

Reviewing the Evidence Supporting Real-Time Continuous Glucose Monitoring (rtCGM): Opportunities for Patient Engagement and Quality Improvement in Managed Care Pharmacy



Jointly provided by:



This activity is supported by an independent educational grant from Dexcom, Inc.

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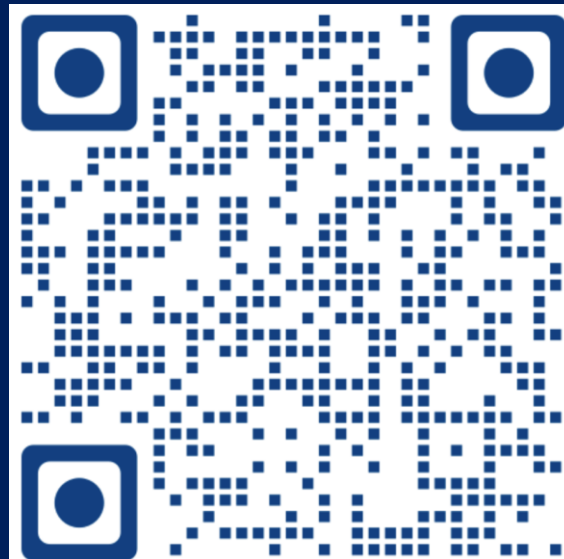


NW AMCP

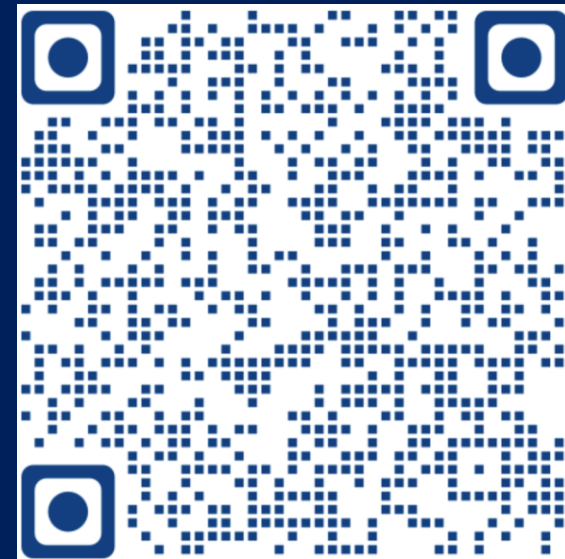
Affiliate Educational Event

April 13, 2023

Instagram



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AFFILIATE UPCOMING EVENTS

LEO Pharma Shadowing Day August 15-17 (Madison, NJ)

Day 1	Meet and greet, topic discussions on drug development, business case assessment, PIE Exchange, regulatory filing & commercialization, manufacturing & channel distribution, legal, compliance, marketing, commercial engagement.
Day 2	Breakout case study activity with assigned experts, followed by discussions on specialty pharmacy & field reimbursement, market access, traditional field medical and HEOR roles, employee engagement, LEO Pharmacy Fellowship Program, and panel discussions.

Other Details

- In partnership between LEO Pharma and the MW, NE, NW and SE Affiliates of AMCP
- 3 students from each of the participating affiliates will be selected
- Application opens **March 27th**
- Applications due May 5th
- Selected students will be notified by May 29th

WELCOME!



Erin Nowak, PharmD
President



Michael Lee, PharmD
Treasurer



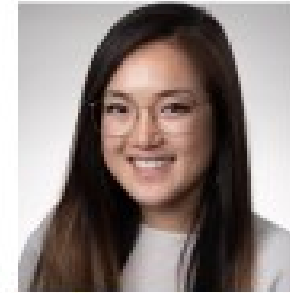
Chris Yates, PharmD
Secretary



Heidi Chinwuba, PharmD
Program and Education
Coordinator



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Communications/Membership
Engagement Chair



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(OR)



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Immediate Past President

2023-2024 NW AMCP Board Members

THANK YOU!

Event Collaborators/Sponsors



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Welcome and Pre-Survey Questions

Jeff Dunn, PharmD
Chief Clinical Officer
Cooperative Benefits Group

Agenda



6:30 PM	Opening Comments, Instructions, and Pre-Survey Jeff Dunn, PharmD
6:35 PM	<i>Evidence-Based Application of CGM to Enhance Patient Care and Outcomes</i> Nicole Ehrhardt, MD
7:05 PM	<i>Improving Diabetes Care Quality with Pharmacy Access to CGM</i> Carly Rodriguez, PharmD, FAMCP
7:20 PM	NW Region Panel Discussion Omar Daoud, PharmD Nicole Ehrhardt, MD Carly Rodriguez, PharmD, FAMCP John Watkins, PharmD, MPh, BCPS
7:50 PM	Audience Q&A Session
8:00 PM	Closing Comments; Post-Activity Assessment and Evaluation

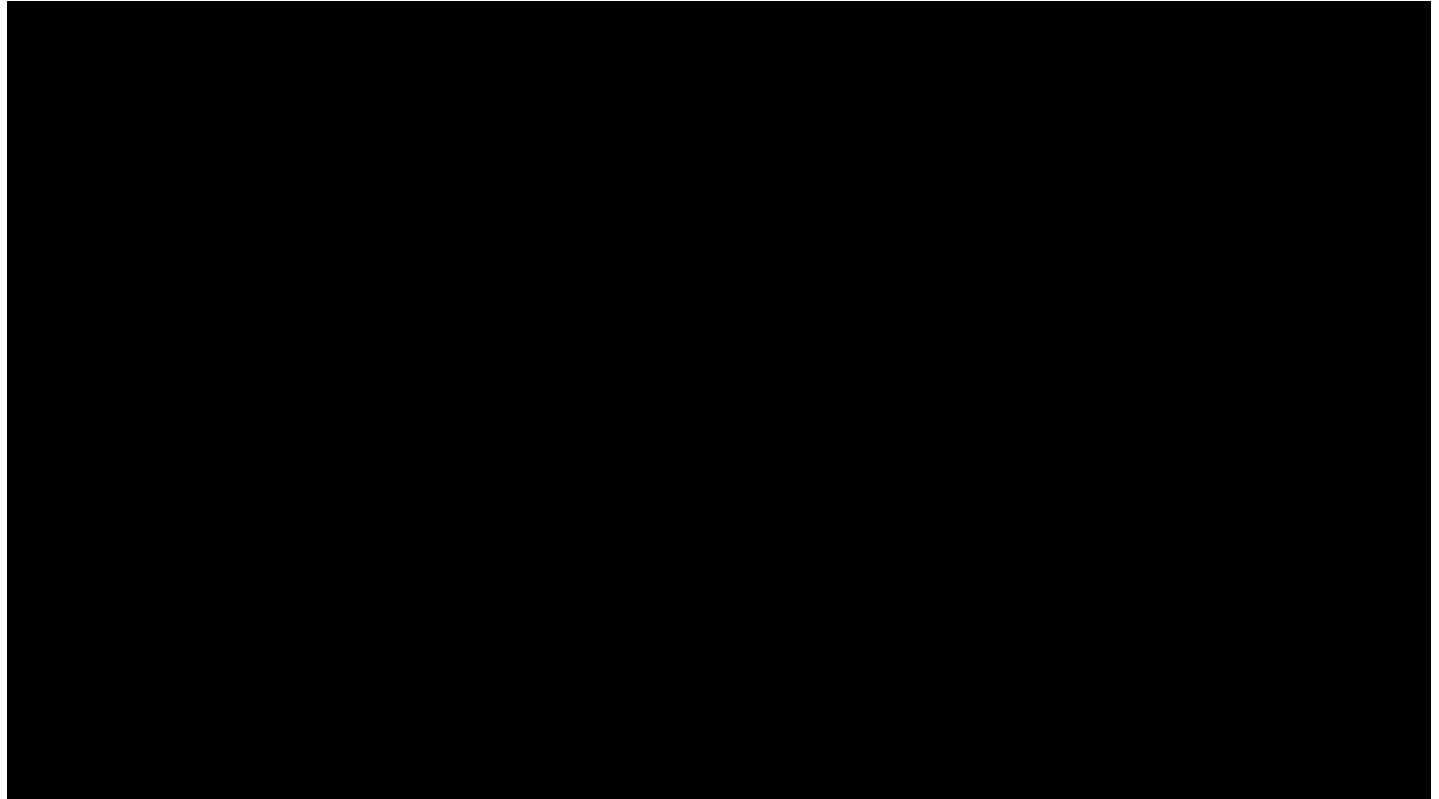
Learning Objectives



- Assess clinical evidence and expert recommendations supporting the use of CGM in patients with type 1 and type 2 diabetes
- Characterize the value of CGM in improving diabetes outcomes via patient engagement and behavior modification
- Describe the role of managed care pharmacy professionals in facilitating appropriate CGM access and utilization

