve glycemic control in adults and children with diabetes mellitus
insulin glulisine (Apidra®) ⁴	Sanofi-Aventis	To improve glycemic control in adults and children with diabetes mellitus
insulin lispro (Admelog®) ⁵	Sanofi-Aventis	To improve glycemic control in adults and children 3 years of age and older with T1DM and adults with T2DM
insulin lispro (Humalog®, Humalog Junior) ^{6,7}	generic†, Eli Lilly	To improve glycemic control in adults and children 3 years of age and older with T1DM and adults with T2DM
insulin lispro-aabc [§] (Lyumjev™) ⁸	Eli Lilly	To improve glycemic control in adults with diabetes mellitus
Regular (R) Insulins		
human insulin (Humulin® R) ⁹	Eli Lilly	To improve glycemic control in adults and children with diabetes mellitus Human insulin 500 U/mL (Humulin R U-500) is for use in patients requiring daily doses > 200 units
human insulin (Novolin® R) ¹⁰	Novo Nordisk	
Intermediate (N) Insulins		
human insulin NPH (Humulin N) ¹¹	Eli Lilly	To improve glycemic control in adults and children with diabetes mellitus
human insulin NPH (Novolin N) ¹²	Novo Nordisk	
Long-Acting Insulins		
insulin degludec (Tresiba®) ¹³	Novo Nordisk	To improve glycemic control in patients 1 year of age or older with diabetes mellitus‡
insulin detemir (Levemir®) ¹⁴	Novo Nordisk	To improve glycemic control in adults and children with diabetes mellitus
insulin glargine U-100¶ (Basaglar®) ¹⁵	Eli Lilly	To improve glycemic control in adults and children with T1DM and adults with T2DM
insulin glargine U-100 (Lantus®) ¹⁶	Sanofi-Aventis	
insulin glargine U-300 (Toujeo®) ¹⁷	Sanofi-Aventis	To improve glycemic control in adults and pediatric patients 6 years and older with diabetes mellitus

NPH = neutral protamine Hagedorn; T1DM = type 1 diabetes mellitus; T2DM = type 2 diabetes mellitus

* Admelog was approved through an abbreviated approval pathway under a 505(b)(2) application that relied, in part, on safety and efficacy data for Humalog; it is a *follow-on* product to Humalog.¹⁸

† Authorized generic

‡ Insulin degludec is not recommended in pediatric patients who require doses of less than 5 units.

§ Insulin lispro-aabc (Lyumjev) is the first commercially available insulin in the US that was approved under the under section 351(a) of the Public Health Service Act¹⁹

¶ Basaglar was the first insulin product approved through a 505(b)(2) application; data for approval relied mostly on Lantus data for safety and efficacy. It is regarded by the FDA as a *'follow-on'* agent to Lantus.²⁰

Insulin degludec (Tresiba), insulin detemir (Levemir), insulin glargine (Basaglar, Lantus, Toujeo) and insulin inhalation powder (Afrezza) are not recommended for treating diabetic ketoacidosis.

FDA-Approved Indications (continued)

Drug	Manufacturer	Indication(s)
Rapid/Intermediate-Acting Combination Insulins		
insulin aspart 70/30 (Novolog® Mix) ²¹	generic †, Novo Nordisk	To improve glycemic control in patients with diabetes mellitus
insulin lispro 50/50, 75/25 (Humalog® Mix) ^{22,23}	Eli Lilly	For the treatment of patients with diabetes mellitus for the control of hyperglycemia
Regular/Intermediate-Acting Combination Insulins		
human insulin 70/30 (Humulin) ²⁴	Eli Lilly	To improve glycemic control in adults with diabetes mellitus
human insulin 70/30 (Novolin 70/30) ²⁵	Novo Nordisk	

NPH = neutral protamine Hagedorn; T1DM = type 1 diabetes mellitus; T2DM = type 2 diabetes mellitus

† Authorized generic

In June 2019, the FDA approved the first ready-to-use insulin for intravenous (IV) infusion, insulin human in 0.9% sodium chloride injection (Myxredlin; Baxter) 100 units/100 mL in a single-dose container.^{26,27} Myxredlin is intended for use in a hospital or other acute care setting and will not be detailed in this therapeutic class review.

OVERVIEW

It is estimated that over **34** million Americans have diabetes mellitus (DM).²⁸ Diabetes is responsible for increased morbidity and mortality. Adequate glycemic control is crucial to minimize chronic microvascular (e.g., blindness, renal dysfunction) and macrovascular (e.g., cardiovascular disease [CVD]) complications.²⁹

Exogenous insulin supplements deficient levels of endogenous insulin, and temporarily restores the ability of the body to properly utilize carbohydrates, fats, and proteins. Multiple insulin products are available and are used as replacement therapy in the management of both T1DM and T2DM when glycemic goals are not met with oral antidiabetic agents.

In 2018, the World Health Organization (WHO) released guidelines regarding diabetes treatment intensification.^{30,31} WHO recommends introduction of human insulin in patients with T2DM who do not achieve glycemic control with metformin and/or a sulfonylurea (SU). In adults with T1DM or adults with T2DM for whom insulin is indicated, human insulin should be used to manage blood glucose; long-acting insulin analogues should be considered for T1DM or adults with T2DM who experience frequent, severe hypoglycemia with human insulin. In addition, in 2019, the WHO updated their classification of diabetes mellitus based on clinical parameters to identify diabetes subtypes, and it includes T1DM, T2DM, hybrid forms of diabetes (e.g., slowly evolving immune-mediated, ketosis-prone T2DM), specific types (e.g., monogenic, drug- or chemical-induced, infection-related), unclassified diabetes, and hyperglycemia first detected during pregnancy.³²

In 2018, the American College of Physicians (ACP) developed a statement to guide clinicians in selecting targets for pharmacologic treatment of T2DM, including recommending a goal hemoglobin A1c (HbA1c) level between 7% and 8% in most patients.³³ In addition, they state that clinicians should consider deintensifying pharmacologic therapy in patients who achieve HbA1c levels < 6.5%, treat patients to minimize symptoms related to hyperglycemia, and avoid targeting an HbA1c level in

patients with a life expectancy < 10 years due to advanced age because the harms outweigh the benefits in this population.

The American Diabetes Association (ADA) 2020 Standards of Medical Care in Diabetes advocate that glycemic goals be tailored to individual patient needs.³⁴ A reasonable HbA1c goal for non-pregnant adults is < 7%; however, more stringent HbA1c goals (< 6.5%) for selected patients (e.g., those with short duration of diabetes, long life expectancy, and no significant CVD) may be considered if this can be achieved without significant hypoglycemia. Less-stringent HbA1c goals (< 8%) may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, extensive comorbid conditions, and those with long-standing diabetes in whom the general goal is difficult to attain. ADA defines clinically significant hypoglycemia as serum glucose < 54 mg/dL and glucose alert value of ≤ 70 mg/dL. For pediatric patients, the ADA recommends a target HbA1c < 7.5% for all age groups. An HbA1c target of 6% to 6.5% for pregnant women is recommended, which can be relaxed or tightened depending on hypoglycemia risk during pregnancy. Relaxed HbA1c goals are recommended in some patients to reduce the risk of hypoglycemia, particularly in older individuals (≥ 65 years of age) with chronic comorbidities, cognitive impairment, or functional dependence. In addition, due to increased red blood cell turnover during pregnancy, HbA1c levels may decrease and thereby not fully reflect glycemic parameter. The ADA advises HbA1c be used as a secondary measure during pregnancy, next to self-monitoring of blood glucose.

According to the ADA, antidiabetic therapy for T2DM should start with metformin, unless contraindicated.³⁵ In patients *without* indicators of high-risk or established atherosclerotic cardiovascular disease (ASCVD), chronic kidney disease (CKD), or heart failure (HF), if monotherapy with metformin at a maximum tolerated dose does not achieve or maintain the HbA1c target over 3 months, an oral agent (e.g., sulfonylurea [SU], thiazolidinedione [TZD], dipeptidyl peptidase-4 [DPP-4] inhibitor, sodium-glucose cotransporter-2 [SGLT2] inhibitor), a glucagon-like peptide 1 (GLP-1) receptor agonist, or basal insulin should be added. On average, any second agent is typically associated with a further reduction in HbA1c of approximately 1%. Early use of insulin should be considered if there is evidence of ongoing catabolism (weight loss), if symptoms of hyperglycemia, high HbA1c (> 10%), or blood glucose levels (≥ 300 mg/dL) levels are present. The ADA generally gives preference of a GLP-1 agonist over insulin in patients who require an injectable agent. In patients *with* indicators of high-risk or established ASCVD, CKD, or HF, the addition of a GLP-1 receptor agonist or SGLT2 inhibitor with known cardiovascular (CV), CKD, and/or HF risk reduction **should be considered independent of HbA1c**. In newly diagnosed T2DM patients with markedly symptomatic and/or elevated blood glucose levels (≥ 300 mg/dL) or HbA1c (≥ 10%), basal insulin therapy, typically plus metformin with or without additional noninsulin agents, should be considered from the beginning, particularly if there is evidence of ongoing weight loss. If target HbA1c is not achieved after 3 months, then the addition of a rapid-acting mealtime insulin or a GLP-1 agonist, or change to premixed insulin should be considered. Insulin therapy is the treatment of choice for T1DM and for T2DM during pregnancy. Unlike metformin and glyburide, insulin does not cross the placenta to a measurable degree. ADA advises that most adults and children with T1DM be treated with multiple daily injections insulin or continuous subcutaneous insulin infusion. Most individuals with T1DM should use rapid-acting insulin analogs to reduce hypoglycemia risk. Continuous glucose monitoring should be considered in **most** patients. Automated insulin delivery systems are recommended to improve glycemic control and reduce hypoglycemia in this populations. In most pediatric patients with T2DM, metformin is preferred as initial treatment in those with HbA1c < 8%. Basal insulin is appropriate as initial therapy if the patients cannot take

metformin, or as add-on to initial metformin titration if HbA1c is $\geq 8.5\%$ or blood glucose is ≥ 250 mg/dL, and the patient is symptomatic, or as add-on if metformin monotherapy is no longer adequate to meet HbA1c goals. As liraglutide has now received FDA approval for T2DM in patients ages ≥ 10 years, if metformin \pm basal insulin is not providing adequate glucose control, liraglutide should be considered for these patients as long as contraindications do not exist.

In 2018, the ADA and the European Association for the Study of Diabetes (EASD) updated their 2015 position statement on the management of T2DM. The update introduced a diabetes care decision cycle for patient-centered glycemic management of T2DM to prevent complications and optimize quality of life.³⁶ It includes factors that impact treatment choice, including HbA1c target, the agent's impact on weight and hypoglycemia and its side effect profile, the frequency and mode of administration, and probability of patient adherence.

The American Association of Clinical Endocrinologists (AACE) and American College of Endocrinology (ACE) 2020 diabetes management algorithm and 2015 clinical practice guidelines for developing a diabetes care plan recommend diabetes treatment with a goal HbA1c $\leq 6.5\%$ if it can be reached without substantial hypoglycemia or other adverse effects.³⁷ A goal HbA1c $> 6.5\%$ is appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced renal disease or macrovascular complications, extensive comorbid conditions, or long-standing T2DM in which the HbA1c goal has been difficult to attain. Choice of antidiabetic agent should be based on glycemic profile, HbA1c, body weight, age, comorbid conditions, ease of use, and affordability. Minimizing the risks of hypoglycemia and weight gain are a main concern. AACE/ACE suggests patients with T2DM and HbA1c $< 7.5\%$ start with monotherapy, preferably with metformin. Alternatives to metformin as initial therapy (in order of preference) include GLP-1 receptor agonists, SGLT2 inhibitors, DPP-4 inhibitors, and α -glucosidase inhibitors (AGI); monotherapy with a TZD or SU should be used with caution. Patients with an HbA1c $\geq 7.5\%$ to $\leq 9\%$ should begin with dual therapy with metformin (unless contraindicated) plus a second agent, including a GLP-1 receptor agonist, SGLT2 inhibitor, DPP-4 inhibitor, TZDs, sulfonylurea, basal insulin, colesevelam, bromocriptine quick release, and AGI. TZDs, basal insulin, and SUs should be used with caution. Patients with an HbA1c $> 9\%$ and no symptoms of hyperglycemia may start with maximum doses of 2 antihyperglycemic agents or 3 antihyperglycemic agents; patients with an HbA1c $> 9\%$ with symptoms should begin insulin therapy with or without other agents. The HbA1c should be reassessed every 3 months and failure to improve glycemic control may warrant additional complementary therapy for optimal glycemic control. The preferred treatment for postprandial hyperglycemia in pregnant women is regular or rapid-acting insulin analogs; basal insulin needs can be met with the use of rapid-acting insulin via infusion pump or long-acting insulin.³⁸

AACE/ACE states that when insulin therapy is indicated in patients with T2DM, therapy with long-acting basal insulin analogs (degludec, glargine, and detemir) should be the initial choice in most cases; basal insulin analogs (degludec, detemir, glargine) are preferred over intermediate-acting neutral protamine Hagedorn (NPH) because basal insulin analog provide a relatively flat serum insulin level and are associated with less hypoglycemia.³⁹ Rapid-acting insulin analogs (aspart, glulisine, lispro, inhaled insulin) are preferred over regular insulin for postprandial hyperglycemia because they have a more rapid onset and offset of action and result in less hypoglycemia. Premixed insulin analog therapy, which contains rapid- and long-acting components in the same vial or pen, may be appropriate for patients in whom adherence to a drug regimen is problematic; although, these preparations lack component dosing flexibility and may increase the risk for hypoglycemia compared with basal insulin

or basal-bolus insulin. Basal-bolus insulin therapy is flexible and is recommended for intensive insulin therapy.

According to AACE/ACE guidelines, insulin is required in all patients with T1DM.⁴⁰ It was estimated in 2005 that in the United States (US) 20% to 30% of patients with T1DM and < 1% of those with T2DM receive insulin therapy via an external insulin pump.⁴¹ These patients require intensive management with ≥ 4 insulin injections and 4 self-monitoring blood glucose measurements each day. The rapid-acting insulins, insulin aspart (**Fiasp**, Novolog), insulin glulisine (Apidra), insulin lispro (Admelog, Humalog U-100), and insulin lispro/protamine lispro (Humalog Mix 50/50 and 75/25) are approved for use with insulin pumps.

In 2013, the American Academy of Pediatrics (AAP) issued new guidance for the management of newly diagnosed T2DM in children and adolescents.⁴² They advise clinicians to initiate insulin therapy in children and adolescents with T2DM who are ketotic or in diabetic ketoacidosis, in patients whom the distinction between T1DM and T2DM is unclear, and for any patient with a blood glucose level at least 250 mg/dL or HbA1c > 9%. The AAP suggests that clinicians monitor HbA1c concentrations every 3 months and intensify treatment if blood glucose and HbA1c goals are not being met.

In 2019, the Endocrine Society issued guidelines on screening for and treating diabetes in patients aged ≥ 65 years.⁴³ They recommend diabetes regimens geared toward minimizing risk for hypoglycemia. Metformin is recommended as first-line oral therapy, unless the patient has significant renal impairment or gastrointestinal intolerance. If additional other agents are required to achieve glycemic goals, avoid those associated with high risk for hypoglycemia (e.g., SUs and glinides) and use insulin sparingly.

Subcutaneously injected insulins can be administered to a single patient via a multidose insulin cartridge, vial, or a prefilled insulin pen device. Insulin pens should not be used to give medication to multiple patients. Sharing insulin pens and needles could result in the transmission of human immunodeficiency virus (HIV), the hepatitis viruses, and other blood-borne diseases. All insulin pens are approved only for single-patient use and product labeling warns against sharing of devices.⁴⁴

Insulin inhalation powder (Afrezza) may be an option for patients with T1DM and T2DM who have barriers to injectable administration, such as visual impairment or neuropathy.

In December 2016, Eli Lilly introduced to the market the first insulin follow-on product, Basaglar (insulin glargine 100 U/mL), the follow-on for Lantus. In December 2017, Sanofi-Aventis's Admelog (insulin lispro 100 U/mL), a follow-on to Humalog 100 U/mL, was also approved. Follow-on products are defined as copies of biologic products approved under the Food, Drug and Cosmetic (FD&C) Act 505(b)(2) pathway.⁴⁵ Beginning March 23, 2020, certain biologic products previously approved under the FD&C 505 pathway that have been designated as drugs will be considered to be biologic products under section 351 of the Public Health Service Act (PHSA).^{46,47,48} This transition will allow products, such as insulin, to receive competition through the biosimilar pathway. The biosimilar pathway for approval also allows biologic products to receive additional designation as an interchangeable biosimilar.^{49,50} Interchangeable biosimilar products can be substituted for the reference product without the intervention of the prescriber at the pharmacy, depending on state substitution laws.⁵¹

PHARMACOLOGY^{52,53}

Insulin, secreted from the pancreatic beta cells, lowers blood glucose levels by stimulating peripheral glucose uptake by skeletal muscle and fat, and by inhibiting gluconeogenesis. Insulin also inhibits lipolysis in the adipocyte, inhibits proteolysis, and enhances protein synthesis. Exogenous insulin is derived from recombinant DNA technology with *E. coli* or yeast.