Patient Video

Biz Velatini
Age 55





Evidence-Based Application of CGM to Enhance Patient Care and Outcomes

Nicole Ehrhardt, MD

Assistant Professor of Medicine
UW Medicine Diabetes Institute

Diabetes Management is an Ongoing Challenge for Patients, With Only 21% of Adults Achieving A1c <7%



Food	Biological
<ul style="list-style-type: none"> ↑↑ 1. Carbohydrate quantity →↑ 2. Carbohydrate type →↑ 3. Fat →↑ 4. Protein →↑ 5. Caffeine ↓↑ 6. Alcohol ↓↑ 7. Meal timing ↑ 8. Dehydration ? 9. Personal microbiome 	<ul style="list-style-type: none"> ↑ 20. Insufficient sleep ↑ 21. Stress and illness ↓ 22. Recent hypoglycemia →↑ 23. During-sleep blood sugars ↑ 24. Dawn phenomenon ↑ 25. Infusion set issues ↑ 26. Scar tissue and lipodystrophy ↓↓ 27. Intramuscular insulin delivery ↑ 28. Allergies ↑ 29. A higher glucose level ↓↑ 30. Periods (menstruation) ↑↑ 31. Puberty ↓ 32. Celiac disease ↑ 33. Smoking
Medication	Environmental
<ul style="list-style-type: none"> →↓ 10. Medication dose ↓↑ 11. Medication timing ↓↑ 12. Medication interactions ↑↑ 13. Steroid administration ↑ 14. Niacin (Vitamin B3) 	<ul style="list-style-type: none"> ↑ 34. Expired insulin ↑ 35. Inaccurate BG reading ↓↑ 36. Outside temperature ↑ 37. Sunburn ? 38. Altitude
Activity	Behavioral & Decision Making
<ul style="list-style-type: none"> →↓ 15. Light exercise ↓↑ 16. High-intensity and moderate exercise →↓ 17. Level of fitness/training ↓↑ 18. Time of day ↓↑ 19. Food and insulin timing 	<ul style="list-style-type: none"> ↓ 39. Frequency of glucose checks ↓↑ 40. Default options and choices ↓↑ 41. Decision-making biases ↓↑ 42. Family relationships and social pressures

42 Factors Affect BG



Daily time for self-care activities for adults with T2D:

234 min



Daily time for self-care activities for children with T1D:

305 min

“If you really look at it, having diabetes means you have an additional job to attend to every day.”

Aus Alzaid, MD. *Diabetes Technol Ther.* 2014;16(8):542–544.

Foster NC, et al. *Diabetes Technol Ther.* 2019;21:61-72.

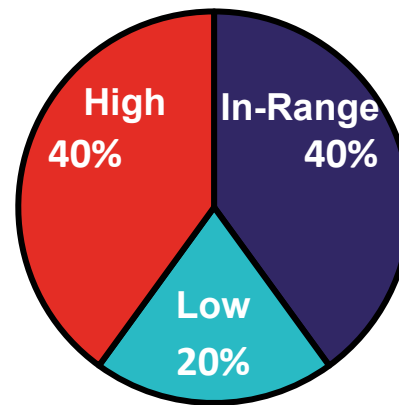
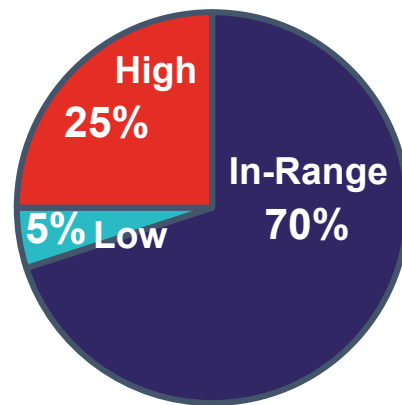
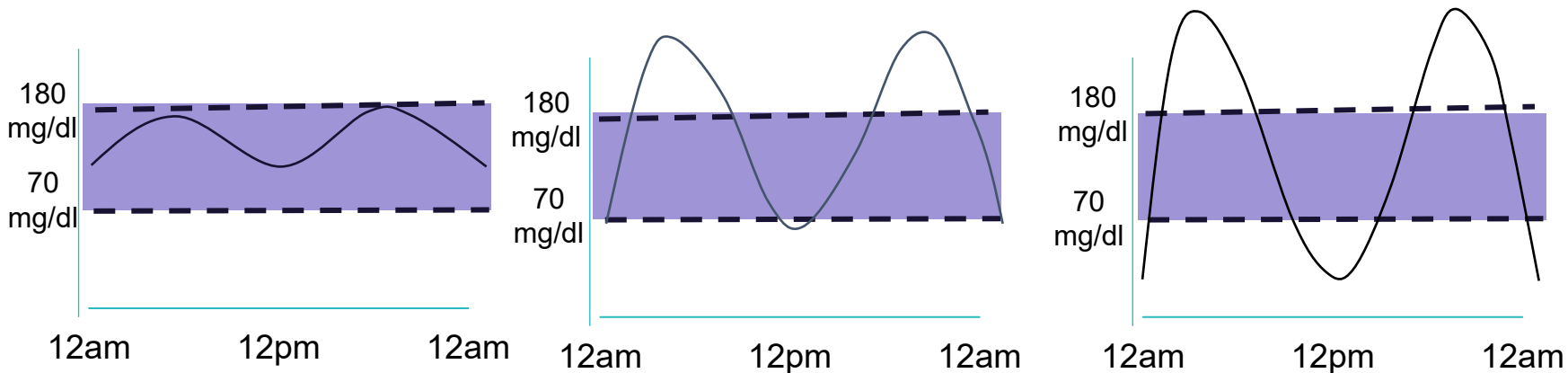
Credit: Adam Brown. diatribe, Feb 2018

Shubrook JH, et al. *Diabetes Spectr.* 2018;31:267-271.