PHARMACOKINETICS^{54,55,56,57,58,59,60,61,62,63,64,65,66,67,68,69,70,71,72,73,74,75,76,77,78,79,80,81,82,83,84}

Comparison of Insulin Products

Drug	Composition of Insulin	Onset (hrs)	Peak (hrs)	Duration (hrs)	Compatibility for Mixing
Rapid-Acting (continued)					
human insulin (Afrezza)	Consists of Technosphere® particles that contain human insulin inhalation powder and an inert excipient, fumaryl diketopiperazine (FDKP)	~0.2	~0.6-0.9	1.5-4.5	--
insulin aspart (Fiasp)	Consists of human insulin aspart in a clear aqueous solution; Created when the amino acid proline is substituted with aspartic acid at position B28; Inclusion of niacinamide (vitamin B ₃) increases the speed of initial insulin absorption	0.27-0.33	1.5-2.2	5-7	infusion fluids (5% dextrose or 0.9% sodium chloride)
insulin aspart (Novolog)	Consists of human insulin aspart in a clear aqueous solution; Created when the amino acid proline is substituted with aspartic acid at position B28	0.25	0.75-1.5	3-5	NPH
insulin glulisine (Apidra)	Created when the amino acid asparagine at position B3 is replaced by lysine and the lysine at position B29 is replaced by glutamic acid	0.33	0.92	5.3	NPH
insulin lispro (Admelog, Humalog)	Consists of zinc-insulin lispro crystals dissolved in clear aqueous fluid; Created when the amino acids at positions 28 and 29 on the insulin B-chain are reversed	0.25-0.5	0.5-1.5	3-4	Admelog: None
				3-5	Humalog: NPH
insulin lispro-aabc (Lyumjev)	Consists of insulin lispro in a clear aqueous fluid; Created when the amino acids at positions 28 and 29 on the insulin B-chain are reversed	0.25-0.28	2-2.9	4.6-7.3	None

Comparison of Insulin Products (continued)

Drug	Composition of Insulin	Onset (hrs)	Peak (hrs)	Duration (hrs)	Compatibility for Mixing
Rapid/Intermediate-acting combinations					
insulin aspart (Novolog Mix)	Suspension containing insulin aspart protamine crystals and soluble insulin aspart	0.17-0.33	1.6-3.2	Up to 24 hours	None
insulin lispro (Humalog Mix)	Suspension containing insulin lispro protamine suspension and insulin lispro solution	0.25-0.5	0.8-6.5	Similar to corresponding Humulin mixes	None
Regular-acting					
human insulin regular 100 U/mL (Humulin R, Novolin R)	Crystalline regular insulin is prepared by precipitation in the presence of zinc chloride at a neutral pH	0.5	2.5-5	8-12	NPH
human insulin 500 U/mL (Humulin R U-500)	A solution identical to human insulin that is produced by recombinant DNA technology utilizing a non-pathogenic laboratory strain of <i>Escherichia coli</i>	< 0.25	4-8	13-24	None
Regular/Intermediate-acting combinations					
human insulin (Humulin 70/30, Novolin 70/30)	Crystalline regular insulin and isophane (NPH) is modified, crystalline protamine zinc insulin	0.5-0.8	2.2-5	Up to 24	None
Intermediate-acting					
human insulin NPH (Humulin N, Novolin N)	Isophane (NPH) is modified, crystalline protamine zinc insulin; Its effects are comparable to a mixture of 2:1 to 3:1 regular insulin and protamine zinc insulin	1.5	4-12	Up to 24	Regular, aspart (Novolog), lispro, and glulisine

Comparison of Insulin Products (continued)

Drug	Composition of Insulin	Onset (hrs)	Peak (hrs)	Duration (hrs)	Compatibility for Mixing
Long-acting					
insulin degludec (Tresiba)	Created when the amino acid threonine in position B30 is omitted and a side-chain consisting of glutamic acid and a C16 fatty acid is attached	1	12	> 42	None
insulin detemir (Levemir) ⁸⁵	Created when the amino acid threonine in position B30 is omitted and a C14 fatty acid chain is added to amino acid B29	0.8-2	6-8	Up to 24	None
insulin glargine U-100 (Basaglar)	Created when the amino acids at position A21 of human insulin are replaced by glycine and 2 arginines are added to the C terminus of the B chain	no data	12*	Up to 24 (only studied up to 24 hrs)	None
insulin glargine U-100 (Lantus)		1.5	5†		
insulin glargine U-300 (Toujeo) ⁸⁶		6	12-16	Up to 36	

* No pronounced peak is detected with Basaglar

† No actual peak is detected with Lantus as insulin glargine is released slowly over 24 hours

In clinical studies, the onset of action of insulin aspart (Fiasp) was 5 minutes earlier and time to maximum glucose reduction was 11 minutes earlier compared to insulin aspart (Novolog).⁸⁷

In clinical studies, the steady state for the 24 hour glucose lowering effect of insulin glargine 300 U/mL (Toujeo) was approximately 27% lower than an equivalent dose of insulin glargine 100 U/mL (Lantus). The glucose lowering effect of insulin glargine 300 U/mL increases with subsequent daily administration.

The AACE/ACE state that the newer basal insulins, insulin glargine 300 units/mL (Toujeo) and insulin degludec (Tresiba), have more prolonged and stable pharmacokinetics compared to other long-acting insulins (insulin glargine 100 units/mL, insulin detemir).⁸⁸ Insulin glargine 300 units/mL (Toujeo) and insulin degludec (Tresiba) have demonstrated similar glycemic control and lower incidence of severe or confirmed hypoglycemia compared to insulin glargine 100 units/mL and insulin detemir. Insulin degludec may also result in a more stable day-to-day variability compared to insulin glargine 300 units/mL.

CONTRAINDICATIONS/WARNINGS^{89,90,91,92,93,94,95,96,97,98,99,100,101,102,103,104,105,106,107,108,109,110}

Insulin therapy is contraindicated during episodes of hypoglycemia.

Changes in insulin dosages should only be made under medical supervision.

A product should not be used in a patient with known hypersensitivity to the active ingredient or its excipients.

Patients with T1DM prescribed insulin inhalation are powder (Afrezza) must also receive a long-acting insulin. Insulin inhalation powder is contraindicated in patients with a hypersensitivity to regular human insulin. Insulin inhalation powder should not be used in patients who smoke or who have

recently stopped smoking (< 6 months ago), as safety and efficacy have not been established in this population.

Insulin inhalation powder is contraindicated in patients with chronic lung disease, such as asthma or chronic obstructive pulmonary disease (COPD), since acute bronchospasm has been experienced in these patients. Prior to initiating therapy, all patients should be evaluated for potential lung disease, including detailed medical history, physical examination, and spirometry. In long-term (up to 2 years) clinical studies, patients without chronic lung disease experienced a small decline (40 mL) in lung function as measured by forced expiratory volume in 1 second (FEV₁). This decline was observed within the first 3 months of therapy and persisted throughout the studies. Impact of treatment longer than 2 years and reversal of impairment after discontinuation has not been assessed. Pulmonary function should be monitored at baseline, after 6 months of therapy, and annually in all patients; more frequent monitoring is needed in those with symptoms such as wheezing, bronchospasm, cough, or difficulty breathing. Alternative therapy should be considered in patients who experience a decline of at least 20% in FEV₁ from baseline.

In clinical trials, the incidence of lung cancer was reported in patients treated with insulin inhalation powder (2 cases per 2,750 patient-years). In both cases, the patients had prior history of heavy tobacco use. Two additional cases of lung cancer (squamous cell and lung blastoma) in non-smokers who were treated with insulin inhalation powder were reported after clinical trial completion. These data are insufficient to establish an association of insulin inhalation powder with respiratory tract tumors. Caution should be used in patients with current or previous lung cancer or who are at increased risk for lung cancer.

In clinical trials with T1DM patients, more patients using insulin inhalation powder experienced diabetic ketoacidosis (DKA) than those receiving comparators (0.43% versus 0.14%, respectively). In patients at risk for DKA, such as those with an acute illness or infection, carefully monitor blood glucose and switch to an alternate route of administration if necessary.

Precautions

Severe, life-threatening, generalized allergy, including anaphylaxis, can occur with insulin therapy.

As with all therapeutic proteins, insulin administration may cause anti-insulin antibodies to form; however, no clinically relevant impact on HbA1c or total daily insulin dose has been found.

Insulin aspart (Fiasp, Novolog), insulin degludec (Tresiba), insulin detemir (Levemir), insulin glulisine (Apidra), insulin glargine (Basaglar, Lantus, Toujeo), insulin lispro (Admelog, Humalog), and **insulin lispro-aabc (Lyumjev)** contain cresol that has been reported to cause localized reactions and generalized myalgias. Insulin aspart contains approximately half the amount of metacresol compared to insulin lispro, **insulin lispro-aabc**, and insulin glulisine.

All insulins can cause a shift in potassium from the extracellular to intracellular space, potentially leading to hypokalemia that if left untreated may cause respiratory paralysis, ventricular arrhythmia, and death. Caution should be used in patients who may be at risk for hypokalemia.

Changes in insulin strength, manufacturer, type, or method or site of administration may affect glycemic control and increase the risk of hypoglycemia or hyperglycemia. Patients and caregivers must be educated to recognize and manage these risks. All insulins may require a dose adjustment for patients with renal or hepatic impairment as they may be at higher risk of hypoglycemia.

The full glucose lowering effect of insulin glargine 300 U/mL (Toujeo) may not be seen for at least 5 days, which should be considered prior to stopping intravenous insulin therapy in patients with T1DM.

The FDA issued a Safety Communication regarding the use of pen needles when injecting medicine.¹¹¹ The FDA has received reports of patients using standard pen needles to administer insulin without removing the inner needle cover, resulting in the insulin not being injected and the risk for hyperglycemia. This included 1 case that resulted in hospitalization and death. The FDA advised healthcare providers (HCP) to instruct patients on the proper use of pen needles for medication delivery and ensure that the patient can demonstrate proper technique. At time of dispensing, HCPs should remind patients of the type of pen needle and how to use it.

The FDA also issued a Safety Communication regarding the use of devices for diabetes management that are unauthorized for sale in the US.¹¹² Devices that are unauthorized have not received FDA review and approval to assure their safety and efficacy. As a result, use of these devices could lead to incorrect blood glucose level measurements and/or an improper dose of insulin which could result in serious or potentially life-threatening medical complications. In addition, combining devices not appropriate for use with other devices also should be avoided. The FDA recommends that patients only use diabetes management devices that have received authorization from the FDA for sale in the US.

Pump or infusion set malfunction during continuous insulin administration can rapidly lead to hyperglycemia and ketoacidosis. Prompt correction is essential, during which time interim subcutaneous injections may be required.

DRUG INTERACTIONS^{113,114,115,116,117,118,119,120,121,122,123,124,125,126,127,128,129,130,131,132,133,134}

Beta-blockers and clonidine are commonly used drugs that may mask the signs and symptoms of hypoglycemia. In addition, beta-blockers, clonidine, lithium salts, and alcohol may either potentiate or weaken the blood glucose-lowering effect of insulin. Pentamidine may cause hypoglycemia, which may sometimes be followed by hyperglycemia.

Substances that may decrease insulin requirements include oral antidiabetic agents, monoamine oxidase inhibitors (MAOIs), angiotensin converting enzyme (ACE) inhibitors, fibrates, fluoxetine, sulfonamide antibiotics, nonselective beta-blockers, and alpha-adrenergic blockers.

Drugs that may increase insulin requirements include oral contraceptives, thiazides, glucocorticoids, growth hormone, isoniazid, niacin, sympathomimetic agents, atypical antipsychotics, and thyroid hormones.

Thiazolidinediones (TZDs) (e.g. pioglitazone and rosiglitazone) are peroxisome proliferator-activated receptor (PPAR)- gamma agonists and can cause dose-related fluid retention, particularly when used in combination with insulin.

ADVERSE EFFECTS^{135,136,137,138,139,140,141,142,143,144,145,146,147,148,149,150,151,152,153,154,155,156}

The most common adverse effect of all insulin products is hypoglycemia. Compared to human insulin, long-acting injectable agents decrease episodes of hypoglycemia by 25% to 50% and decrease nocturnal hypoglycemic episodes by 25% to 33%.

Injection site reactions can occur with any type of injectable insulin. Other possible adverse effects of the injectable insulins include lipodystrophy, localized cutaneous amyloidosis, pruritus, and rash.

In clinical trials, insulin glargine U-100 (Lantus) had treatment-emergent injection site pain in 2.7% of patients versus 0.7% of patients on NPH insulin. Treatment discontinuation was not required. Insulin detemir (Levemir) was associated with more frequent mild injection site reactions than with insulin NPH. In clinical trials, injection site reactions occurred in 3.8% of patients treated with insulin degludec. In clinical trials, injection site reactions occurred in $\geq 5\%$ of patients treated with insulin glargine (Basaglar). Clinical trials with insulin aspart (Fiasp) injection site reaction was reported in 1.6% of patients treated, which included 4.2% of pediatric patients with T1DM.

Use of insulin inhalation powder (Afrezza) is associated with cough (26.9%) and throat pain or irritation (4.8%). Coughing usually occurred within 10 minutes, was generally mild, dry, intermittent, and tended to decrease over time. Postmarketing experience of bronchospasm has been reported.

The potential for weight gain is associated with insulin therapy. In clinical studies insulin detemir was associated with a mean weight loss of 0.5 kg compared to a weight gain of 1 kg with insulin glargine; however, it was also found to be slightly less effective than insulin glargine in reducing HbA1c (0.48% versus 0.74%).¹⁵⁷ In clinical trials with insulin aspart (Fiasp), average weight gain experienced by patients with T1DM and T2DM was 0.7 kg and 2.2 kg, respectively. Clinical trials in patients with T1DM, noted modest weight loss with insulin inhalation powder (Afrezza) in contrast to weight gain with comparator insulin. In insulin-using patients with T2DM, insulin inhalation powder was associated with a more modest weight gain than comparator over the 52-week trial duration. Adverse effects data are obtained from prescribing information and therefore, should not be considered comparative or all-inclusive.

Insulin therapy may cause sodium retention and edema, particularly if treatment is intensified after poor metabolic control.

As with all therapeutic proteins, insulin therapy have the potential for immunogenic antibody formation.

SPECIAL POPULATIONS^{158,159,160,161,162,163,164,165,166,167,168,169,170,171,172,173,174,175,176,177,178,179}

Pediatrics

Safety and efficacy of insulin inhalation powder (Afrezza) have not been established in pediatric patients. Human insulin (Humulin, Novolin) products have been used in all age groups. Although no well-controlled studies of human insulin 500 U/mL (Humulin R U-500) have been performed in children, standard precautions for its use in adults can be applied to children.

Human insulin lispro (Admelog, Humalog) can be used in children 3 years of age and older with T1DM, but it has not been studied in pediatric patients with T2DM. Human insulin aspart (Fiasp, Novolog) can be given to pediatric patients 2 years of age and older with T1DM or T2DM. Insulin degludec (Tresiba) is approved for use in patients 1 year of age and older with T1DM or T2DM. Insulin glulisine (Apidra) is approved for use in pediatric patients with T1DM from 4 to 17 years of age. The safety and efficacy of insulin NPH combinations with insulin aspart (Novolog) and insulin lispro in children have not been evaluated by the FDA, and little data exist.

The safety and efficacy of insulin glargine (Basaglar, Lantus, Toujeo) have not been established in patients less than 6 years of age. Insulin detemir (Levemir) has not been studied in children with T1DM less than 2 years of age. In general, intermediate- and long-acting insulins can have slightly higher exposure (area-under-the-curves) and maximum concentrations in children.

Insulin aspart (Fiasp, Novolog), insulin glulisine (Apidra), and insulin lispro U-100 (Admelog, Humalog) are approved for use in a continuous insulin infusion pump in the pediatric population.

Insulin lispro-aabc (Lyumjev) is not approved for use in patients < 18 years of age.

Pregnancy

Available data from published studies over decades have not established an association between use of human insulin (Humulin R, Humulin N, Novolin R, Novolin N) or human insulin isophane/human insulin (Novolin 70/30) during pregnancy and major birth defects, miscarriage, or adverse maternal or fetal outcomes. Notably, however, there are risks to the mother and fetus associated with poorly controlled diabetes in pregnancy.

The labels for insulin lispro (Admelog), insulin lispro (Humalog), insulin lispro protamine/insulin lispro (Humalog 75/25, Humalog 50/50, Novolog 70/30), and human insulin isophane/human insulin (Humulin 70/30) have been updated to comply with the Pregnancy and Lactation Labeling Rule (PLLR) and state that data are insufficient to inform of developmental risks to the fetus if administered during pregnancy. Labeling for insulin lispro-aabc (Lyumjev) states published studies with insulin lispro during pregnancy have not reported an association between insulin lispro and adverse maternal or fetal outcomes. The labeling for insulin aspart (Novolog) and insulin aspart protamine/insulin aspart (Novolog Mix) state that, based on available data, no major adverse maternal or fetal outcomes have been reported when used during the second trimester. Likewise, the labeling for insulin detemir (Levemir) has been updated to comply with the PLLR and state that available data have not identified a drug-associated risk for adverse maternal or fetal outcomes.

Previously assigned Pregnancy Category C, labeling for insulin inhalation powder (Afrezza), insulin glargine 100 U/mL (Basaglar, Lantus), and insulin glulisine (Apidra) have been updated to comply with the PLLR; labeling for all state that the limited available data during pregnancy is inadequate to determine risks to the fetus and mother.

There are no clinical studies of the use of insulin glargine 300 U/mL (Toujeo) in pregnant women; it should not be used during pregnancy unless the potential benefit justifies the potential risk. Labeling for insulin aspart (Fiasp) and insulin degludec (Tresiba) advises that there are no data available in pregnant women to inform of drug-associated risk for birth defects and miscarriage.

In 2012, the pregnancy category for insulin detemir was modified from C to B. In an open-label study that included 310 women with T1DM who were pregnant or intended to become pregnant, no differences in pregnancy outcomes or the health of the fetus and newborn between groups treated with insulin detemir or NPH insulin.

In general, poorly controlled diabetes during pregnancy increases maternal and fetal risks.

Geriatrics

In elderly patients with diabetes, the initial dosing, dose adjustments, and maintenance dosage should be conservative to reduce the risk of hypoglycemia.

Renal impairment

Renally impaired patients are subject to increased levels of circulating insulin and be at increased risk of hypoglycemia. More frequent insulin dose adjustments may be warranted in this patient population.

No differences in safety or effectiveness were observed in a subgroup analysis of insulin degludec-treated patients with T2DM who had with eGFR < 60 mL/min/1.73 m² or eGFR < 30 mL/min/1.73 m².

Hepatic impairment

Due to an increased risk of hypoglycemia, more frequent dose adjustments and blood glucose monitoring may be needed in patients with hepatic impairment.

Other

For categories such as age, gender, and obesity, there are no significant data that suggest a difference in drug effect in these patients.

DOSAGES 180,181,182,183,184,185,186,187,188,189,190,191,192,193,194,195,196,197,198,199,200,201,202

Drug	Dosing	Time of administration related to mealtime	Availability
Rapid-Acting Insulins			
human insulin inhalation powder (Afrezza)	Dosing should be titrated to glycemic control in combination with a long acting insulin	At the beginning of the meal	Cartridge: 4 units, 8 units, and 12 units packaged as: <ul style="list-style-type: none"> 90 x 4-unit cartridges 90 x 8-unit cartridges 90 x 12-unit cartridges 90 x 4-unit + 90 x 8-unit cartridges 90 x 8-unit + 90 x 12-unit cartridges 60 of each 4-unit/8-unit/12-unit 2 inhalers are contained in each package
insulin aspart (Fiasp)	Dosing should be titrated to glycemic control in combination with an intermediate- or long-acting insulin (and/or with oral antidiabetic agents for T2DM)	At start of a meal or within 20 minutes after starting a meal	100 units/mL: <ul style="list-style-type: none"> 10 mL vial 3 mL prefilled FlexTouch® pen 3 mL PenFill cartridges
insulin aspart (Novolog)		5 to 10 minutes before eating	100 units/mL: <ul style="list-style-type: none"> 10 mL vial † 3 mL prefilled FlexPen® † 3 mL cartridge †
insulin glulisine (Apidra)		Within 15 minutes before a meal or within 20 minutes after starting a meal	100 units/mL: <ul style="list-style-type: none"> 10 mL vial 3 mL prefilled SoloStar pen
insulin lispro (Admelog, Humalog, Humalog Junior)	Dosing should be titrated to glycemic control in combination with an intermediate- or long-acting insulin (and/or with oral antidiabetic agents for T2DM)	No more than 15 minutes before a meal or immediately after a meal	100 units/mL: <ul style="list-style-type: none"> 3 mL vial (Admelog; Humalog) 10 mL vial (Admelog; Humalog) † 3 mL prefilled pen (Admelog SoloStar; Humalog KwikPen) † 3 mL prefilled pen (Humalog Junior KwikPen) † 3 mL cartridge (Humalog) 200 units/mL: <ul style="list-style-type: none"> 3 mL prefilled pen (Humalog KwikPen)
insulin lispro-aabc (Lyumjev)	Dosing should be titrated to glycemic control in combination with an intermediate- or long-acting insulin (and/or with oral antidiabetic agents for T2DM)	No more than 20 minutes before a meal or immediately after a meal	100 units/mL: <ul style="list-style-type: none"> 10 mL vial 3 mL prefilled pen (KwikPen) 200 units/mL: <ul style="list-style-type: none"> 3 mL prefilled pen (KwikPen)

* Authorized generic available.

† Human insulin U-100 products (Humulin 70/30, Humulin N, Humulin R, Novolin 70/30, Novolin N, Novolin R) are available over-the-counter (OTC).

Dosages (continued)

Drug	Dosing	Time of administration related to mealtime	Availability
Rapid-Acting Insulins (continued)			
human insulin [†] (Humulin R, Novolin R)	Dosing should be titrated to glycemic control in combination with an intermediate or long acting insulin (and/or with oral antidiabetic agents for T2DM)	30 minutes prior to meal	100 units/mL: <ul style="list-style-type: none"> ▪ 3 mL vials (Humulin R U-100) ▪ 3 mL pen (Novolin R) ▪ 10 mL multi-dose vials (Humulin R U-100; Novolin R U-100) 500 units/mL: <ul style="list-style-type: none"> ▪ 20 mL vials (Humulin R U-500) 500 units/mL: <ul style="list-style-type: none"> ▪ 3 mL prefilled pen (Humulin R KwikPen)
Intermediate (N) Insulins			
human insulin NPH (Humulin N, Novolin N) [†]	Dosing should be titrated to glycemic control. Can be used in combination with an quick- or long-acting insulin (and/or with oral antidiabetic agents for T2DM); Total daily dose is given as 1 to 2 injections per day	30 to 60 minutes prior to meal or bedtime	100 units/mL: <ul style="list-style-type: none"> ▪ 3 mL vials (Humulin N) ▪ 10 mL vials (Humulin N; Novolin N) ▪ 3 mL prefilled pen (Humulin N KwikPen; Novolin FlexPen)
Long-Acting Insulins			
insulin degludec (Tresiba)	Dosing should be individualized based on the type of diabetes and whether the patient is insulin-naïve; Initial dose in patients with T1DM is one-third of the total daily insulin requirements; Short-acting, pre-meal insulin should be used to satisfy the remainder of the daily insulin requirement	Adults: Administer SC once daily at any time during the day There should be a minimum interval of 8 hours after the last injection Pediatrics: Administer SC once daily at the same time each day; for patients requiring < 5 units each day, use the U-100 vial	100 U/mL: <ul style="list-style-type: none"> ▪ 10 mL vial ▪ 3 mL FlexTouch pen 200 U/mL: <ul style="list-style-type: none"> 3 mL FlexTouch pen
insulin detemir (Levemir)		Once daily (with the evening meal or at bedtime) or twice daily (with the evening meal, at bedtime, or 12 hours after the morning dose)	100 units/mL: <ul style="list-style-type: none"> ▪ 10 mL vial 3 mL FlexTouch pen
insulin glargine (Basaglar)		Administer SC once daily at any time during the day, at the same time every day	100 units/mL: <ul style="list-style-type: none"> 3 mL prefilled KwikPen
insulin glargine (Lantus)			100 units/mL: <ul style="list-style-type: none"> ▪ 10 mL vial ▪ 3 mL SoloStar pen
insulin glargine (Toujeo)			300 units/mL: <ul style="list-style-type: none"> ▪ 1.5 mL SoloStar prefilled pen 3 mL Max SoloStar prefilled pen

Dosages (continued)

Drug	Dosing	Time of administration related to mealtime	Availability
Rapid/Intermediate-Acting Combination Products			
insulin aspart/protamine aspart (Novolog Mix 70/30)	Dosing should be titrated to glycemic control	Within 15 minutes before meal initiation or immediately after a meal Typically dosed on a twice-daily basis (breakfast and dinner)	<ul style="list-style-type: none"> ▪ 10 mL vial* ▪ 3 mL prefilled FlexPen†
insulin lispro/protamine lispro (Humalog Mix 75/25, Humalog Mix 50/50)		Within 15 minutes before meal initiation or immediately after a meal	<ul style="list-style-type: none"> ▪ 10 mL vial ▪ 3 mL prefilled KwikPen
human insulin [†] (Humulin 70/30, Novolin 70/30)	Dosing should be titrated to glycemic control in combination with an intermediate or long acting insulin (and/or with oral antidiabetic agents for T2DM)	30 to 60 minutes prior to meal	<ul style="list-style-type: none"> ▪ 3 mL vials (Humulin 70/30) ▪ 10 mL vials (Humulin 70/30; Novolin 70/30) ▪ 3 mL prefilled pen (Humulin 70/30 KwikPen, Novolin 70/30 FlexPen)

* Authorized generic available.

† Human insulin U-100 products (Humulin 70/30, Humulin N, Humulin R, Novolin 70/30, Novolin N, Novolin R) are available OTC.

Injectable insulins may be administered via subcutaneous injection into the thigh, upper arm, and abdomen regions. Injection sites should be rotated within the same region.

Regular insulin, insulin glulisine (Apidra), insulin lispro 100 units/mL (Admelog, Humalog U-100), **insulin lispro-aabc 100 units/mL (Lyumjev)**, and insulin aspart (Fiasp, Novolog) can be administered intravenously under medical supervision. Insulin lispro 200 units/mL (Humalog U-200), insulin aspart/protamine aspart (Novolog Mix), insulin lispro/protamine lispro (Humalog Mix), insulin detemir (Levemir), and insulin glargine (Basaglar, Lantus, Toujeo) should not be given intravenously or used in insulin infusion pumps. See prescribing information for dilution and administration details.

Insulin aspart (Fiasp, Novolog), insulin glulisine (Apidra), insulin lispro (Admelog, Humalog U-100), and insulin lispro/protamine lispro (Humalog Mix 50/50, Humalog Mix 75/25) may also be administered via continuous subcutaneous infusion in accordance with insulin infusion pump system instructions for use. Rotate infusion sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. Repeated insulin injections into areas of lipodystrophy or localized cutaneous amyloidosis or a sudden change in the injection site (to an unaffected area) may result in hyperglycemia.

Human insulin 500 U/mL use in combination with other insulins and its use as a continuous subcutaneous infusion have not been established. Becton-Dickenson has created a syringe specific for U-500 insulin administration that does not require dose conversion as previously needed when using U-100 insulin/TB syringe to deliver U-500 insulin.²⁰³ The syringes are only available by prescription and should be co-prescribed with U-500 insulin.

Doses of insulin should be individualized. Generally, for both children and adults, an initial dose is 0.5 to 1 unit/kg/day. Insulin requirements may be altered during major illness, emotional disturbances, stress, or changes in exercise, meal patterns, or coadministered drugs. The duration of action of all

insulins will vary according to the dose, injection site, blood flow, temperature, and level of physical activity.

To minimize risk of hypoglycemia, the starting dose of insulin degludec (Tresiba) in pediatric patients who are already on long- or intermediate-acting insulin therapy is 80% of the previous total daily insulin dose. Adults switching to insulin degludec may start at the same unit-per-unit dosage. Insulin degludec is not recommended in pediatric patients who require doses less than 5 units. Healthcare professionals should be contacted if a dose is missed in pediatric patients receiving insulin degludec.

Two open-label phase 3 studies in patients with T1DM (n=493) or T2DM (n=687) evaluated insulin degludec given in flexible once-daily dosing intervals compared with insulin degludec and insulin glargine administered once daily at the same time each day. The flexible dosing intervals were predefined with variations between 8 and 40 hours. In patients with T1DM or T2DM flexible dosing was shown to be non-inferior (upper limit of the 95% confidence interval (CI) for the treatment difference was $\leq 0.4\%$) with respect to HbA1c reduction versus same time dosing for insulin degludec and insulin glargine. In addition, nocturnal hypoglycemic events were reduced by 40% ($p < 0.01$) in the flexible dosing group versus the insulin glargine group. In patients with T2DM, rates for hypoglycemia were comparable between all groups.

The FlexPen delivery system is a disposable prefilled pen for insulin aspart (Novolog), and insulin aspart/protamine aspart (Novolog Mix). The FlexPen is able to dial up to 60 units of insulin in 1-unit increments. The FlexTouch delivers from 1 to 80 units of insulins aspart (Fiasp), detemir (Levemir), and degludec U-100 and up to 160 units of insulin degludec U-200.²⁰⁴

The KwikPen™ prefilled pen device for human insulin NPH (Humulin N), insulin NPH/regular (Humulin 70/30), insulin lispro (Humalog), insulin lispro-aabc (Lyumjev), and insulin lispro/protamine lispro (Humalog Mix) can provide up to 60 units of insulin in 1-unit increments utilizing a dial mechanism. The KwikPen prefilled pen device for insulin glargine (Basaglar) can provide up to 80 units of insulin per injection in 1-unit increments. No dose conversion is needed when using the Humulin R U-500 KwikPen since the dose window shows the number of units to be injected. Humalog Junior KwikPen contains 300 units of insulin lispro U-100 and can deliver doses in 0.5 unit of insulin to a maximum of 30 units in a single injection.

Two refillable pen devices are currently available for patients that may require smaller doses of insulin (e.g., children). The HumaPen® Luxura™ HD allows patients to dial insulin in half-unit increments (from 1 to 30 units), and should only be used with insulin lispro (Humalog) cartridges.²⁰⁵ The NovoPen Echo®, has replaced the NovoPen® Junior. NovoPen Echo provides half-unit dosing capabilities (from 0.5 to 30 units) and a memory function that records the dose and the date and time since the previous dose. NovoPen Echo should only be used with the Novo Nordisk product line of insulin cartridges.²⁰⁶

The SoloStar® prefilled pen devices for insulin glargine (Lantus, Toujeo), insulin glulisine (Apidra), insulin lispro (Admelog) are useful for patients that require larger doses of insulin.^{207,208} This pen system is able to dial up to 80 units of insulin in 1-unit increments. Insulin glargine 300 units/mL (Toujeo) is also available in the 3 mL Max Solostar pen that delivers doses in 2-unit increments up to 160 units per injection. It is recommended for patients requiring at least 20 units/day. If switching from the Toujeo SoloStar to Max SoloStar pen, increase or decrease dose by 1 unit. In addition, Toujeo should be used with caution in patients with visual impairment who may rely on audible clicks to dial their dose.

People who are blind or have impaired vision should not use the prefilled pens without help from a person trained to use the pen. The FlexTouch (Fiasp, Novolog, Novolog Mix) and KwikPen (Humulin, Humalog, Humalog Mix) should be used with caution in patients with visual impairment who may rely on audible clicks to dial their dose.

Do not transfer insulin degludec (Tresiba) or insulin glargine (Toujeo) from the prefilled pen/cartridge into a syringe as dosing errors may result.

Most pens and their compatible cartridges are refrigerated before use. Following the first use, these formulations should be stored at room temperature. Expiration dates are typically 10 to 14 days for regular insulin and insulin NPH, as well as mixes of regular insulin, insulin aspart, or insulin lispro with insulin NPH at room temperature. The rapid-acting insulins and insulin glargine cartridges and pens expire in 28 days, while those for insulin detemir last 42 days.

Insulin inhalation powder (Afrezza) should only be administered via oral inhalation using the breath-powered inhaler provided. The recommended initial mealtime dose is 4 units at each meal for insulin-naïve individuals. For patient using subcutaneous mealtime insulin, the mealtime inhalation dose should be determined by using the dose conversion table provided in the package insert, which instructs that 4 units of injected mealtime insulin is equal to 4 units of inhaled mealtime insulin. Doses should be rounded up to the nearest 4 units of insulin inhalation powder. For individuals using subcutaneous pre-mixed insulin, estimate the mealtime injected dose by dividing half of the total daily injected pre-mixed insulin dose equally among the 3 meals of the day. Then, convert each estimated injected mealtime dose to an appropriate insulin inhalation powder dose as outlined in the package insert and administer half of the total daily injected pre-mixed dose as an injected basal insulin dose.