CGM Can Unlock Vital Insights for Patients and Clinicians to Optimize Diabetes Management



The many faces of a 7% HbA1c (and an average blood glucose of 154 mg/dL)

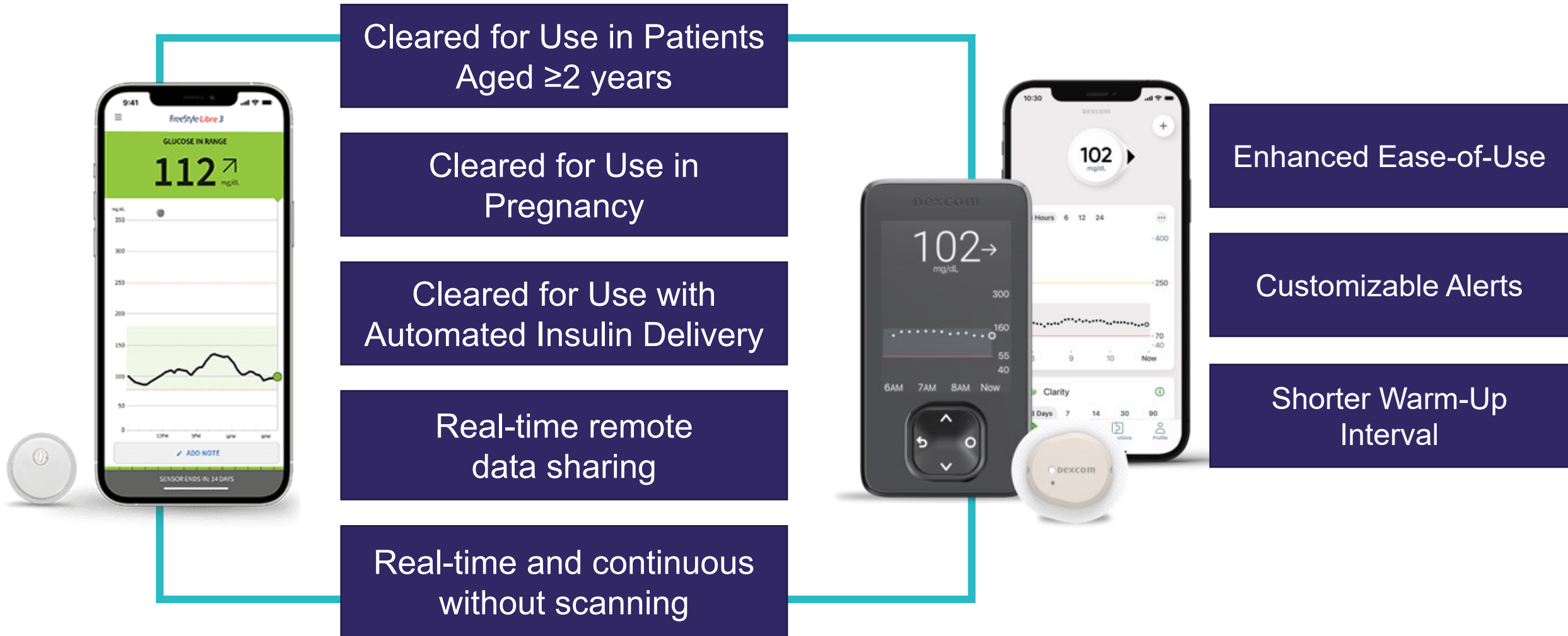
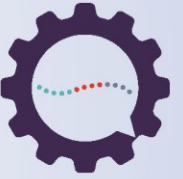


Metrics that only CGM can provide:

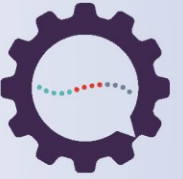
- Time in Range (TIR)
- Time Above Range (TAR)
- Time Below Range (TBR)
- Glycemic Variability (GV)
- Glycemic Management Indicator (GMI)

CGM=continuous glucose monitoring

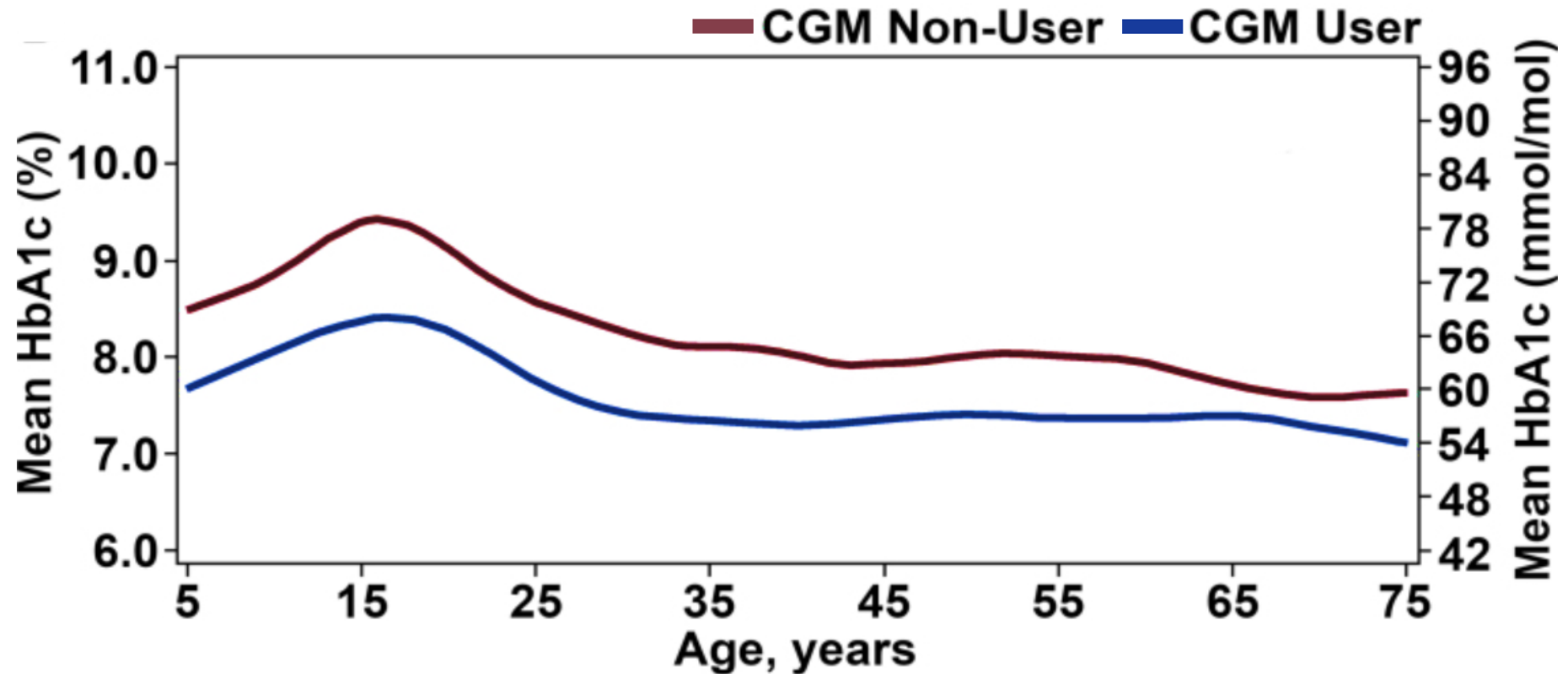
The Latest Generation of Integrated CGM (iCGM) Systems Support Enhanced Diabetes Management