Multiple cartridges are needed for insulin inhalation powder dosages above 12 units. Administer a single inhalation per cartridge. Only 1 inhaler should be used at a time. Replace the inhaler every 15 days. Insulin inhalation powder cartridges should be kept refrigerated and must be used within 10 days at room temperature and 3 days once the foil package is opened.

To administer insulin inhalation powder, fully exhale, close lips around the mouthpiece, tilt the inhaler downward while keeping the head level, inhale deeply and hold breath as long as comfortable. To avoid loss of drug powder once the drug cartridge has been inserted into the inhaler, the inhaler must be kept level with the white mouthpiece on top and the purple base on the bottom; the inhaler must not be shaken or dropped. If any of the above occurs, the cartridge should be replaced before use.

CLINICAL TRIALS

Search Strategies

Studies were identified through searches performed on PubMed and review of information sent by manufacturers. Search strategy included the FDA-approved use of all brand names in this class. Randomized, comparative, controlled trials comparing agents within this class in an outpatient setting for the approved indications are considered the most relevant in this category. Studies included for analysis in the review were published in English, performed with human participants and randomly allocated participants to comparison groups. In addition, studies must contain clearly stated, predetermined outcome measure(s) of known or probable clinical importance, use data analysis techniques consistent with the study question and include follow-up (endpoint assessment) of at least 80% of participants entering the investigation. Despite some inherent bias found in all studies,

including those sponsored and/or funded by pharmaceutical manufacturers, the studies in this therapeutic class review were determined to have results or conclusions that do not suggest systematic error in their experimental study design. While the potential influence of manufacturer sponsorship/funding must be considered, the studies in this review have also been evaluated for validity and importance.

Numerous studies were found meeting standard criteria. The data included here were further evaluated to remove studies that were found to be unacceptable for the following reasons: small treatment group, *post hoc* analysis, use of insulin pumps, studies relying on outcomes from self-reported data, inappropriate treatment duration, and unapproved formulation, dosage regimen, or route of administration.

The method of administration and associated monitoring makes it difficult to perform properly blinded studies with these drugs. Due to the lack of double-blind studies, open-label studies have been included; while these large studies may produce accurate results, the study design should be taken into consideration.

In countries outside of the US, blood glucose values are typically reported in mmol/L. For those studies reporting blood glucose values in mmol/L, the value in mg/dL can be estimated by multiplying the mmol/L value by 18.

Injectable insulin

insulin aspart (Fiasp) versus insulin aspart (Novolog)

Onset 1:^{209,210} A 26-week, phase 3, multicenter, active-controlled, parallel-group trial evaluated the efficacy of faster-acting insulin aspart (Fiasp) compared to conventional insulin aspart (Novolog) in 1,143 adults with inadequately controlled T1DM (HbA1c, 7% to 9.5%). During an 8-week run-in period, patients were optimized on background basal insulin detemir (once- or twice-daily) and switched their bolus insulin to mealtime Novolog on a unit-to-unit basis. After run-in, patients were randomized 1:1:1 to blinded mealtime (0 to 2 minutes before a meal) Fiasp or Novolog, or open-label postmeal (20 minutes after start of a meal) Fiasp; insulin detemir was continued. Patients adjusted bolus insulin doses based on preprandial plasma glucose levels. The primary endpoint was change from baseline in HbA1c after 26 weeks of treatment. Fiasp met the prespecified noninferiority criteria (0.4%) for the primary endpoint (difference between mealtime Fiasp and Novolog, -0.15% [95% CI, -0.23 to -0.07]; difference between postmeal Fiasp and mealtime Novolog, 0.04% [95% CI, -0.4 to 0.12]). Compared to Novolog, the likelihood of achieving an HbA1c < 7% was statistically significantly higher with mealtime Fiasp (estimated odds ratio [OR], 1.47 [95% CI, 1.02 to 2.13]; p=0.04), but not with postmeal Fiasp. The difference in mean 1-hour and 2-hours postprandial plasma glucose (PPG) was statistically significantly lower with mealtime Fiasp compared to Novolog. However, when comparing the PPG for postmeal Fiasp and mealtime Novolog, the 1-hour PPG was statistically significantly lower for Novolog, but not significant difference was seen at 2-hours. Incidence of hypoglycemia, including severe episodes, was similar between the groups.

Onset 2:^{211,212} In a 26-week, phase 3, double-blind trial, faster-acting insulin aspart (Fiasp) was compared to conventional insulin aspart (Novolog) in 689 adults with inadequately controlled T2DM with basal insulin and oral antidiabetic agents. During an 8-week run-in period, patients were optimized to basal insulin glargine (once-daily) and switched their bolus insulin to mealtime Novolog on a unit-to-unit basis. Patients were then randomized 1:1 to mealtime Fiasp or Novolog administered

0 to 2 minutes before each main meal, both with background insulin glargine and metformin. Bolus insulin dose adjustments were made daily by the patient base on plasma glucose levels and reviewed weekly by the investigator. The primary endpoint was change from baseline in HbA1c after 26 weeks of treatment. At 26-weeks mean HbA1c decreased to 6.6% in both groups; mean change was -1.38% for Fiasp and -1.36% for Novolog. Fiasp improved 1-hour PPG compared to Novolog, but no differences were seen in 2-hour PPG. Overall incidence of hypoglycemia was similar except for an increase in 0-2-hour postmeal hypoglycemia with Fiasp (2.27 versus 1.49 per patient-year of exposure).

insulin aspart (Fiasp) versus insulin aspart (Novolog) added to insulin degludec in pediatric patients

In a 26-week, active-controlled, parallel-group trial, 777 pediatric patients 2 to 17 years of age with T1DM were randomized 1:1:1 to blinded mealtime insulin aspart, blinded mealtime Novolog, or open-label postmeal Fiasp, all added to once daily insulin degludec.²¹³ Mealtime doses were administered 0 to 2 minutes before the meal, and postmeal doses were administered 20 minutes after the start of the meal. After 26 weeks, both mealtime and postmeal Fiasp demonstrated noninferiority to Novolog in change in HbA1c from baseline (difference from Novolog for mealtime Fiasp, -0.17% [95% CI, -0.3 to -0.03]; difference from Novolog for postmeal Fiasp, 0.13% [95% CI, -0.01 to 0.26]).

insulin aspart (Novolog) versus regular human insulin

A prospective, multicenter, randomized, parallel-group, open-label study was performed in 423 basal-bolus treated patients with T1DM.²¹⁴ Main outcome measures included blood glucose control assessed by HbA1c, 9-point self-monitored blood glucose profiles, insulin dose, quality of life, hypoglycemia, and adverse events. An algorithm-driven increase occurred in the dose and number of daily injections of basal insulin, particularly in the insulin aspart group. After 12 weeks of treatment, HbA1c was significantly lower in the insulin aspart group compared to regular human insulin groups by 0.17% (95% CI, 0.3 to 0.04; $p < 0.05$). Comparison of the blood glucose profiles showed lower blood glucose levels with insulin aspart after breakfast ($p < 0.0001$) and dinner ($p < 0.01$). There were no differences between treatments in the incidence of hypoglycemic episodes or in the adverse event profiles. The WHO Diabetes Treatment Satisfaction Questionnaire score for perceived hyperglycemia was lower with insulin aspart ($p = 0.005$).

In a 6-month, similarly designed trial in 1,070 adults with T1DM, HbA1c was significantly lower in the insulin aspart group (0.12% reduction in HbA1c) after 6 months.²¹⁵ The insulin aspart group had lower post-prandial blood glucose levels, but had higher preprandial glucose levels before breakfast and dinner ($p < 0.01$). Major hypoglycemia episodes overall were similar in both treatment groups, but major hypoglycemia episodes occurring at night that required parenteral treatment occurred more often in the regular insulin group.

Another similarly designed study was performed over 6 months with a 6-month extension period. In 882 men and women with T1DM, HbA1c values were significantly lower with insulin aspart than with regular insulin (7.78% versus 7.93%; $p = 0.005$) at 6 months.²¹⁶ In the extension period ($n = 714$), the difference in HbA1c continued to remain significant at 12 months. The mean basal NPH dose at 12 months was significantly higher for the insulin aspart group than that for the regular insulin group (0.314 versus 0.296 units/kg; $p = 0.011$). A similar percentage of patients in each treatment group had a major hypoglycemic episode by 6 months. Fewer subjects in the insulin aspart group than in the regular insulin group (4% versus 8%) experienced a major hypoglycemic episode during the night.

A trial was conducted in patients with T1DM who were randomized to mealtime insulin aspart with up to 4 daily NPH doses and a 25% increase in bedtime NPH dose (n=187) or to mealtime human unmodified insulin with once or twice daily basal NPH insulin (n=181).²¹⁷ Efficacy and safety were evaluated at 12 weeks (primary evaluation period) and 64 weeks. At 12 and 64 weeks, there was no statistically significant difference in HbA1c reduction between the insulin aspart and regular insulin groups (-0.09% and -0.14%, respectively). Post-prandial glucose values were lower with insulin aspart, and no significant differences were found in mild or severe hypoglycemia or adverse event rates. At 64 weeks, treatment satisfaction was higher in the insulin aspart group while quality of life was not different.

To compare quality of life (QOL) and treatment satisfaction, 424 patients were randomized to basal-bolus treatment with either insulin aspart (n=283) or regular human insulin (n=141) in a 6-month, multinational, randomized, open-label trial.²¹⁸ After 6 months, insulin aspart was associated with significantly greater improvement in treatment satisfaction than human insulin in 2 different scales (p<0.01), and in QOL with respect to diet restrictions (p<0.01). Improved satisfaction was mainly due to increased dietary and leisure time flexibility (p<0.0001).

In the multinational, double-blind, crossover trial, 155 patients with T1DM were randomized to two 16-week treatment periods with either insulin aspart or human insulin.²¹⁹ NPH insulin was given as basal insulin once or twice daily as needed. Treatment periods were separated by a 4-week washout. The rate of major nocturnal hypoglycemic episodes was 72% lower with insulin aspart than with human insulin (0.067 versus 0.225 events/month; p=0.001). The total rate of major hypoglycemia did not differ significantly between treatments (insulin aspart/human insulin relative risk, 0.72 [95% CI, 0.47 to 1.09]; p=0.12). Mean HbA1c remained constant, slightly below 7.7% on both treatments.

biphasic insulin aspart (Novolog Mix 70/30) versus human insulin 70/30

In a randomized, open-label, parallel trial, 177 patients with T2DM were assigned to meal-related injection of biphasic insulin aspart 3 times a day or biphasic human insulin twice a day over a study period of 24 weeks.²²⁰ The mean difference between treatment groups in HbA1c after 24 weeks of treatment was 0.08% (p=0.6419). Significant differences in blood glucose levels were observed after lunch (156 versus 176 mg/dL, p=0.0289), before dinner (142 versus 166 mg/dL p=0.006), and after dinner (154 versus 182 mg/dL; p=0.002) in favor of biphasic insulin aspart. No differences were found regarding safety parameters in the 2 treatment groups.

The clinical efficacy and safety of 2 treatment regimens, biphasic insulin aspart at all 3 meals plus NPH insulin at bedtime versus premixed human insulin at breakfast and regular insulin at lunch and dinner plus NPH at bedtime, were compared in 167 adolescents with T1DM.²²¹ This open-label, parallel-group trial reported that after 4 months on biphasic insulin aspart therapy, HbA1c was not significantly different from that with human insulin (9.39% versus 9.3%, respectively). The body mass index increased in both groups, but significantly (p=0.005) less in the biphasic insulin aspart group. No significant group differences were found for the rate of hypoglycemic episodes.

insulin aspart (Novolog) versus regular human insulin versus insulin 70/30

A total of 231 patients with T2DM were randomized to insulin aspart (n=75), regular insulin (n=80), or insulin 70/30 (n=76) for 3 months with or without bedtime NPH insulin.²²² A total of 204 patients completed the trial according to protocol. The primary endpoint was change in HbA1c from baseline. HbA1c decreased 0.91% ± 1% for insulin aspart, 0.73% ± 0.87% for regular insulin, and 0.65% ± 1.1% for

insulin 70/30. Postprandial blood glucose decreased more in the insulin aspart group compared with regular insulin and insulin 70/30. Incidence of hypoglycemic events per month were 0.56 with regular insulin, 0.4 with insulin aspart, and 0.19 with insulin 70/30.

biphasic insulin aspart (Novolog Mix 70/30) versus NPH human insulin

In a double-blind study of 403 patients with T2DM not controlled on oral hypoglycemic agents, patients were randomized to receive either biphasic insulin aspart or NPH insulin immediately before breakfast and dinner for 16 weeks.²²³ Oral hypoglycemic agents were discontinued. In both groups, HbA1c decreased by greater than 0.6% ($p < 0.0001$ versus baseline). The biphasic insulin aspart group had a decreased daily postprandial glycemic exposure (mean difference, 0.69 mmol/L; $p < 0.0001$). Overall safety profile of both groups was similar.

biphasic insulin aspart (Novolog Mix 70/30) versus biphasic insulin lispro (Humalog Mix 75/25)

Patients ($n=137$) with T2DM currently receiving insulin treatment were randomized to a multicenter, open-label, crossover comparison of biphasic insulin aspart and biphasic insulin lispro.²²⁴ Efficacy and safety profiles were assessed after 12 weeks of treatment. Treatment with biphasic insulin aspart was not inferior to treatment with biphasic insulin lispro. Adverse event profiles were similar between treatments, as was the incidence of hypoglycemic episodes (0.69 episodes/month with biphasic insulin aspart and 0.62 episodes/month with biphasic insulin lispro; $p = \text{not significant [NS]}$). For all device features assessed, the biphasic insulin aspart FlexPen consistently received higher scores (all $p < 0.005$). Furthermore, 74.6% of patients preferred to continue using the FlexPen, whereas 14.3% preferred the biphasic insulin lispro pen ($p < 0.001$).

insulin degludec (Tresiba) versus insulin detemir (Levemir)

The efficacy and safety of insulin degludec used in combination with mealtime insulin aspart for the treatment of T1DM were evaluated in an open-label, active-controlled clinical trial. A total of 455 patients with inadequately controlled diabetes were randomized to insulin degludec U-100 or insulin detemir once-daily in the evening.²²⁵ After 8 weeks, insulin detemir could be dosed twice-daily. By trial end, 32.9% of patients on insulin detemir were dosed twice daily. At week 26, the difference in HbA1c reduction from baseline between insulin degludec and insulin detemir was -0.09% (95% CI, -0.23 to 0.05). Noninferiority was met. At week 26, 41.1% of patients on insulin degludec and 37.3% of those on insulin detemir achieved HbA1c $< 7\%$. The incidence of severe hypoglycemia was similar between treatment groups (10.5% versus 10.6%). Mean weight gain reported was 1.5 kg for insulin degludec versus 0.4 kg for insulin detemir. In an open-label extension study, after 1 year the rate of nocturnal hypoglycemia was 33% lower with insulin degludec than insulin detemir ($p < 0.05$).²²⁶ Change in HbA1c was similar in both groups, but insulin degludec produced a significantly greater reduction in FPG than insulin detemir (difference degludec compared to detemir, -1.11 mmol/L [95% CI, -1.83 to -0.4]; $p < 0.05$).

insulin degludec (Tresiba) versus insulin glargine (Lantus)

In a 52-week, open-label study, 629 patients with inadequately controlled T1DM were randomized to insulin degludec U-100 once-daily with the evening meal or insulin glargine U-100 once-daily according to the package insert.²²⁷ Mealtime insulin aspart was also administered in both arms. At week 52, the difference in HbA1c reduction from baseline between insulin degludec and insulin glargine was -0.01% (95% CI, -0.14 to 0.11). Noninferiority was met. At week 52, 39.8% of patients on insulin degludec and

42.7% of those on insulin glargine achieved HbA1c < 7%. Severe hypoglycemia occurred in 12.3% of patients in the insulin degludec group and 10.4% in the insulin glargine group. Mean weight gain reported was comparable between the groups (2.1 kg versus 2 kg, respectively).

In a 26-week open-label study, 493 patients with inadequately controlled T1DM were randomized to insulin degludec U-100 injected once daily with the main evening meal, or insulin degludec injected once daily at any time of day, or insulin glargine dosed once daily in the evening.²²⁸ Mealtime insulin aspart was administered in all groups. At week 26, the difference in HbA1c reduction from baseline between insulin degludec administered at the same time and at alternating times, each compared to insulin glargine was 0.16% and 0.17%, respectively. Noninferiority was met. Severe hypoglycemia occurred in 10.4% of patients in the insulin degludec flexible-dose group, 12.7% of patients in the insulin degludec evening meal dose group, and 9.9% in the insulin glargine group. Mean weight gain reported was 1.3 kg for insulin degludec flexible dose group, 0.9 kg in the insulin degludec evening meal dose group, and 1.7 kg in the insulin glargine group.

An open-label study randomized 1,030 insulin-naïve patients with inadequately controlled T2DM to insulin degludec U-100 once-daily with the evening meal or insulin glargine U-100 once-daily.²²⁹ Background therapy consisted of metformin with or without a dipeptidyl peptidase-4 (DPP-4) inhibitor in both groups. At week 52, the difference in HbA1c reduction from baseline between insulin degludec and insulin glargine was 0.09% (95% CI, -0.04 to 0.22). Noninferiority was met. At week 52, 51.7% of patients on insulin degludec and 54.1% of those on insulin glargine achieved HbA1c < 7%. Severe hypoglycemia was reported in 0.3% of patients in the insulin degludec group, 1.9% of patients in the insulin glargine group.²³⁰ Mean weight gain reported was similar between the groups (2.6 kg versus 2.3 kg, respectively).

A total of 457 insulin-naïve patients with T2DM were randomized to insulin degludec U-200 once-daily with the evening meal or insulin glargine U-100 once-daily in an open-label study.²³¹ Background therapy consisted of metformin with or without a DPP-4 inhibitor in both groups. At week 26, the difference in HbA1c reduction from baseline between insulin degludec and insulin glargine was 0.04% (95% CI, -0.11 to 0.19). Noninferiority was met. At week 26, 52.2% of patients on insulin degludec and 55.9% of those on insulin glargine achieved HbA1c < 7%. No incidences of severe hypoglycemia were reported in either group.²³² Mean weight gain reported was similar between the groups (2.3 kg versus 1.9 kg, respectively).

In an open-label study, 435 insulin-naïve patients with T2DM were randomized to insulin degludec U-100 once-daily with the evening meal or insulin glargine U-100 once-daily.²³³ Background therapy with 1 or more oral anti-diabetic drugs (OADs) was continued. At week 26, the difference in HbA1c reduction from baseline between insulin degludec and insulin glargine was 0.11% (95% CI, -0.03 to 0.24). At week 26, 40.8% of patients on insulin degludec and 48.6% of those on insulin glargine achieved HbA1c < 7%. Noninferiority was met. No incidence of severe hypoglycemia was reported in either group.²³⁴ Mean weight gain reported was similar between the groups (1.6 kg and 1.7 kg, respectively).

In an open-label study, 687 patients with T2DM were randomized to insulin degludec U-100 injected once-daily with the main evening meal, insulin degludec injected once daily at any time each day, or to insulin glargine U-100 injected once daily according to the approved labeling.²³⁵ Background therapy with up to 3 of the following agents was continued, metformin, a sulfonylurea, a glinide, or a TZD. At week 26, the difference in HbA1c reduction from baseline between insulin degludec administered at the same

time and at alternating times, each compared to insulin glargine was 0.18% and 0.04%, respectively. Noninferiority was met. The proportion of patients who achieved HbA1c < 7% were 40.8% for those given insulin degludec dosed at the same time each day, 38.9% for insulin degludec dosed at varying times, and 43.9% for insulin glargine. Severe hypoglycemia occurred in < 1% of patients in all treatment groups.²³⁶ Mean weight gain reported was similar between the insulin degludec groups (1.9 kg and 1.6 kg).

A total of 992 patients with T2DM were randomized to insulin degludec U-100 injected once-daily with the main evening meal, or insulin glargine U-100 injected once-daily.²³⁷ Insulin aspart was administered before each meal in both treatment arms in an open-label study. Metformin and/or pioglitazone were used as background therapy in both treatment arms. At week 52, the difference in HbA1c reduction from baseline between insulin degludec and insulin glargine was 0.08% (95% CI, -0.05 to 0.21). Noninferiority was met. A similar proportion of patients achieved HbA1c < 7% in each group. The incidence in severe hypoglycemia was similar between treatment groups (4.5% versus 4.4%).²³⁸ Mean weight gain was also similar between the groups (3.2 kg versus 3.5 kg).

Two, 64-week, double-blind, crossover trials, SWITCH-1 and SWITCH-2, assessed hypoglycemic episodes with insulin degludec compared to insulin glargine 100 IU/mL in adults with T1DM (SWITCH-1; n=501) and T2DM (SWITCH-2; n=721).^{239,240} In both studies, patients were randomized to receive once daily insulin degludec followed by insulin glargine 100 IU/mL or insulin glargine 100 IU/mL followed by insulin degludec. The studies consisted of two, 32-week treatment periods, each with a 16-week titration period and a 16-week maintenance period. During the maintenance period in both trials, insulin degludec demonstrated significantly lower rates of overall symptomatic hypoglycemia (SWITCH-1 rate ratio [RR] of 0.89 [95% CI, 0.85 to 0.94; p<0.001 for noninferiority and p<0.001 for superiority]; SWITCH-2 RR, 0.7 [95% CI, 0.61 to 0.8; p<0.001]). Similarly, insulin degludec was associated with a lower rate of severe hypoglycemic episodes and nocturnal symptomatic hypoglycemia

insulin degludec (Tresiba) versus insulin glargine U-100 (Lantus) on cardiovascular outcomes

The DEVOTE trial was a 2-year, phase 3b, multicenter, international, randomized, double-blind, active comparator-controlled trial that compared the cardiovascular safety of insulin degludec and insulin glargine U-100 (1:1) in 7,637 patients with T2DM when added to standard of care.^{241,242} Patients enrolled had a history of CVD, chronic kidney disease, or multiple CV risk factors. The primary endpoint was the time to first occurrence of cardiovascular death, nonfatal MI, or nonfatal stroke. There was no statistically significant difference in occurrence of the primary endpoint between insulin degludec and insulin glargine U-100 (hazard ratio [HR], 0.91; in favor of insulin degludec). However, statistically significantly fewer patients in the degludec group experienced severe hypoglycemia (27% fewer patients; 40% reduction in severe hypoglycemia episodes overall; 54% relative risk reduction in severe nocturnal hypoglycemia).

insulin detemir (Levemir) versus insulin NPH (Novolin N)

A 6-month, prospective, randomized, open-label, controlled, parallel-group trial conducted at 92 sites included 749 men and women with T1DM with HbA1c < 12% who were already taking daily intermediate- or long-acting insulin and a fast-acting human insulin or insulin analog as bolus insulin.²⁴³ Patients were randomized to insulin detemir or NPH insulin at bedtime in combination with human insulin with main meals. Main outcome measures included HbA1c, FPG, and hypoglycemia. After 6 months, FPG was lower with insulin detemir than with NPH insulin (difference, -1.16 mmol/L; p=0.001), whereas HbA1c did not differ significantly between treatments (difference, -0.12%; p=NS). Day-to-day

variability in self-measured fasting blood glucose was lower with insulin detemir (2.82 versus 3.6 mmol/L; $p < 0.001$). Lower glucose levels were seen before breakfast with insulin detemir compared to NPH ($p < 0.001$). There was a 26% reduction in the relative risk of nocturnal hypoglycemia with insulin detemir compared with NPH ($p = 0.003$). The adverse effect profiles were similar between treatment groups.

In a 26-week, open-label, randomized, parallel-group study, 347 children with T1DM, aged 6 to 17 years, received insulin detemir or NPH insulin once or twice daily plus insulin aspart before meals.²⁴⁴ The mean HbA1c decreased by approximately 0.8% with both treatments. Within-subject variation in self-measured fasting plasma glucose was significantly lower with insulin detemir than with NPH insulin ($p < 0.001$), as was mean fasting plasma glucose (8.4 versus 9.6 mmol/L; $p = 0.022$). The risk of nocturnal hypoglycemia was 26% lower with insulin detemir ($p = 0.041$).

A 1-year open-labeled, parallel group trial compared insulin detemir with NPH insulin, in combination with mealtime insulin aspart in 348 patients aged 2 to 16 years with T1DM.^{245,246} Randomization was stratified by age (2 to 5 years, $n = 82$; 6 to 16 years, $n = 265$). Mean HbA1c was similar between groups at baseline (8.2% versus 8.1%), and changed little over 1 year (8.1% versus 8.3%). FPG was similar at baseline (8.44 versus 8.56 mmol/L) and decreased during the study (-1 versus -0.45 mmol/L). A lower rate of hypoglycemia was observed with insulin detemir compared with NPH (24-h; 50.6 versus 78.3 episodes per patient-year; nocturnal hypoglycemia, 8 versus 17.4 episodes per patient-year). No severe hypoglycemic episodes occurred with insulin detemir, while 3 subjects reported 6 episodes with NPH insulin.

In an open-label study, 310 women with T1DM who were pregnant or intended to become pregnant were randomized to insulin detemir (once or twice daily) or NPH insulin (1 to 3 times daily). Insulin aspart was administered before each meal. Mean HbA1c was $< 7\%$ at 10, 12, and 24 weeks of gestation in both arms. In the intent-to-treat population, the adjusted mean HbA1c at gestational week 36 was similar in each arm. There were no differences in pregnancy outcomes or the health of the fetus and newborn between the groups.

In a controlled, open-label, single-center, noninferiority trials, insulin detemir was compared to NPH insulin in women with pregestational and gestational T2DM.²⁴⁷ Women who failed medical nutrition therapy or oral hypoglycemic therapy were randomized to receive detemir ($n = 42$) or NPH insulin ($n = 45$) between 14 and 32 weeks of gestation. Initial total daily insulin dose was 0.7, 0.8, and 0.9 units/kg of body weight during the first, second, and third trimester, respectively. Sixty percent of the total daily dose was given in the morning and 40% in the evening and 2/3 was given as basal insulin (detemir or NPH) twice a day and one-third as prandial rapid-acting insulin. Mean fasting blood glucose (101.2 versus 99.3, respectively), mean postprandial glucose (115.2 versus 113.4, respectively), proportion of women achieving overall glycemic control, time to achieve glycemic control, and maternal weight gain were all similar between the groups. In addition, birth weight, gestational age at delivery, Apgar score and neonatal hypoglycemia were also similar. However, insulin detemir was associated with a lower rate of hypoglycemia per week compared to NPH insulin (28 versus 102, respectively; $p < 0.001$).

In the 20-week, multicenter, randomized, open-label, parallel-group trial, 504 (intent-to-treat group [ITT] $n = 498$) patients with T2DM, poorly controlled on oral antidiabetic therapy, were randomly assigned to receive an evening SC injection of insulin detemir, a pre-breakfast injection of insulin detemir, or an evening injection of NPH insulin, in addition to their existing oral antidiabetic

regimen.²⁴⁸ Morning and evening detemir were associated with reductions in HbA1c similar to those receiving evening NPH (-1.58%, -1.48%, and -1.74%, respectively). Compared with evening NPH insulin, 24-hour and nocturnal hypoglycemia were reduced by 53% (p=0.019) and 65% (p=0.031), respectively, with evening insulin detemir. Incidences of hypoglycemia did not differ significantly between groups that received morning and evening insulin detemir, but nocturnal hypoglycemia was reduced further, by 87%, with morning insulin detemir compared with evening NPH insulin (p<0.001). Weight gain was 1.2 kg, 0.7 kg, and 1.6 kg with morning insulin detemir, evening insulin detemir, and NPH, respectively (p=0.005 for evening detemir versus NPH).

Patients with T2DM (n=476) with HbA1c 7.5% to 10% were randomized to add-on insulin detemir or NPH insulin twice daily to existing oral antidiabetic agent therapy in a parallel-group, open-label, multicenter trial.²⁴⁹ At 24 weeks, HbA1c had decreased by 1.8% and 1.9% for insulin detemir and NPH insulin, respectively (p=NS). In both groups, 70% of participants achieved an HbA1c < 7%, but the proportion achieving this without hypoglycemia was higher with insulin detemir than with NPH insulin (26% versus 16%, p=0.008). Compared with NPH insulin, the risk for all hypoglycemia with insulin detemir was reduced by 47% (p<0.001) and nocturnal hypoglycemia by 55% (p<0.001). The mean weight gain was 1.2 kg with insulin detemir and 2.8 kg with NPH insulin (p<0.001).

A randomized, controlled noninferiority trial compared use of insulin detemir and NPH insulin for the treatment of gestational diabetes mellitus and T2DM in pregnancy.²⁵⁰ Insulin aspart was added as needed. Patients were instructed to test blood glucose levels 4 times a day (fasting and 2-hour postprandial). Insulin dosages were adjusted to meet targets of FPG < 90 mg/dL and PPG < 120 mg/dL. The primary outcome was overall mean blood glucose during insulin treatment. Results from 87 women were analyzed. The difference in the mean blood glucose of the groups was 2.1 mg/dL (p=0.2937). The time to achieve glycemic control was similar in both groups. There were no differences in perinatal outcomes and maternal weight gain among the groups. There were more hypoglycemic events per patient in the NPH group.

insulin detemir (Levemir) versus insulin aspart (Novolog) versus biphasic insulin aspart (Novolog Mix 70/30)

In an open-label, controlled, multicenter trial, 708 patients with HbA1c levels between 7% to 10% who were receiving maximally tolerated doses of metformin and sulfonylurea were randomly assigned to receive biphasic insulin aspart twice daily, prandial insulin aspart 3 times daily, or basal insulin detemir once daily (twice if necessary).²⁵¹ The primary outcome measure at 1 year was HbA1c. Secondary measures included the proportion of patients with an HbA1c of ≤ 6.5%, the rate of hypoglycemia, and weight gain. At 1 year, HbA1c was similar in the biphasic group and the insulin aspart group (7.3% versus 7.2%, respectively; p=0.08), but higher in the basal group (7.6%, p<0.001 for both comparisons). The proportions of patients with a HbA1c ≤ 6.5% were similar in the biphasic and prandial groups (17% and 23.9%, respectively; p=0.08), but was lower in the basal group (8.1%; p≤0.01 for both comparisons). Mean numbers of hypoglycemic events per patient per year were 5.7%, 12%, and 2.3%, for the biphasic, prandial and basal groups, respectively; and mean weight gains were 4.7 kg, 5.7 kg, and 1.9 kg, respectively. Rates of adverse events were similar among the 3 groups.

insulin detemir (Levemir) versus insulin NPH (Novolin N) with insulin aspart (Novolog)

An open-label, parallel-group comparison study conducted at 46 centers in 5 countries included 448 patients (n=447 ITT) with T1DM. Patients were randomized to insulin detemir or NPH insulin before

breakfast and at bedtime. Insulin aspart was given to both groups at meals.²⁵² After 6 months, comparable HbA1c levels were found between the 2 treatment groups. FPG was lower in patients treated with insulin detemir (-0.76 mmol/L), but this difference was not statistically significant ($p=0.097$). Within-subject variation of self-measured FPG was lower with insulin detemir than with NPH insulin (3.37 versus 3.78 mmol/L; $p<0.001$). Risk of hypoglycemia was 22% lower with insulin detemir than with NPH insulin ($p<0.05$) and 34% lower for nocturnal hypoglycemia ($p<0.005$). Nightly plasma glucose profiles were smoother and more stable with insulin detemir ($p=0.05$). Body weight was significantly lower with insulin detemir at the end of the trial ($p<0.001$).

Patients with T1DM ($n=408$) were randomized in a 16-week, open-label, parallel-group trial to insulin detemir administered twice daily either before breakfast and at bedtime or at a 12-hour interval or NPH insulin administered before breakfast and at bedtime.²⁵³ Insulin aspart was the mealtime insulin. Although HbA1c for each insulin detemir group was not different from the NPH group at endpoint, HbA1c for the pooled insulin detemir groups was significantly lower than the NPH group (mean difference -0.18%; $p=0.027$). With both insulin detemir groups, clinician measured FPG was lower than with NPH insulin (-1.5 mmol/L, $p=0.004$; -2.3 mmol/L, $p<0.001$, respectively), as was self-measured pre-breakfast plasma glucose ($p=0.006$ and $p=0.004$, respectively). Within-person between-day variation of self-measured pre-breakfast plasma glucose was lower for both detemir groups (both $p<0.001$). The risk of minor hypoglycemia was lower in both insulin detemir groups (25%, $p=0.046$; 32%, $p=0.002$; respectively) compared with NPH insulin in the last 12 weeks of treatment, mainly attributable to a reduction in nocturnal hypoglycemia in the insulin detemir breakfast/bedtime group ($p<0.001$). Few severe hypoglycemic episodes were recorded, with no statistical differences between the groups. The NPH group gained weight during the study, but there was no clinically significant change in weight in either of the insulin detemir groups (-0.8 kg, $p=0.006$; -0.6 kg, $p=0.04$, respectively).