HbA1c Levels in Type 1 Diabetes from Early Childhood to Older Adults



A Deeper Dive into the Influence of Technology and Socioeconomic Status



CGM Improves Glycemic Control Regardless of Socioeconomic Status

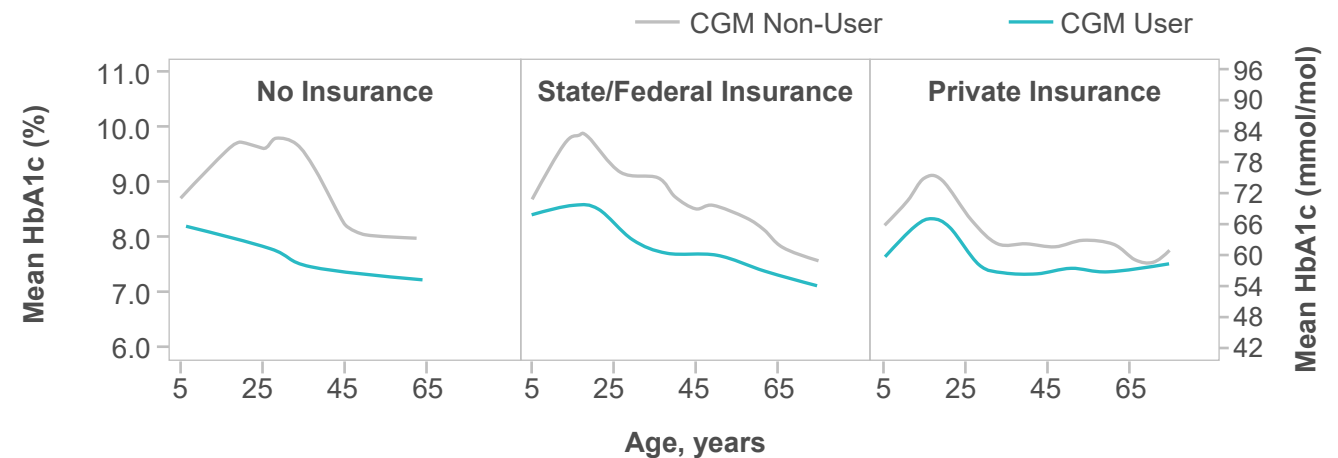
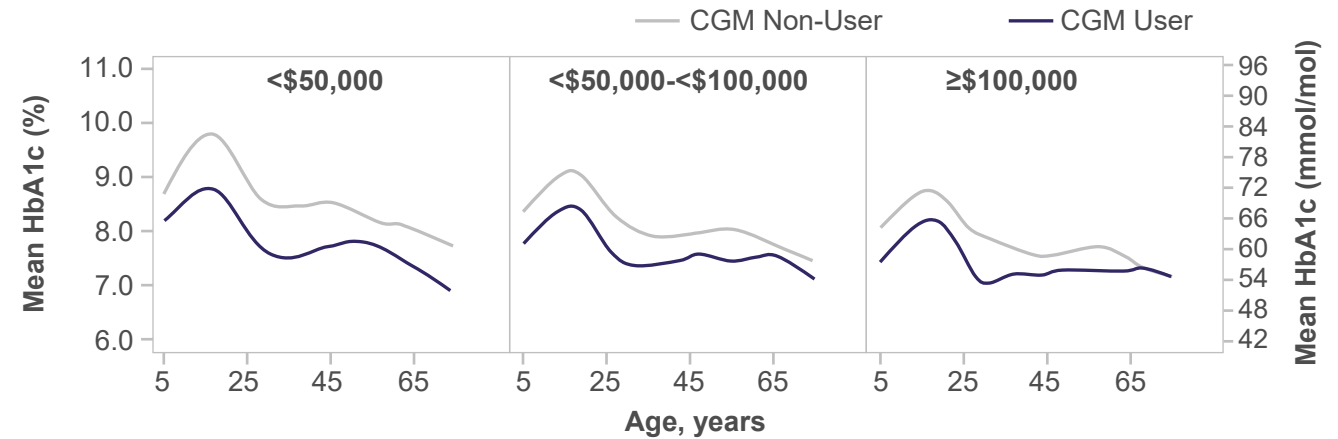


Average A1C from early childhood to older adult by **household income** and CGM use.

- CGM non-users: n=7,903
- CGM users: n=3,198

Average A1C from early childhood to older adult by **insurance status** and CGM use.

- CGM non-users: n=10,541
- CGM users: n=4,055

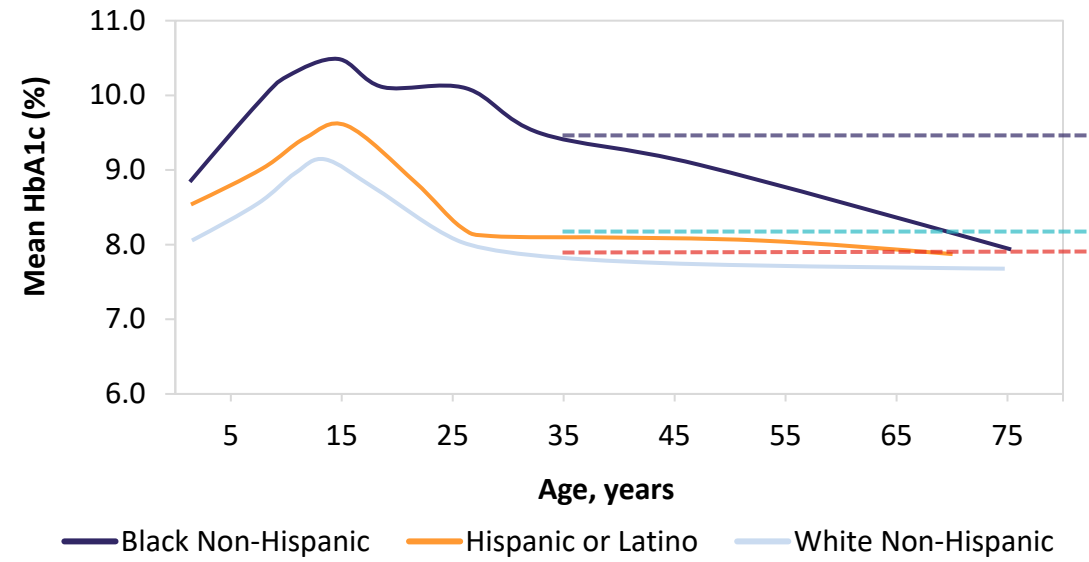


US data from 21,253 T1D Exchange Clinic Registry participants with an HbA1c measurement between January 1, 2016, and March 31, 2018, according to device use, race/ethnicity, and measures of SES