A multinational, open-label, parallel-group trial studied 505 patients with T2DM.²⁵⁴ Patients were randomized to insulin detemir or NPH, receiving basal insulin either once or twice daily, according to their pretrial insulin treatment, and insulin aspart at mealtimes. After 26 weeks of treatment, significant reductions in HbA1c were observed for insulin detemir ($p=0.004$) and NPH insulin ($p=0.0001$), resulting in comparable levels at study end (detemir, 7.6%; NPH, 7.5%). The number of basal insulin injections administered per day had no effect on HbA1c levels ($p=0.5$). At study end, FPG concentrations were similar for the 2 treatment groups ($p=0.66$), as were reductions in FPG (detemir, 0.5 mmol/L; NPH, 0.6 mmol/L). However, within-subject day-to-day variation in fasting FPG was significantly lower with insulin detemir ($p=0.021$). The frequency of adverse events and the risk of hypoglycemia were comparable for the 2 treatment groups.

A multinational, 16-week, open-label, parallel-group trial included 400 people with T1DM randomized to insulin detemir in the morning and before dinner or morning and bedtime, or to NPH insulin morning and bedtime, all in combination with mealtime insulin aspart.²⁵⁵ HbA1c was comparable among the 3 groups after 16 weeks, with reductions of 0.39% to 0.49% ($p=0.64$). Lower FPG was observed with insulin detemir morning/dinner and insulin detemir morning/bedtime compared with NPH groups (9.8 mmol/L and 9.1 mmol/L versus 11.1 mmol/L, $p=0.006$), but the insulin detemir groups did not differ significantly ($p=0.15$). Within-person variation in self-measured FPG was significantly lower for both insulin detemir regimens than for NPH insulin (SD: insulin detemir morning/dinner 2.5, insulin detemir morning/bedtime 2.6, NPH 3.1 mmol/L, $p<0.001$) but was comparable between the 2 insulin detemir groups ($p=0.48$). Ten-point plasma glucose profiles were lower between dinner and

breakfast in the insulin detemir morning/dinner group ($p=0.043$) compared with the 2 other groups. Risk of overall and nocturnal hypoglycemia was similar for the 3 groups.

insulin detemir (Levemir) + insulin aspart (Novolog) versus insulin NPH (Novolin N) + regular insulin (Novolin R)

In an 18-week, randomized, open-label, parallel trial, 595 patients with T1DM received insulin detemir or NPH insulin in the morning and at bedtime in combination with mealtime insulin aspart or regular human insulin, respectively.²⁵⁶ Glycemic control with insulin detemir/insulin aspart was improved in comparison with NPH insulin/regular human insulin (HbA1c: 7.88% versus 8.11%; $p<0.001$). Lower postprandial plasma glucose levels were seen in the insulin detemir/insulin aspart group ($p<0.001$), as well as lower within-person day-to-day variation in plasma glucose (SD: 2.88 versus 3.12 mmol/L; $p<0.001$). Risk of overall and nocturnal hypoglycemia was 21% ($p=0.036$) and 55% ($p<0.001$) lower in the insulin detemir/insulin aspart group than in the NPH insulin/regular human insulin group, respectively.

A 22-week, multinational, open-label, randomized, parallel-group trial enrolled 395 patients with T2DM. Patients were randomized to treatment with either basal insulin detemir in combination with insulin aspart at meals or basal insulin NPH in combination with regular human insulin at meals.²⁵⁷ At 22 weeks, HbA1c was comparable between treatments (insulin detemir group: 7.46%, NPH group: 7.52%, $p=0.515$) with decreases from baseline of 0.65% and 0.58%, respectively. The insulin detemir group was associated with a significantly lower within-person variation in self-measured FPG (SD, 1.2 versus 1.54 mmol/L; $p<0.001$), as well as a lower body weight gain (0.51 kg versus 1.13 kg; $p=0.038$) than in the NPH group. The risk of nocturnal hypoglycemia was 38% lower with the insulin detemir group compared to the NPH group ($p=0.14$). The overall safety profile was similar between the 2 treatments.

insulin glargine 100 U/mL (Basaglar)

Basaglar was approved through an abbreviated approval pathway (505[b][2]). FDA approval was based on clinical trials that included patients with T1DM or T2DM, and on the safety and effectiveness data for Lantus.²⁵⁸

A 24-week, open-label, phase 3 trials demonstrated that Basaglar was non-inferior to another insulin glargine U-100 product (including a non-US-approved insulin glargine U-100) in 535 adult patients with inadequately controlled T1DM.²⁵⁹ Both insulin glargine products were given in combination with mealtime insulin lispro. The adjusted mean difference in change from baseline in HbA1c was 0.11% (95% CI, -0.002 to 0.219).

In a 24-week, double-blind trial, once-daily Basaglar or another insulin glargine U-100 product (including a non-US-approved insulin glargine U-100) were given in combination with oral antidiabetic agents to 756 patients with inadequately controlled T2DM.²⁶⁰ The difference in adjusted mean change from baseline in HbA1c was 0.05% (95% CI, -0.07 to 0.17); noninferiority of Basaglar was established.

insulin glargine 100 U/mL (Lantus) versus NPH human insulin

In an open-label study patients with T1DM were randomized to receive insulin glargine 100 U/mL once daily ($n=310$) or NPH insulin ($n=309$) over 16 weeks.²⁶¹ NPH insulin patients maintained their regimen of either once daily or twice daily injections whereas insulin glargine patients received once daily injections at bedtime. All patients continued to administer individually titrated insulin lispro before

meals. Insulin glargine patients had lower self-reported fasting blood glucose concentrations. More patients achieved a fasting blood glucose concentration of less than 119 mg/dL in the insulin glargine group (29.6%) than in the NPH insulin group (16.8%). No differences were noted in the HbA1c or hypoglycemic episodes between the groups. Less variability of blood glucose concentrations was noted in the insulin glargine group. More injection site pain was reported in the insulin glargine group (6.1%) than in the NPH group (0.3%).

In a multicenter, randomized, open-label, parallel-group study, 534 patients with T1DM were randomized to receive pre-meal regular insulin and either daily insulin glargine 100 U/mL or NPH insulin (once or twice daily) for up to 28 weeks.²⁶² A small decrease in HbA1c levels was noted with both insulin glargine (-0.16%) and NPH insulin (-0.21%; $p>0.05$). Significant reductions in median FPG levels from baseline (-1.67 versus -0.33 mmol/L with NPH insulin, $p=0.0145$) were achieved with insulin glargine compared to NPH insulin. After the 1-month titration phase, significantly fewer subjects receiving insulin glargine experienced symptomatic hypoglycemia (39.9% versus 49.2%; $p=0.0219$) or nocturnal hypoglycemia (18.2% versus 27.1%; $p=0.0116$) compared with subjects receiving NPH insulin.

Patients with T1DM were treated for up to 28 weeks with once-daily insulin glargine 100 U/mL ($n=199$) or twice-daily NPH insulin ($n=195$) in addition to preprandial regular insulin in a randomized, parallel-group study.²⁶³ A greater mean decrease in FBG was achieved at endpoint with insulin glargine compared with NPH insulin (-21 versus -10 mg/dL; $p=0.015$), and a greater percentage of patients treated with insulin glargine reached the target FBG (32.6% versus 21.3%; $p=0.015$). Similar percentages of patients in both treatment groups achieved HbA1c $\leq 7\%$ at endpoint. After the 1-month titration phase, the percentage of patients who reported at least 1 symptomatic hypoglycemic event confirmed by a blood glucose < 50 mg/dL was significantly lower with insulin glargine than with NPH insulin (73.3% versus 81.7%; $p=0.021$). Severe hypoglycemia was also significantly reduced in insulin glargine patients.

Glycemic control and symptomatic hypoglycemia rates with insulin glargine 100 U/mL versus NPH insulin were studied in 125 poorly controlled T1DM patients.²⁶⁴ Patients received preprandial insulin lispro and either insulin glargine or NPH insulin at bedtime for 30 weeks in a randomized, single-blinded fashion. Basal insulin dosage was titrated to achieve FBG < 5.5 mmol/L. At endpoint, mean HbA1c was 8.3% versus 9.1% for the insulin glargine versus NPH groups, but HbA1c was lower in the insulin glargine versus NPH group at study initiation (9.2% versus 9.7%). Adjusted least-squares mean change from baseline was -1.04% versus -0.51%, a significant treatment benefit in favor of insulin glargine ($p<0.01$). The mean values for end-point FBG were 7.9 versus 9 mmol/L in favor of insulin glargine ($p<0.05$). Significantly fewer moderate or severe nocturnal hypoglycemic episodes were observed in the insulin glargine group ($p=0.04$ and $p=0.02$, respectively).

In a multicenter, open-label, randomized, 6-month study, 349 T1DM patients ages 5 to 16 years received insulin glargine 100 U/mL once daily or NPH insulin either once or twice daily.²⁶⁵ There was no difference between insulin glargine and NPH insulin in the primary efficacy measure of change in HbA1c from baseline to endpoint. Fasting blood glucose levels decreased significantly more in the insulin glargine group (-1.29 mmol/L) than in the NPH insulin group (-0.68 mmol/L; $p=0.02$). The percentage of patients that reported at least 1 symptomatic hypoglycemic episode was similar between groups; however, fewer patients in the insulin glargine group reported severe hypoglycemia (23% versus 29%, respectively) and severe nocturnal hypoglycemia (13% versus 18%, respectively),

although these differences were not statistically significant. Fewer serious adverse events occurred in the insulin glargine group than in the NPH insulin group ($p < 0.02$).

In an open-label, 24-week, multicenter trial, 765 patients with T2DM with inadequate glycemic control ($\text{HbA1c} > 7.5\%$) while on 1 or 2 oral medications were randomized to either bedtime insulin glargine 100 U/mL or NPH insulin once daily, in addition to their prestudy medications.²⁶⁶ Mean FPG at end point was similar with insulin glargine and NPH (117 versus 120 mg/dL), as was HbA1c (6.96% versus 6.97%). A majority of patients (approximately 60%) attained $\text{HbA1c} < 7\%$ with each insulin type. However, nearly 25% more patients attained this without documented nocturnal hypoglycemia (≤ 72 mg/dL) with insulin glargine (33.2% versus 26.7%; $p < 0.05$). Rates of other categories of symptomatic hypoglycemia were 21% to 48% lower with insulin glargine.

A total of 518 patients with T2DM who were receiving NPH insulin with or without regular insulin for postprandial control were randomized to receive insulin glargine 100 U/mL once daily ($n=259$) or NPH insulin once or twice daily ($n=259$) for 28 weeks in an open-label, multicenter trial.²⁶⁷ The treatment groups showed similar improvements in HbA1c from baseline to end point on intent-to-treat analysis. The mean change in HbA1c from baseline to endpoint was similar in the insulin glargine group ($-0.41\% \pm 0.1\%$) and the NPH group ($-0.59\% \pm 0.1\%$). The treatments were associated with similar reductions in fasting glucose levels. Overall, mild symptomatic hypoglycemia was similar in insulin glargine subjects (61.4%) and NPH insulin subjects (66%). However, nocturnal hypoglycemia in the insulin glargine group was reduced by 25% more than the NPH group during the treatment period after the dose-titration phase (26.5% versus 35.5%; $p=0.0136$). Patients in the insulin glargine group experienced less weight gain than those in the NPH group (0.4 versus 1.4 kg; $p < 0.0007$).

In an open-label, randomized, controlled trial, 695 patients with T2DM previously treated with oral antidiabetic agents were randomized to treatment with morning insulin glargine 100 U/mL, bedtime NPH insulin, or bedtime insulin glargine for 24 weeks in addition to 3 mg of glimepiride.²⁶⁸ HbA1c levels improved by -1.24% with morning insulin glargine, -0.96% with bedtime insulin glargine, and -0.84% with bedtime NPH insulin. HbA1c improvement was more pronounced with morning insulin glargine than with NPH insulin ($p=0.001$) or bedtime insulin glargine ($p=0.008$). Baseline to endpoint fasting blood glucose levels improved similarly in all 3 groups. Nocturnal hypoglycemia was less frequent with morning (17%) and bedtime insulin glargine (23%) than with bedtime NPH insulin (38%; $p < 0.001$).

In a multicenter, open-label, randomized study, 570 patients with T2DM were treated with insulin glargine 100 U/mL or NPH insulin given once daily at bedtime.²⁶⁹ Previous oral antidiabetic therapy was continued throughout the study. At 52 weeks, there was a trend toward a decrease in HbA1c values from baseline to endpoint with both drugs (insulin glargine: -0.46% ; NPH insulin: -0.38% ; $p=0.415$). Over the entire treatment period, NPH insulin-treated patients (41%) and insulin glargine-treated patients (35%) experienced a similar level of symptomatic hypoglycemia, but there was a statistically significant difference in the percentage of patients that experienced nocturnal hypoglycemia in NPH patients compared with those treated with insulin glargine in the overall population (24% versus 12%, respectively; $p=0.002$). The incidence of adverse events was similar for the 2 treatments.

An open-label, 24-week, randomized study compared the efficacy and safety of insulin glargine 100 U/mL and insulin NPH, both in combination with a daily fixed dose of glimepiride, in terms of glycemic control and incidence of hypoglycemia.²⁷⁰ Patients with poorly controlled T2DM on oral antidiabetic agents ($\text{HbA1c} 7.5\%$ to 10.5%) received glimepiride plus insulin glargine ($n=231$) or NPH insulin ($n=250$) using a forced titration algorithm. Insulin glargine and insulin NPH achieved similar HbA1c reductions.

Confirmed nocturnal hypoglycemia was significantly lower with insulin glargine versus NPH insulin (16.9% versus 30%; $p < 0.01$).

insulin glargine 100 U/mL (Lantus) plus glimepiride and metformin versus human insulin 70/30

In a 24-week, multinational, multicenter, open-label, parallel-group clinical trial, 371 insulin-naïve patients with T2DM and poor glycemic control on a sulfonylurea plus metformin were randomized to daily morning insulin glargine 100 U/mL plus glimepiride and metformin or to insulin 70/30 twice daily without oral antidiabetic agents.²⁷¹ Mean HbA1c decrease from baseline was significantly more pronounced (-1.64% versus -1.31%; $p = 0.0003$), and more patients reached HbA1c < 7% without confirmed nocturnal hypoglycemia (45.5% versus 28.6%; $p = 0.0013$) with the insulin glargine arm than with insulin 70/30. Similarly, FBG decrease was greater in the insulin glargine group (adjusted mean difference, -17 mg/dL; $p < 0.0001$), and more patients reached target FBG < 100 mg/dL with insulin glargine than with insulin 70/30 (31.6% versus 15%; $p = 0.0001$). Insulin glargine patients had fewer confirmed hypoglycemic episodes than insulin 70/30 patients (4.07 versus 9.87 episodes/patient-year; $p < 0.0001$).

insulin glargine 100 U/mL (Lantus) versus insulin detemir (Levemir)

In a 52-week multinational, open-label, parallel-group, treat-to-target, noninferiority trial 443 patients with T1DM and a mean age of 42 years; a mean body mass index of 26.5; a mean HbA1c of 8.1% and a mean duration of diabetes of 17.2 years were randomized to receive either insulin detemir or insulin glargine 100 U/mL for 52 weeks.²⁷² Insulin aspart was administered in both groups as the mealtime insulin. The basal insulin was initially administered once daily in the evening for both groups. If patients in the insulin detemir group achieved target plasma glucose levels before breakfast but not before dinner, administration was changed to twice a day regimen. Insulin glargine patients continued with once daily administration throughout the trial. The primary efficacy endpoint was HbA1c after 52 weeks while the secondary endpoints included the number of patients achieving an HbA1c \leq 7% with or without a major hypoglycemic episode in the last month of treatment and FBG. Results after 52 weeks showed no significant differences in mean HbA1c between insulin detemir and insulin glargine groups (7.57% and 7.56%, respectively; mean difference, 0.01% [95% CI, -0.13 to 0.16]). Additionally, there was no significant difference in the proportion of patients receiving insulin detemir and insulin glargine in achieving an HbA1c value equal to or lower than 7% without major hypoglycemia (31.9% and 28.9%, respectively). In addition, there were no significant differences in estimated mean FPG (8.58 and 8.81 mmol/L; mean difference, -0.23 mmol/L [95% CI, -1.04 to 0.58]) or in basal insulin doses. The relative risks for total and nocturnal hypoglycemia were not significantly different between insulin detemir and insulin glargine (0.94 and 1.12, respectively; $p = \text{NS}$).