CGM Improves Glycemic Control Regardless of Race/Ethnicity



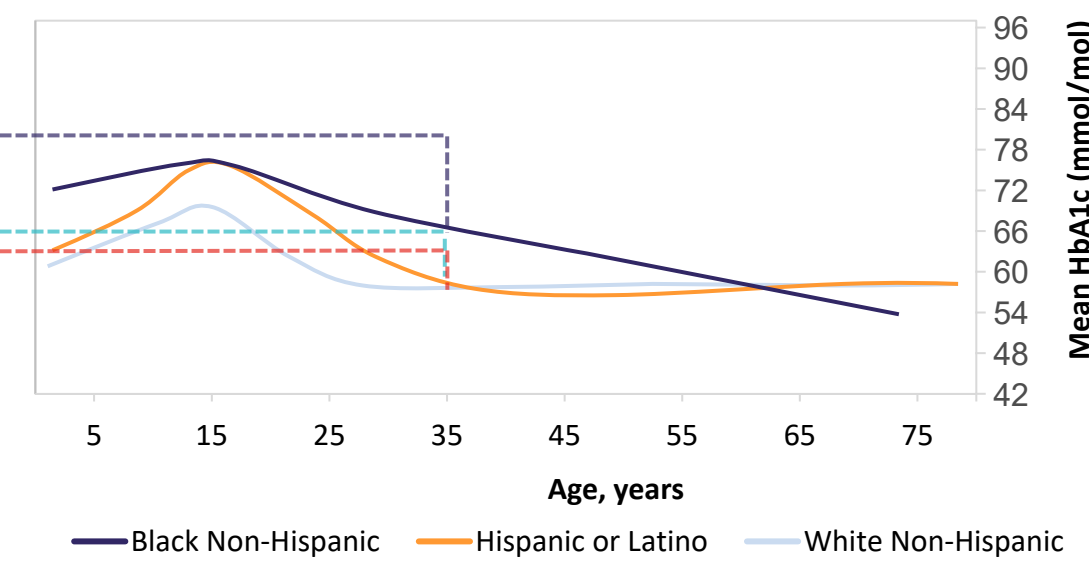
A1C Whole population



Average A1C from early childhood to older adult by race/ethnicity

- NH Black: n=942
- Hispanic/Latino: n=1,664
- NH White: n=12,339

A1C CGM Users



Average A1C from early childhood to older adult by race/ethnicity & CGM users

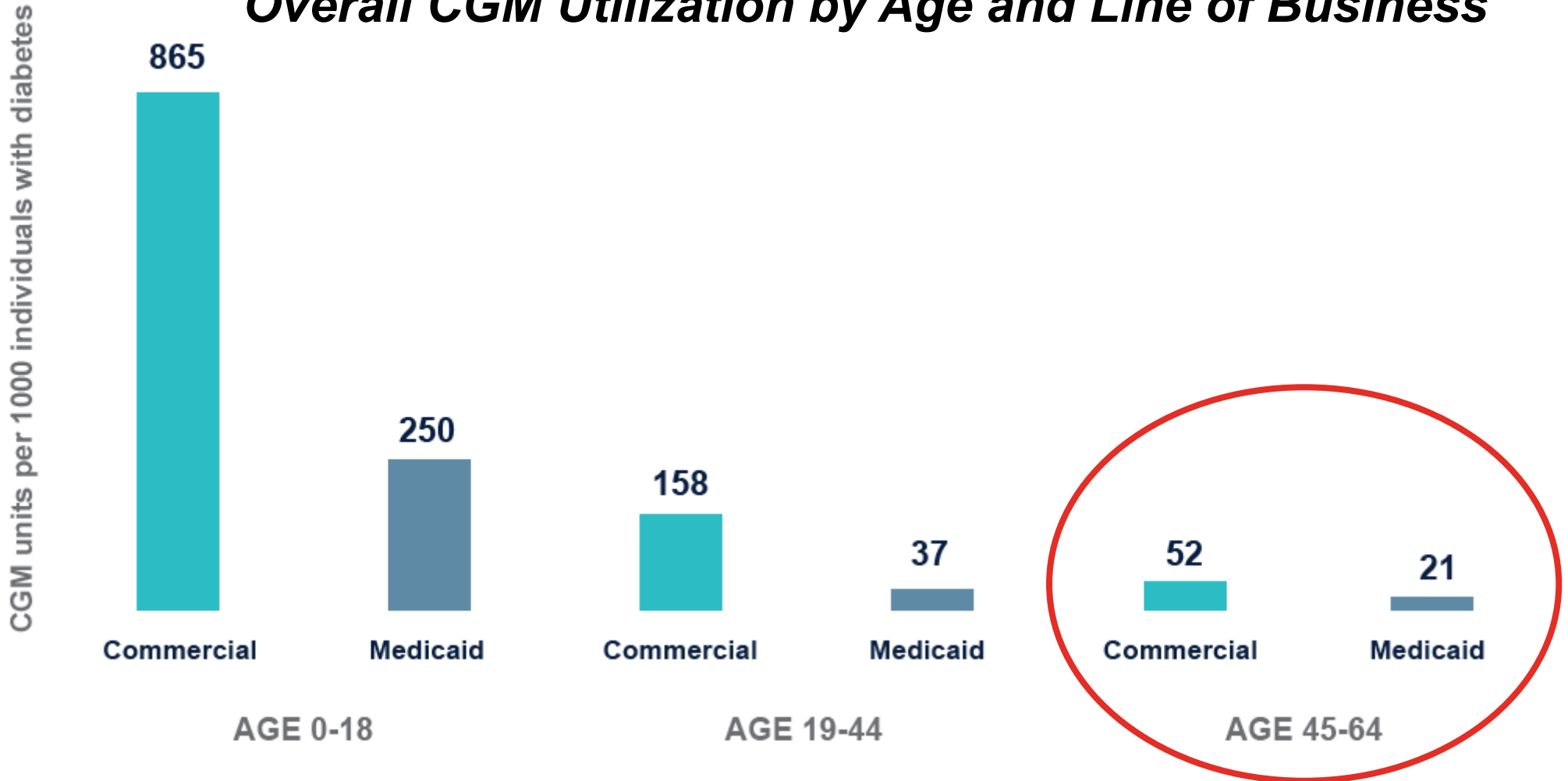
- NH Black: n=73 (7.7%)
- Hispanic/Latino: n=304 (18%)
- NH White: n=3,641 (29.5%)

US data from 21,253 T1D Exchange Clinic Registry participants with an HbA1c measurement between January 1, 2016, and March 31, 2018, according to device use, race/ethnicity, and measures of SES

CGM is Underutilized in Demographics Characterized by Worsening Diabetes Outcomes: Aging Populations and Those Affected by SDOH

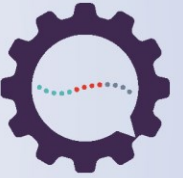


Overall CGM Utilization by Age and Line of Business



ADA. <https://diabetes.org/sites/default/files/2021-10/ADA%20CGM%20Utilization%20White%20Paper.pdf>.

Clinical Practice Guidelines on CGM



ADA Standards of Care^{1,2} 2023

RT-CGM (**Grade A[§]**) or IS-CGM (**Grade B[¶]**)
should be offered for diabetes management in adults
with diabetes on MDI or CSII.

Initiation of CGM, CSII, or AID **early in the treatment
of diabetes** can be beneficial (**Grade C[¶]**).

RT-CGM (**Grade A[§]**) or IS-CGM (**Grade C[¶]**) should be
offered for diabetes management in adults with
diabetes on basal insulin.



AAACE Clinical Practice Guideline³ 2022

RT-CGM or IS-CGM **is recommended** for all
persons with T1D regardless of insulin delivery
system. (**Grade A[†]**)

RT-CGM or IS-CGM **is recommended** for
persons with T2D who are treated with insulin
therapy, or who have high risk of hypoglycemia
and/or hypoglycemia unawareness (**Grade A[†]**)

[†]High strength of evidence; BEL 1. [§]Clear evidence from well-conducted, generalizable randomized controlled trials that are adequately powered. [¶]Supportive evidence from well-conducted cohort studies. [¶]Supportive evidence from poorly controlled or uncontrolled studies. ADA=American Diabetes Association. AAACE=American Association of Clinical Endocrinology. MDI=multiple daily injections. CSII=continuous subcutaneous insulin infusion. AID=automated insulin delivery. BEL=best evidence level.. RT-CGM=real-time continuous glucose monitoring. IS-CGM=intermittent scanning continuous glucose monitoring. T1D=type 1 diabetes. T2D=type 2 diabetes.

1. American Diabetes Association. *Diabetes Care*. 2023;46(Suppl. 1):S1-S2. 2. American Diabetes Association. *Diabetes Care*. 2023;46(Suppl. 1):S111-S127. 3. Blonde L. et al. *Endocr Pract*. 2022 Oct;28(10):923-1049.

CGM Improved Glycemic Outcomes Across Different Ethnic Backgrounds, Ages, Income, Numeracy & Education Levels



MOBILE Study Population



53% ethnically diverse



55% high school diploma or less



58% with non-private insurance

A1C Reduction



1.1% A1C reduction from baseline

Medication Usage



rt-CGM improved patient engagement with no increase in medication use

- Randomized controlled trial
- 176 patients with T2D randomized into rtCGM and BGM groups and followed up for 8 months in primary care
- Patients were **non-intensively treated with 1-2 daily injections of long-or intermediate-acting basal insulin**

A Post Hoc Analysis from MOBILE Showed the Effectiveness of CGM in Older Adults with T2D



Cohort of 42 older adults (aged ≥ 65 years) who completed MOBILE



Mean change in A1c - 1.08% in the CGM group and -0.38% in the BGM group (adjusted mean difference, -0.65%)

Adjusted mean difference in A1c between treatment groups: **-0.35% in the <65 years age group**



Comparable treatment group differences favoring the CGM group were observed in both the ≥ 65 and < 65 years age groups for TIR, time in hyperglycemia, and mean glucose