In a 24-week, multinational, open-label, treat-to-target trial, 973 insulin-naïve patients with T2DM and an HbA1c of 7% to 10.5% were randomized to insulin detemir twice daily or insulin glargine 100 U/mL once daily.²⁷³ Patients in this study had been treated with metformin for 3 months or greater prior to the study. The primary outcome was the percentage of patients reaching an HbA1c < 7% without symptomatic hypoglycemia. In the insulin glargine and insulin detemir groups, 27.5% and 25.6% of patients, respectively, reached HbA1c < 7%. It was demonstrated that insulin glargine once-daily is non-inferior to insulin detemir twice-daily regarding the percentage of patients who achieve a target HbA1c without hypoglycemia. Insulin detemir-treated patients had less weight gain and more often achieved HbA1c < 6.5% ($p = 0.017$). However, the drop-out rate and daily insulin doses were lower in the insulin glargine group.

insulin glargine 100 U/mL (Lantus) versus insulin detemir (Levemir) with insulin aspart (Novolog)

In a 26-week, multicenter, open-label, parallel-group trial, 320 patients with T1DM received either insulin detemir twice daily or insulin glargine 100 U/mL once daily, each in combination with pre-meal insulin aspart.²⁷⁴ After 26 weeks, HbA1c decreased from 8.8% to 8.2% in the insulin detemir group and from 8.7% to 8.2% in the insulin glargine group. The overall risk of hypoglycemia was similar; however, the risk of severe and nocturnal hypoglycemia was 72% and 32% lower, respectively, with insulin detemir than with insulin glargine ($p < 0.05$). Body weight gain was not significantly different between treatment arms.

insulin glargine 100 U/mL (Lantus) versus biphasic insulin aspart (Novolog Mix 70/30)

The 28-week parallel-group study randomized 233 insulin-naïve patients on more than 1,000 mg daily metformin alone or in combination with other oral antidiabetic agents to receive biphasic insulin aspart twice daily or insulin glargine 100 U/mL at bedtime and titrated to target blood glucose.²⁷⁵ At study end, the mean HbA1c value was lower in the biphasic insulin aspart group than in the insulin glargine group (6.91% versus 7.41%; $p < 0.01$). The HbA1c reduction was greater in the biphasic insulin aspart group than in the insulin glargine group (-2.79% versus -2.36%; $p < 0.01$), especially for subjects with baseline HbA1c $> 8.5\%$ ($p < 0.05$). Minor hypoglycemia was greater in the biphasic insulin aspart group than in the insulin glargine group (3.4 and 0.7 episodes/year; $p < 0.05$), and weight gain at study end was greater for biphasic insulin aspart-treated subjects than for insulin glargine-treated subjects (5.4 versus 3.5 kg; $p < 0.01$).

In the randomized, open-label, parallel study, biphasic insulin aspart plus metformin twice daily were compared with insulin glargine 100 U/mL plus glimepiride daily in 255 insulin-naïve patients.²⁷⁶ The primary endpoint was the difference in absolute change in HbA1c between groups after 26 weeks of treatment. HbA1c change was significantly greater in the insulin aspart group than the insulin glargine group (between-group difference, -0.5%; $p = 0.0002$). During the maintenance phase, 1 major hypoglycemic episode occurred in each group; 20.3% and 9% of patients experienced minor hypoglycemic episodes in the insulin aspart and insulin glargine groups, respectively ($p = 0.0124$). Insulin glargine patients experienced significant weight gain of 1.5 kg ($p < 0.0001$); the weight change with insulin aspart patients of +0.7 kg was not statistically significant ($p = 0.0762$).

In a 26-week, open-labeled, randomized, parallel-group, multinational, treat-to-target trial, 480 insulin-naïve patients with T2DM who were inadequately controlled on oral anti-diabetic medications were randomized to receive either biphasic insulin aspart prior to dinner or insulin glargine 100 U/mL at bedtime in combination with metformin and glimepiride.²⁷⁷ A total of 433 patients completed the trial. At the end of treatment, biphasic insulin aspart and insulin glargine reduced the mean HbA1c levels by -1.41% and 1.25%, respectively (95% CI, -0.3 to -0.02; $p = 0.029$). After 26 weeks, the mean HbA1c levels were 7.1% for the biphasic insulin aspart group and 7.3% for the insulin glargine group. The relative risk for a nocturnal hypoglycemic episode was greater in the biphasic insulin aspart group than for insulin glargine (relative risk, 2.41 [95% CI, 1.34 to 4.34]; $p = 0.003$), although hypoglycemic rates were overall low with 3 major episodes occurring in each group.

insulin glargine 100 U/mL (Lantus) versus insulin lispro (Humalog)

In an open-label, multicenter study, 418 patients with T2DM inadequately controlled with oral hypoglycemic agents were randomized to receive either insulin glargine 100 U/mL administered once daily ($n = 205$) or insulin lispro administered 3 times daily ($n = 210$).²⁷⁸ The primary efficacy endpoint was

the change in HbA1c from baseline to endpoint (week 44). There was no significant difference between the 2 treatment groups relative to mean reduction in HbA1c. The percentage of patients that reached HbA1c \leq 7% was 57% in the glargine group and 69% in the lispro group. However, the mean change in fasting blood glucose was significantly greater in the insulin glargine group (-4.3 mmol/L) compared to the insulin lispro group (-1.8 mmol/L; $p < 0.0001$). Patients treated with insulin glargine were also shown to have greater reductions in nocturnal blood glucose compared with patients treated with insulin lispro (-3.3 versus -2.6 mmol/L; $p = 0.0041$). Hypoglycemic episodes occurred at a rate of 5.2 events per patient per year for insulin glargine and 24 events per patient per year for insulin lispro ($p < 0.001$). There was no significant difference in mean weight gain between the 2 treatment groups.

insulin glargine 100 U/mL (Lantus) versus biphasic insulin lispro (Humalog Mix)

Patients with T2DM ($n = 374$) were randomly assigned to insulin lispro mix 50/50 three times daily with meals or insulin glargine 100 U/mL at bedtime plus mealtime insulin lispro in a 24-week, multicenter, open-label, noninferiority trial.²⁷⁹ Investigators could replace insulin lispro mix 50/50 with 75/25 at the evening meal if the fasting plasma glucose target was unachievable. At week 24, HbA1c was lower with insulin glargine (6.78% versus 6.95%; $p = 0.021$), but HbA1c was reduced significantly from baseline for both therapies ($p < 0.0001$). Noninferiority of insulin lispro mix to insulin glargine was not demonstrated based on the prespecified noninferiority margin of 0.3%. The percentages of patients achieving target HbA1c varied depending on the specific target; statistically significant differences did occur in favor of insulin glargine at HbA1c $< 7\%$ and HbA1c $< 6.5\%$. Rates of hypoglycemia were similar for both groups.

insulin glargine 300 U/mL (Toujeo) versus insulin degludec (Tresiba)

BRIGHT, a 24-week, multicenter, open-label, active-controlled, 2-arm, parallel-group, noninferiority study, compared insulin glargine 300 U/mL ($n = 466$) to insulin degludec 100 U/mL ($n = 463$) in insulin-naive patients with uncontrolled T2DM.²⁸⁰ Both agents were titrated to a fasting self-monitored plasma glucose of 80 to 100 mg/dL. Noninferiority of insulin glargine 300 U/mL compared to insulin degludec was demonstrated (least squares mean difference, 20.05% [95% CI, 20.15 to 0.05]; $p < 0.0001$) based on change in HbA1c from baseline to 24 weeks. The incidence of hypoglycemia, defined as blood glucose ≤ 70 mg/dL, was comparable between the groups; however, during the active titration period (0 to 12 weeks), both the incidence and rate of anytime (24-h) confirmed hypoglycemia were lower with insulin glargine 300 U/mL (66.5% versus 69%; OR, 0.88 [95% CI, 0.66 to 1.17]).

insulin glulisine (Apidra) versus regular human insulin

Patients with T1DM ($n = 860$) received daily insulin glargine 100 U/mL and were randomized to either insulin glulisine injected within 15 minutes before or immediately after meals or regular human insulin, injected 30 to 45 minutes before meals in an open-label, controlled, multicenter, parallel-group, 12-week study.²⁸¹ Changes in mean HbA1c were -0.26%, -0.11%, and -0.13% in the pre-meal insulin glulisine, post-meal insulin glulisine, and regular insulin groups, respectively. The reduction in HbA1c was greater for the pre-meal insulin glulisine group in comparison with the regular insulin group ($p = 0.02$) and the post-meal insulin glulisine group ($p = 0.006$); no significant difference was found between post-meal insulin glulisine versus regular insulin. Overall, blood glucose profiles were similar in all 3 treatment groups but were significantly lower for pre-meal insulin glulisine post-breakfast and post-dinner measurements. Severe hypoglycemic episodes were comparable for all groups. Body weight increased (0.3 kg) in the regular insulin and pre-meal insulin glulisine groups; however, weight decreased in the post-meal insulin glulisine group (-0.3 kg; $p = 0.03$).

Patients with T2DM who had received at least 6 months of continuous insulin therapy were randomized in a multinational, controlled, open-label, parallel group, 26-week study.²⁸² Patients (n=890) received NPH insulin twice daily and either insulin glulisine or regular insulin at least twice daily. There were no differences in HbA1c reductions (insulin glulisine: -0.32%; regular insulin: -0.35%; p=0.57). Insulin glulisine lowered plasma glucose significantly more versus regular insulin at 2 hours (14.14 mmol/L versus 15.28 mmol/L; p=0.0025). Nocturnal hypoglycemia from the fourth month to the end of treatment was less frequent with insulin glulisine versus regular insulin (9.1% versus 14.5%; p=0.029).

insulin glulisine (Apidra) versus insulin lispro (Humalog)

The objective of the multinational, multicenter, controlled, open-label, randomized, parallel-group study was to compare the efficacy and safety of insulin glulisine to that of insulin lispro in adults diagnosed with T1DM.²⁸³ Of the 683 patients randomized, 672 received treatment. Over the 26-week study, a similar reduction in mean HbA1c occurred in both groups (adjusted mean change from baseline, -0.14% in both groups). The basal insulin dose was relatively unchanged from baseline in the insulin glulisine group but increased in the insulin lispro group (0.12 units versus 1.82 units, respectively; p=0.0001). There was no relevant difference between the 2 groups in the reporting of symptomatic hypoglycemia (overall, nocturnal, or severe).

In an effort to compare the safety and efficacy of insulin glulisine to that of insulin lispro in children and adolescents with T1DM, 572 patients aged ≥ 4 years were randomized to receive either insulin glulisine or insulin lispro, administered subcutaneously within 15 minutes before a meal, in an open-label, active-controlled, noninferiority trial.²⁸⁴ During this 26-week study, patients also received insulin glargine 100 U/mL (administered once daily in the evening) or NPH insulin (administered once in the morning and once in the evening). There were no significant differences observed between the 2 treatment groups with respect to glycemic control.

insulin lispro (Admelog)

Admelog was approved through an abbreviated approval pathway (505[b][2]). FDA approval was based on 2 phase 3 trials with Admelog and on the safety and effectiveness data for Humalog (insulin lispro injection).²⁸⁵ In two 26-week, open-label, phase 3 trials, Admelog was non-inferior to another insulin lispro U-100 product (including a non-US-approved insulin lispro U-100) in patients with T1DM (n=507) and patients with T2DM (n=505).²⁸⁶ In both trials, insulin lispro products were given in combination with insulin glargine. The adjusted mean difference in change from baseline in HbA1c was 0.06% in both the T1DM and the T2DM studies (95% CI, -0.086 to 0.201 for T1DM; 95% CI, -0.209 to 0.091 for T2DM).

insulin lispro (Humalog) versus regular human insulin

In a 5.5-month randomized, open-label, parallel study of 148 patients with T2DM receiving either insulin lispro (n=70) or regular human insulin (n=78), 8-point blood glucose profiles and HbA1c measurements were collected at baseline, 1.5, 3.5, and 5.5 months.²⁸⁷ Two-hour post-breakfast and 2-hour post-supper blood glucose levels were significantly lower for insulin lispro than for regular human insulin at the end point (p=0.02 in both cases). HbA1c improved from 10.5% (insulin lispro) and 10.3% (regular human insulin) to 8% in each treatment arm. Hypoglycemia rates were similar during the day with a trend towards a reduced incidence in the night hours with insulin lispro (0.08 episodes/month versus 0.16 episodes/month; p=0.057).

insulin lispro-aabc (Lyumjev)

The approval of insulin lispro-aabc was based on two, 26-week studies in adults with either T1DM (PRONTO-T1D; n=1,222) or T2DM (PRONTO-T2D; n=673).²⁸⁸ In PRONTO-T1D, patients were randomized 4:4:3, in combination with either insulin glargine or insulin degludec, to blinded mealtime (0 to 2 min prior to the meal) insulin lispro-aabc, blinded mealtime insulin lispro (Humalog), or open-label postmeal (20 minutes after meal start) insulin lispro-aabc. At week 26, mealtime and postmeal insulin lispro-aabc met the prespecified noninferiority margin in HbA1c reduction (0.4%) when compared to mealtime insulin lispro. In all groups, insulin doses were similar at baseline and at 26 weeks. In PRONTO-T2D, patients who were on ≥ 3 oral antidiabetic agents, basal insulin and ≥ 1 prandial insulin, or premixed insulin with ≥ 2 injections daily were randomized 1:1, in combination with either insulin glargine or insulin degludec, to blinded mealtime (0 to 2 min prior to the meal) insulin lispro-aabc or insulin lispro (Humalog). At week 26, mealtime insulin lispro-aabc met the prespecified noninferiority margin in HbA1c reduction (0.4%) when compared to mealtime insulin lispro. In both groups, insulin doses were similar at baseline and at 26 weeks.

insulin glargine 300 U/mL (Toujeo) versus insulin glargine 100 U/mL (Lantus)

EDITION 4: In a 26-week, open-label study, 546 adults with T1DM were randomized to basal-bolus treatment with insulin glargine 300 U/mL or 100 U/mL administered once daily in the morning (time period covering from pre-breakfast until pre-lunch) or in the evening (time period defined as prior to the evening meal until at bedtime).²⁸⁹ A mealtime insulin analog was administered before each meal. At week 26, treatment with insulin glargine 300 U/mL provided a similar reduction in HbA1c as insulin glargine 100 U/mL (-0.4% versus -0.44%, respectively) and met the pre-specified noninferiority margin of 0.4%. Patients treated with insulin glargine 300 U/mL used 17.5% more basal insulin than patients treated with insulin glargine 100 U/mL. There were no clinically important differences in glycemic control when insulin glargine 300 U/mL was administered once daily in the morning or in the evening. Hypoglycemia was similar between the groups, except for during the first 8 weeks, when nocturnal confirmed or severe hypoglycemia was lower with insulin glargine 300 U/mL (rate ratio, 0.69 [95% CI, 0.53 to 0.91]).²⁹⁰ There were no clinically important differences in body weight between treatment groups.

EDITION 1: In a 26-week, open-label study, 804 adults with T2DM were randomized to a once-daily treatment in the evening with insulin glargine 300 U/mL or 100 U/mL. Patients also received mealtime insulin analogs with or without metformin.^{291,292} At week 26, insulin glargine 300 U/mL provided a mean reduction in HbA1c that met the pre-specified noninferiority margin of 0.4% compared to insulin glargine 100 U/mL. Patients treated with insulin glargine 300 U/mL used 11% more basal insulin compared to those treated with insulin glargine 100 U/mL. A lower percentage of patients experienced ≥ 1 confirmed (≤ 70 mg/dl) or severe hypoglycemic event with the 300 U/mL concentration than the 100 U/mL concentration at any time of day (86% versus 92%; relative risk [RR], 0.94 [95% CI, 0.89 to 0.99]) and during the night (54% versus 65%; RR, 0.84 [95% CI, 0.75 to 0.94]), although the annualized rates of such hypoglycemic events were similar. There were no clinically important differences in body weight between treatment groups.

In two, 26-week, open-label studies, 1,670 adults with T2DM were randomized to either insulin glargine 300 U/mL or 100 U/mL once daily in combination with non-insulin anti-diabetic drugs.²⁹³ At the time of randomization, 808 patients were treated with basal insulin for more than 6 months (EDITION 2) and 862 patients were insulin-naïve (EDITION 3). At week 26, treatment with insulin

glargine 300 U/mL provided a mean reduction in HbA1c that met the pre-specified noninferiority margin of 0.4% compared to insulin glargine 100 U/mL. A lower percentage of patients experienced nocturnal hypoglycemia in the 300 U/mL groups than in the 100 U/mL groups (EDITION 2: RR, 0.86 [95% CI, 0.73 to 1.01]; EDITION 3: RR, 0.76 [95% CI, 0.59 to 0.99]).^{294,295} When annualized, the EDITION 2 study reported a 37% relative reduction in nocturnal confirmed or severe hypoglycemic events with glargine 300 U/mL versus 100 U/mL, while the EDITION 3 study reported similar event rates in the 2 groups. Patients treated with insulin glargine 300 U/mL used 12% (EDITION 2) and 15% (EDITION 3) more basal insulin than patients treated with insulin glargine 100 U/mL. There were no clinically important differences in body weight between treatment groups.

SENIOR, an open-label, 2-arm, parallel-group, randomized, multicenter phase 3b trial that included 1,014 patients (mean age, 71 years) with T2DM, compared insulin glargine 300 U/mL and insulin glargine 100 U/mL.²⁹⁶ At 26 weeks, the reduction in HbA1c from baseline was similar in both groups in the overall populations (least squares mean difference, 0.02% [95% CI, -0.092 to 0.129]) and in the subgroup of patients \geq 75 years of age (least squares mean difference, -0.11% [95% CI, -0.33 to 0.106]). Confirmed or severe hypoglycemia also occurred at similar rates in each group. In patients \geq 75 years of age, significantly lower annualized rates of documented symptomatic hypoglycemia (\leq 70 mg/dL) were reported with insulin glargine 300 U/mL (1.12 versus 2.71, respectively; rate ratio, 0.45 [95% CI, 0.25 to 0.83]).

A 26-week, randomized, open-label, trial compared basal-bolus doses of insulin glargine 300 U/mL and insulin glargine 100 U/mL in 463 pediatric patients ages 6 to 17 years with T1DM.²⁹⁷ Study drug was administered once daily in the morning or evening and a mealtime insulin analogue was administered before each meal. At week 26, insulin glargine 300 U/mL met the prespecified noninferiority margin (0.3%) based on difference in HbA1c reduction from baseline compared to insulin glargine 100 U/mL (difference, 0.02% [95% CI, -0.16 to 0.2]). Common adverse reactions in pediatrics treated with insulin glargine 300 U/mL were similar as seen in adults. In patients treated with insulin glargine 300 U/mL, the incidence of severe hypoglycemia was 6% and the incidence of hypoglycemia accompanied by a self-monitored or plasma glucose $<$ 54 mg/dL regardless of symptoms was 80.3%.

Inhalation insulin

insulin inhalation powder (Afrezza) versus insulin aspart (Novolog)

A 24-week open-label, active-controlled study enrolled patients with inadequately controlled T1DM to evaluate the glucose lowering effect of mealtime insulin inhalation powder used in combination with a basal insulin.²⁹⁸ During a 4-week run-in period, subjects were converted to mealtime insulin aspart using a 1:1 unit conversion and titrated their basal insulin dosage to achieve a fasting plasma glucose (FPG) $<$ 120 mg/dL and \geq 100 mg/dL (and not to exceed 180 mg/dL for eligibility). All subjects remained on their prior basal insulin (NPH, glargine 100 U/mL, or detemir) throughout the study. After the run-in period, 344 patients were randomized 1:1 to insulin inhalation powder or insulin aspart administered at each meal of the day. During the first 12 weeks, mealtime and basal insulin doses were titrated to pre-specified glycemic goals, after which doses remained relatively unchanged and adjusted only for safety or change in patients' clinical status such as infection. Supplemental insulin doses were allowed in the inhaled insulin group. At week 24, the mean daily doses for inhaled insulin increased by 30.7 units (equivalent to approximately 7.7 units SC insulin) and for insulin aspart by 1.6 units. The mean daily basal insulin dose was also higher in the inhaled insulin group than the insulin aspart group, 37.1

units versus 31.6 units, respectively. At week 24, treatment with basal insulin plus mealtime inhaled insulin provided less HbA1c reduction than insulin aspart (-0.21 versus -0.4%, respectively; difference, -0.19% [95% CI, 0.02 to 0.36]). The mean reduction provided by basal insulin plus inhaled insulin narrowly met the pre-specified noninferiority margin of 0.4%. A greater proportion of patients in the insulin aspart group achieved the target HbA1c \leq 7% (30.7% versus 18.3%; $p=0.0158$). Patients treated with insulin inhalation powder experienced a mean decrease in weight of 0.39 kg, while those treated with insulin aspart showed a mean increase of 0.93 kg. Severe hypoglycemia was experienced in 18.4% of subjects on inhaled insulin and 29.2% of those on insulin aspart; the incidence of mild to moderate hypoglycemia was similar between the groups (96% and 99.6%, respectively). The most common respiratory adverse reaction was cough, which was reported in 31.6% of subjects in the inhaled insulin group and 2.3% for the insulin aspart group. Cough was generally mild and intermittent, but led to study discontinuation in 5.7% of patients that received inhaled insulin and 0% subjects on insulin aspart.

In a 52-week, open-label trial, 539 patients with T1DM were randomized to insulin glargine 100 U/mL (basal) plus either insulin inhalation powder or insulin aspart.²⁹⁹ Dose titration was permitted during the entire trial based on pre-meal and postprandial blood glucose levels. This trial did not meet its primary efficacy endpoint of noninferiority margin of 0.4% for insulin inhalation powder compared with insulin aspart. At week 52 mean change in HbA1c was -0.13% and -0.37% for insulin inhalation powder and insulin aspart, respectively (difference, 0.24 [95% CI, 0.08 to 0.404]). A similar proportion of patients achieved HbA1c \leq 7% in both groups (16.3% versus 16%, respectively). Patients treated with insulin inhalation powder reported a mean decrease in weight of 0.5 kg, while those treated with insulin aspart showed a mean increase of 1.4 kg. Incidence of hypoglycemia was reported in 0.08 events/subject-month for the inhaled insulin group and 0.1 events/subject-month for the insulin aspart group.

A 24-week double-blind, placebo-controlled trial, enrolled adults with T2DM inadequately controlled on optimal or maximally tolerated doses of metformin monotherapy, or at least 2 oral antidiabetic agents.³⁰⁰ Following a 6-week run-in period, 353 patients were randomized 1:1 to add-on therapy with insulin inhalation powder or an inhaled placebo powder. Insulin doses were titrated for the first 12 weeks and remained stable thereafter. Oral antidiabetic doses remained unchanged. Open-label rescue therapy (insulin glargine 100 U/mL or glimepiride) in addition to the study treatment was allowed in patients who experienced persistent or worsening hyperglycemia greater than pre-specified thresholds. At week 24, the insulin group reported statistically significantly greater mean reduction in HbA1c compared to the placebo group (0.82% versus 0.42%; $p<0.0001$). A greater proportion of patients in the insulin group achieved the target HbA1c \leq 7% (32.2% versus 15.3%, respectively; $p=0.0005$). Patients in the insulin group experienced a mean increase in weight of 0.5 kg, while those in the placebo group reported a mean decrease of 1.1 kg. Severe hypoglycemia was reported in 5.7% of patients on inhaled insulin and 1.7% of those who received placebo. Cough was reported in 24% of the active treatment group and 20% of the placebo group.

insulin inhalation powder (Afrezza) plus insulin glargine 100 U/mL (Lantus) versus human insulin 70/30

A 52-week, open-label trial randomized 618 patients with T2DM who had been receiving SC insulin therapy to a basal/bolus regimen with insulin glargine 100 U/mL plus insulin inhalation powder or to a twice daily regimen with 70/30 biphasic insulin.³⁰¹ For patients assigned to insulin glargine plus inhaled

insulin, half of the total daily pre-randomization insulin dose was replaced with mealtime inhaled insulin and the remaining was replaced by basal insulin glargine. Dose titration was permitted throughout the study. At week 52, mean change in HbA1c were -0.59% and -0.71% for insulin glargine/inhaled insulin and biphasic insulin, respectively. Noninferiority (margin 0.4%) of inhaled insulin plus basal insulin was demonstrated compared to biphasic insulin (difference, 0.12% [95% CI, -0.05 to 0.29]). A greater proportion of patients in the biphasic insulin group achieved the target HbA1c \leq 7% (26.8% versus 22.1%, respectively; $p=0.28$). A lower incidence of severe hypoglycemia, defined as blood glucose $<$ 37 mg/dL, was reported with inhaled insulin/insulin glargine than biphasic insulin (4.3% versus 10%, respectively; $p<0.01$). Patients in the inhaled insulin/insulin glargine group experienced a mean increase in weight of 0.9 kg and those in the biphasic insulin group reported a mean increase of 2.5 kg.

META-ANALYSES

A systematic review of 45 studies was performed to compare premixed insulin analogs with any other antidiabetic agents for the treatment of T2DM in adults.³⁰² The outcomes examined included fasting glucose, postprandial glucose, HbA1c, and weight gain. Mortality data are scant. Of the 45 studies, 43 were randomized controlled trials. The studies included a total of 14,603 patients with a mean age of 59 years, a median HbA1c of 8.7%, and a mean body mass index (BMI) of 29.4 kg/m². When compared with long-acting insulin analogs, premixed insulin analogs were found to be more effective in reducing postprandial glucose levels (pooled difference, -27.9 mg/dL [95% CI, -34.3 to -21.5]) and HbA1c (pooled difference, -0.39% [95% CI, -0.5 to -0.3]). However, premixed insulin analogs were found to be less effective than long-acting insulin analogs in reducing fasting glucose levels (pooled difference, 12 mg/dL [95% CI, 6 to 18.1]). Premixed insulin analogs were also associated with an increased incidence of hypoglycemia (OR, 2; CI, 1.3 to 3) and weight gain (pooled difference, 2 kg [95% CI, 1.1 to 3 kg]) compared with long-acting insulins. Premixed insulin analogs were similar to premixed human insulin in decreasing fasting glucose levels, HbA1c levels, and the incidence of hypoglycemia but were more effective in decreasing postprandial glucose levels (mean difference, 219.2 mg/dL [95% CI, 225.9 to 212.5]). Compared to other non-insulin anti-diabetic agents, premixed insulin analogs were more effective in decreasing fasting glucose levels, postprandial glucose levels and HbA1c levels, but were associated with a higher incidence of hypoglycemia.

Four studies were included in a meta-analysis that compared efficacy and hypoglycemia occurrence of once-daily insulin glargine U-100 with NPH insulin in T2DM insulin-naïve patients ($n=2,091$) who were also on oral antidiabetic drugs (OAD).³⁰³ Mean HbA1c and FPG reductions and proportion of patients that achieved HbA1c $<$ 7% were similar with both insulin products, regardless of concurrent OAD therapy. Rates of overall and nocturnal hypoglycemia were lower for insulin glargine than insulin NPH (overall relative risk [RR], 0.93 [95% CI, 0.87 to 1; $p=0.41$]; nocturnal RR, 0.73 [95% CI, 0.65 to 0.83]; $p<0.001$). Weight gain was higher with insulin glargine, as was the insulin dosage after 24 week of therapy.

A total of 13 randomized, 24-week, controlled trials ($n=5,401$) were included a meta-analysis comparing premixed insulin lispro and insulin glargine in patients with T2DM.³⁰⁴ Insulin lispro was favored over insulin glargine in HbA1c reduction (parallel trials: weighted mean difference [WMD], -0.18% [95% CI, -0.31 to -0.06]; $p=0.004$; crossover trials: WMD, 0.37% [95% CI, -0.51 to -0.23]; $p<0.00001$). Insulin lispro led to more weight gain compared to insulin glargine (parallel trials: WMD, 0.64 kg [95% CI, 0.14 to 1.15]; $p=0.01$; crossover trials: WMD, 0.74 kg [95% CI, 0.19 to 1.29]; $p=0.009$).

Insulin lispro was also associated with a higher risk of hypoglycemia than insulin glargine (parallel trials: OR, 1.2 [95% CI, 1.06 to 1.36]; p=0.005; crossover trials: OR, 2.24 [95% CI, 1.45 to 3.46]; p=0.0003).

Another meta-analysis included 18 trials (n=16,791) that compared safety and efficacy of insulin degludec with insulin glargine in patients with T1DM or T2DM.³⁰⁵ The HbA1c was slightly higher with insulin degludec compared to insulin glargine; however, this was not clinically significant (estimated treatment difference, 0.03 [95% CI, 0 to 0.06]; p=0.06). There was a significant reduction in confirmed hypoglycemia rate with insulin degludec was at the maintenance treatment period (estimated rate ratio [ERR], 0.81 [95% CI, 0.72 to 0.92]; p=0.001). The differences in the rates of hypoglycemia were more evident during the nocturnal period and maintenance periods and in T2DM patients than those with T1DM. The incidence of severe hypoglycemia in T2DM was lower with insulin degludec (ERR, 0.65 [95% CI, 0.52 to 0.89]; p=0.005), but this was not the case in patients with T1DM. The rate of adverse events, including total mortality and cardiovascular events, was not significantly different between the 2 treatment strategies.

Eleven systematic reviews containing randomized controlled trials (dated through October 2016) were identified to compare the efficacy of the long-acting insulin analogs (e.g., insulin glargine or insulin detemir) to NPH insulin for T1DM.³⁰⁶ The reviews were comprised of 7 original systematic reviews, 4 with meta-analysis, 2 indirect comparisons, and 2 complete health technology assessment studies. There was a statistically significant reduction in HbA1c (mean difference from baseline to study end) with the long-acting insulin analogues compared to NPH insulin (95% CI, -0.23 to -0.12; I²=99.7%). The meta-analysis revealed a statistically significant difference between the insulin analogue and NPH insulin (RR, 0.95 [95% CI 0.91 to 0.99]; I²=97.5%) for hypoglycemia. Of the studies that reported severe hypoglycemia, no statistically significant difference between long-acting insulin analogues and NPH insulin was shown.

SUMMARY

Human insulin products (Humulin and Novolin), produced by recombinant DNA technology, contain the exact same insulin amino acids and have the same action as endogenous insulin. Depending on the composition of the product, the onset, peak, and duration of activity can vary, but the effects of these products on HbA1c, fasting plasma glucose, and hypoglycemia are very similar.

Human analog insulins include insulin aspart (Fiasp, Novolog), insulin glulisine (Apidra), insulin lispro (Admelog, Humalog), and **insulin lispro-aabc (Lyumjev)**, which are injectable insulin products that have a faster onset of activity and shorter duration of action than human insulin. Insulin aspart and insulin lispro have been shown to decrease HbA1c (by an additional 0.1% to 0.2%), the incidence of hypoglycemia episodes (by approximately 20%), nocturnal hypoglycemic episodes (by 25% to 50%), and fasting plasma glucose levels compared to human insulins. Insulin glulisine studies show an additional decrease in HbA1c of about 0.1%, as well. All of these products may be administered with a meal rather than the 30 to 60 minutes prior to a meal for regular human insulin. Insulin aspart vials and cartridges are latex-free, and the solution contains less metacresol than insulin lispro **or insulin lispro-aabc**, as does insulin glulisine. All of the rapid-acting insulins are approved for use in pediatric patients as well as for use in external insulin pumps. All also are available in cartridge and/or pen delivery systems.

The biphasic injectable insulins (Humalog Mix 50/50 and 75/25, Novolog Mix 70/30, and human insulin 70/30) combine both a fast-acting and a long-acting insulin. Their purpose is to decrease the number of

injections needed per day. Both insulin lispro and insulin aspart combinations have a faster onset of activity and shorter duration of action than biphasic human insulin. Insulin glulisine is not available in such a combination.

Insulin degludec (Tresiba), insulin detemir (Levemir), insulin glargine 100 U/mL (Basaglar, Lantus), and insulin glargine 300 U/mL (Toujeo) have changes in the insulin amino acid sequence. They produce a longer duration of action with minimal peak effect and are used as basal insulins. All 4 agents may be used in patients with T1DM as basal insulin and in combination with oral antidiabetic medications in patients with T2DM. Each agent consistently controls glycemic levels better than insulin NPH, with less hypoglycemia. Compared to human insulin, these injectable agents decrease episodes of hypoglycemia by 25% to 50%, decrease nocturnal hypoglycemic episodes by 25% to 33%, and generally result in lower fasting plasma glucose levels. Effects on HbA1c are comparable with human insulin.

In December 2016, Eli Lilly introduced to the market the first insulin follow-on product, Basaglar (insulin glargine 100 U/mL), the follow-on for Lantus. In December 2017, Sanofi-Aventis's Admelog (insulin lispro 100 U/mL), a follow-on to Humalog 100 U/mL, was also approved. These products, considered to be follow-on products of the reference products Lantus and Humalog, respectively, were approved as drugs under the Food, Drug and Cosmetic (FD&C) Act 505(b)(2) pathway. Beginning March 23, 2020, all insulin products previously approved under this pathway will be considered to be biologic products under section 351 of the Public Health Service Act (PHSA). This transition will allow insulin products to receive competition through the biosimilar pathway, which also allows biosimilar products to receive additional designation as an interchangeable biosimilar. Substitution of an interchangeable biosimilar product for the reference product without the intervention of the prescriber at the pharmacy, depending on state substitution laws, will be allowed.

Insulin inhalation powder (Afrezza) provides an alternative dosage form to prandial (mealtime) insulin and should be prescribed with injectable basal insulin for T1DM and injectable basal insulin or oral antidiabetic agents for patients with T2DM. The inhaled dosage form could be an option for adults with diabetes in whom the injectable administration is a barrier to insulin therapy. Insulin inhalation powder is contraindicated in patients with chronic lung disease due to increased risk of bronchospasm. The long-term pulmonary safety of insulin inhalation is unknown.

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