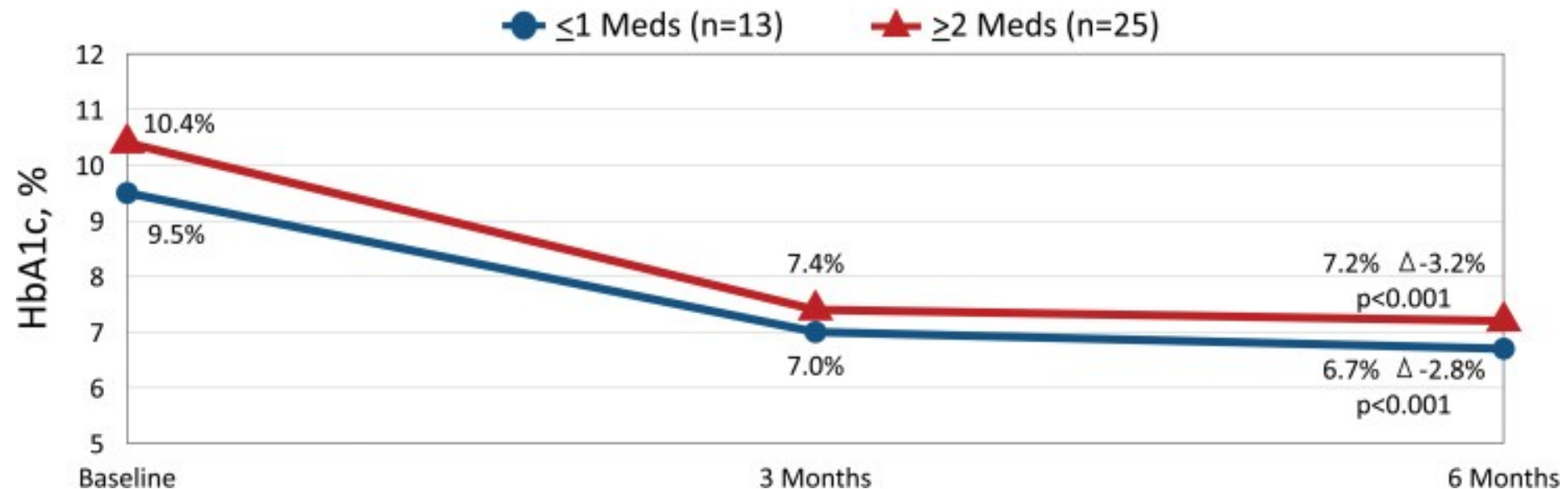
The glycemic improvement associated with CGM in older adults with T2D on basal insulin were at least as great as that observed in younger adults

CGM Optimizes Outcomes in T2D Treated with Less Intensive Therapy



At 6 months, patients with T2D treated with **basal insulin only or noninsulin therapy** using CGM demonstrated...

- ...significant reductions in HbA1c and average glucose
- ...significantly increased %TIR, with all patients maintaining %TBR targets



CGM Use in the Medicaid Population



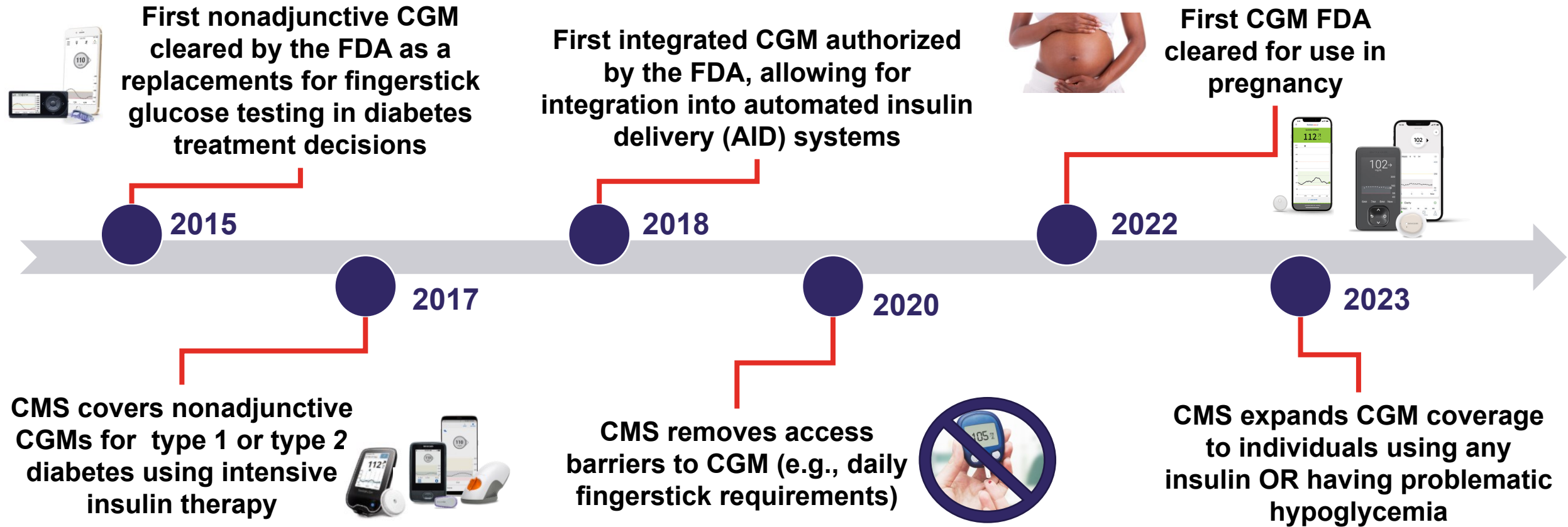
Higher CGM Utilization Improves T2D Outcomes in Underserved Populations

Retrospective Cohort Study

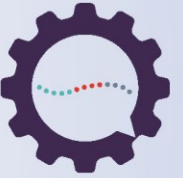
- 3,036 adults with diabetes*
- Enrolled in a US Medicaid program that fully subsidized CGM
- CGM use was associated with improved A1c (-1.2%; $P < 0.001$) among those with T2D comparable between major racial/ethnic groups
- Those with higher CGM fill adherence achieved greater A1c reduction (-1.4%; $P < 0.001$) compared with lower adherence (-1.0%; $P < 0.001$)

*422 adults with T2D were dispensed CGM, with various insulin regimens (once-daily, twice-daily, or MDI/pump)

Regulatory and Coverage Milestones Reflect Advances in Technology and Support for CGM as Standard of Care



Considering Recent Evidence and Expert Recommendations, CMS Has Expanded CGM Coverage



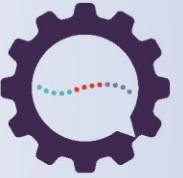
LCD—Glucose Monitors (DL33822) (Effective 4/16/2023)

To be eligible for coverage of CGM, patients must only be **insulin treated**:

- Includes both intensive and non-intensive patients
- No language specific to once-daily insulin, allowing for coverage in those treated with weekly insulins in the future

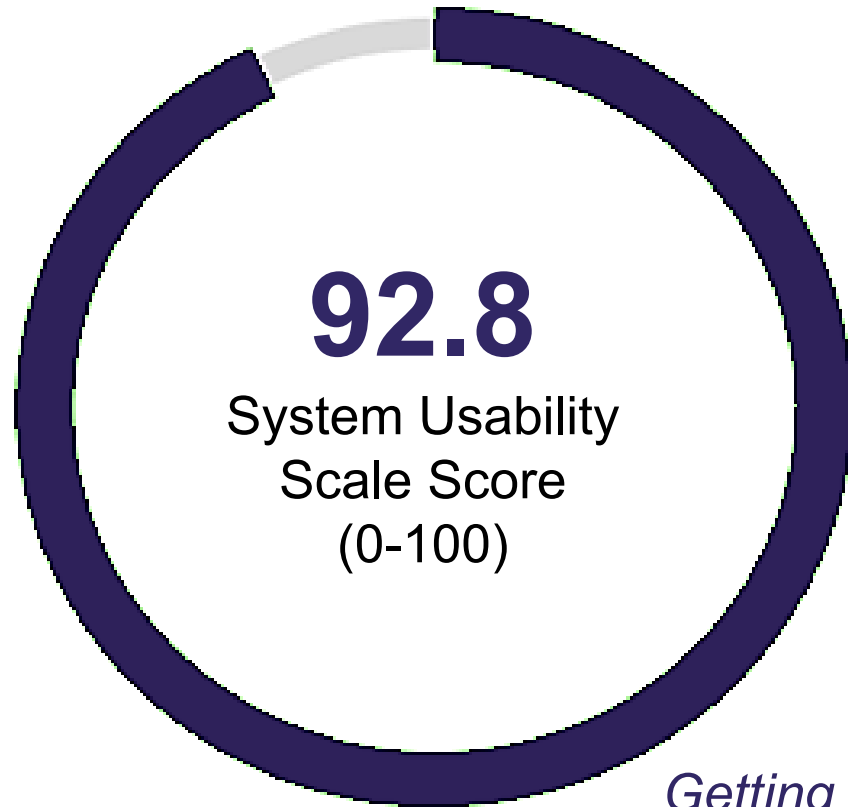
Those with a history of **problematic hypoglycemia** are also eligible for coverage of CGM:

- Patients who are treated with sulfonylureas or other non-insulin therapies are often at risk for hypoglycemia, which imposes a serious safety concern
- These patients present an opportunity for enhanced management with CGM



Older Adults Report High Usability

**Among Adults Aged ≥ 65 Years
with T2D on MDI...**



Mean Post-Test Survey Results (1-5)

I believe I can set up the CGM system
on my own

4.9

The CGM system showed information
clearly and effectively


4.9

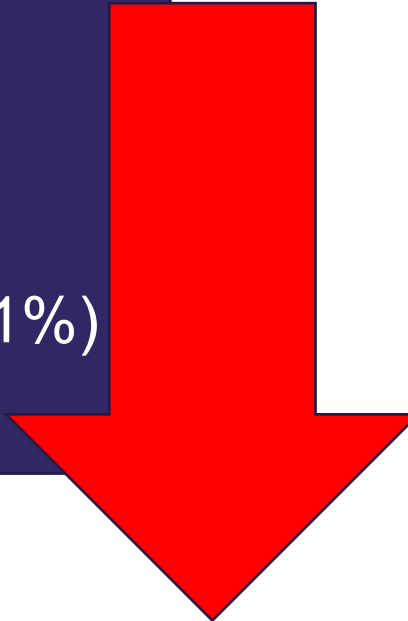
*Getting started on the newest CGM system requires **approximately half the steps** of getting started on the previous version*

Clinicians Can Leverage CGM to Improve Patient Engagement and QoL



A survey of 498 adults with **insulin-treated** diabetes highlighted QoL and health outcome benefits associated with CGM:

- 
- Improved hypoglycemic confidence (75.9%)
 - Improved overall well-being (50.0%)
 - Improved HbA1c (73.1%)

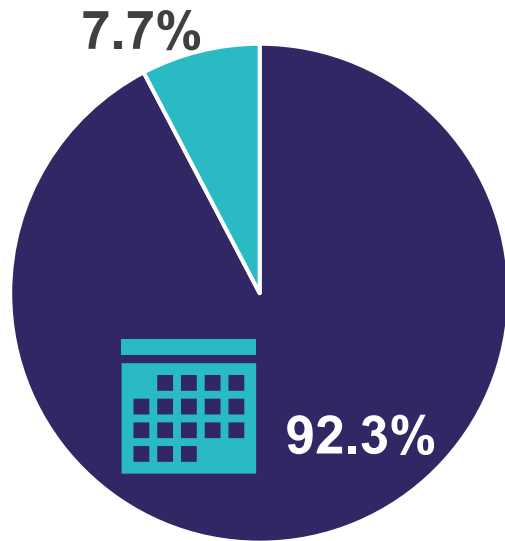
- 
- Reduced diabetes distress (59.3% - 74.1%)
 - Reduced problems with hypoglycemia (61.8%) and chronic hyperglycemia (73.1%)

n=300 T1D; n=198 T2D



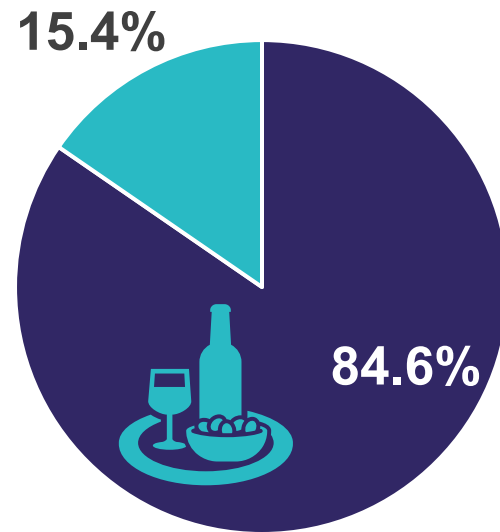
Behavior Modification with CGM Use

Would Like to Wear CGM on a Regular Basis



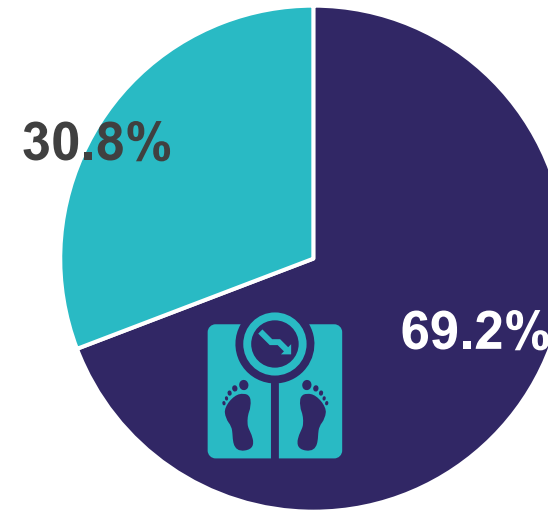
■ Yes ■ No

Excluded or Limited Certain Foods as a Result of CGM



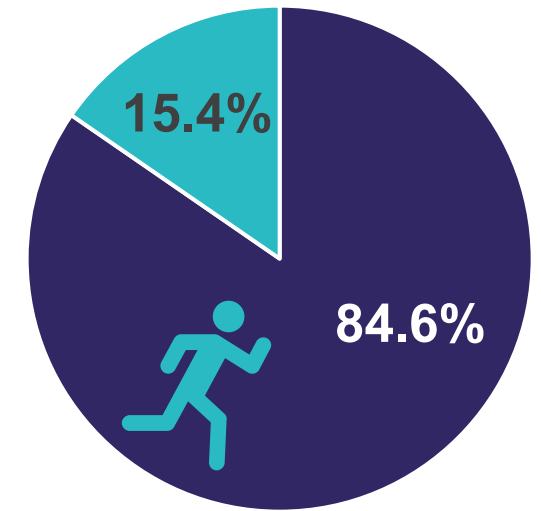
■ Yes ■ No

Self-Reported Weight Loss from CGM Use



■ Yes ■ No

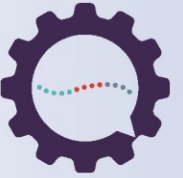
Motivated to Increase Activity Level



■ Yes ■ No

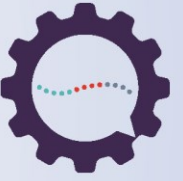
Distribution of Yes/No Responses to Week 24 Survey of CGM Users (N=13)

Case 1: Background



- Nursing home resident aged 87 years
- Medication regimen:
 - Metformin 750 mg XR - 2 tablet q am
 - Semaglutide 2 mg
 - Mixed insulin 70/30 - 32 units bid
- Due to increasing physical therapy (PT) frequency, patient was instructed to take 30 units bid insulin on days with scheduled PT

Based on SMBG Findings in this Patient, Reducing Insulin Would Not Normally Be Considered



SMBG 2x/day: Average Glucose in the 180s

BG Distribution BGM data from 59 readings	
2% >250 mg/dL (0.03 readings/day)	
54% 180-250 mg/dL (1.1 readings/day)	
44% 70-180 mg/dL (0.9 readings/day)	
0% 54-70 mg/dL (0 readings/day)	
0% <54 mg/dL (0 readings/day)	

BG readings

Mon	Tue	Wed	Thu	Fri	Sat	Sun
Jan 30	31	Feb 1	2	3	4	5
		••	••	••	••	••
6	7	8	9	10	11	12
••	••	••	••	••	••	••
13	14	15	16	17	18	19
••	••	••	••	••	••	••
20	21	22	23	24	25	26
••	••	••	••	••	••	••
27	28	Mar 1	2	3	4	5
••	••	••	•			

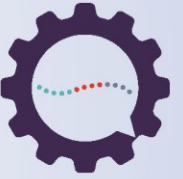
Avg BG readings / day	2
Meter	59
Manual	0
Below 54 mg/dL	0
Above 250 mg/dL	1

Avg. Glucose (BGM)	184
--------------------	------------

Bolusing

This section requires data from an insulin pump, so there's nothing to display.

Given Continued Increased Activity, CGM was Prescribed



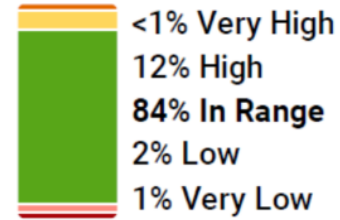
Average Glucose

143 mg/dL

Standard Deviation
36 mg/dL

Coefficient Of Variation
25%

Time in Range

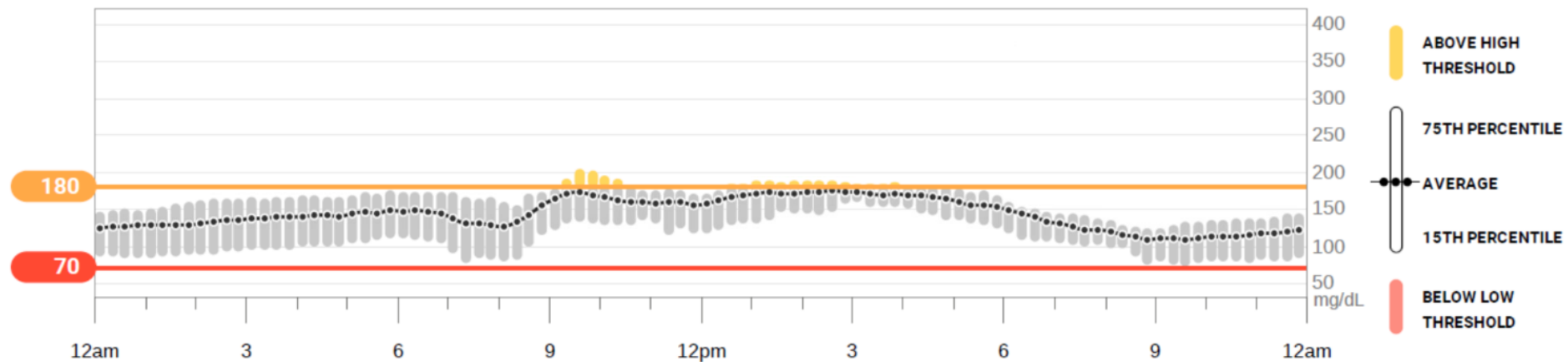


Target Range:
70-180 mg/dL

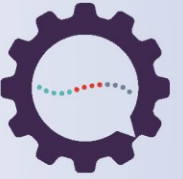
Sensor Usage

Days with CGM data
90%
9/10

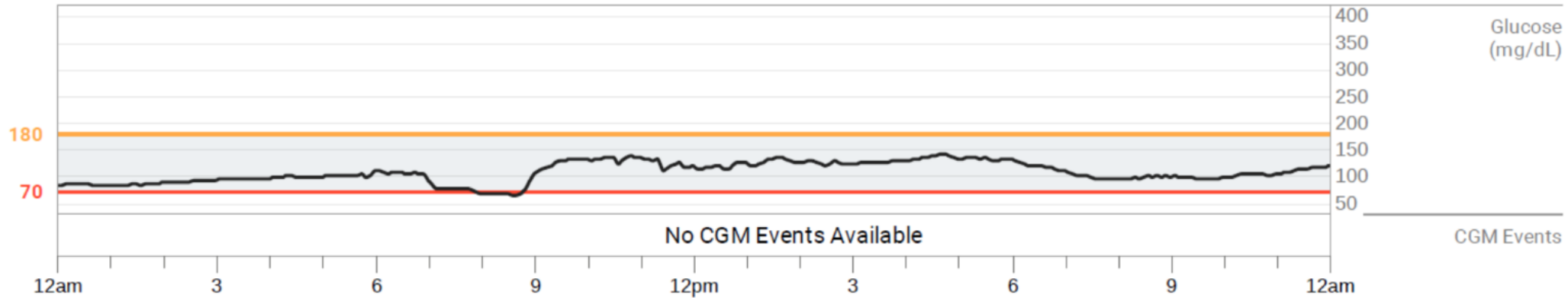
Pro Session Trends



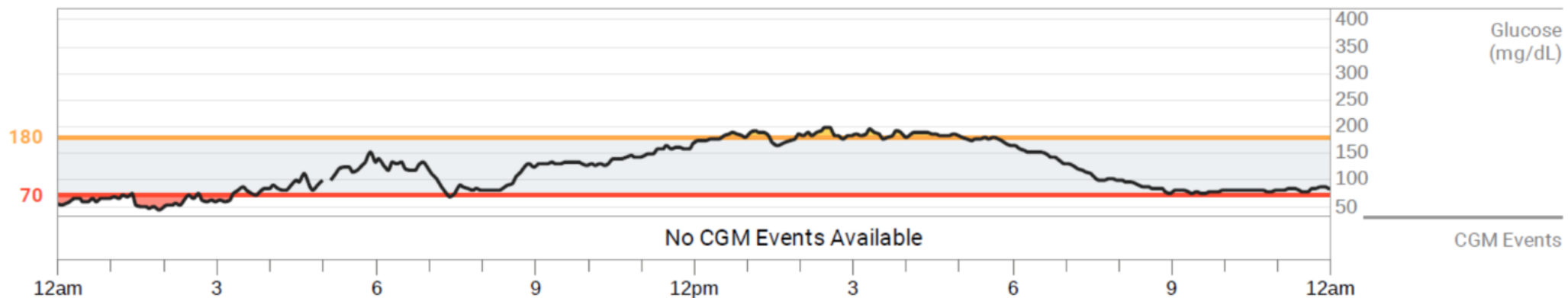
Some Hypoglycemia was Observed, so Insulin Was Further Reduced



Sat, Mar 4, 2023



Fri, Mar 3, 2023



Further insulin reduction was warranted considering that an HbA1c goal of <7.0 does not apply to insulin-treated patients aged 80+ years

Case 2: Background



- Patient aged 72 years, s/p recent left leg revascularization for PVD
 - Now potential need for right leg revascularization (non-healing ulcer on right)
 - Previously in 150-160s by CGM at last visit, but now presenting with substantially worsening control
- Usually eating 2 free meals a day at the senior home
 - Example of 6 pm, high-carbohydrate cafeteria meal: Hot dog on bun with beets, potatoes, and dessert
- Currently on 2 mg semaglutide, empagliflozin, and 20-25 units mixed insulin/Humalog 75/25 with 2 meals a day
 - Intolerant to metformin

Patient Was Switched to Mixed Insulin/ Humalog 50/50 bid with 2 Large Meals



Patient was instructed to consider an extra 10 units if eating lunch (patient does not always eat at 20 units bid)

AGP Report

February 2, 2023 - March 1, 2023 (28 Days)

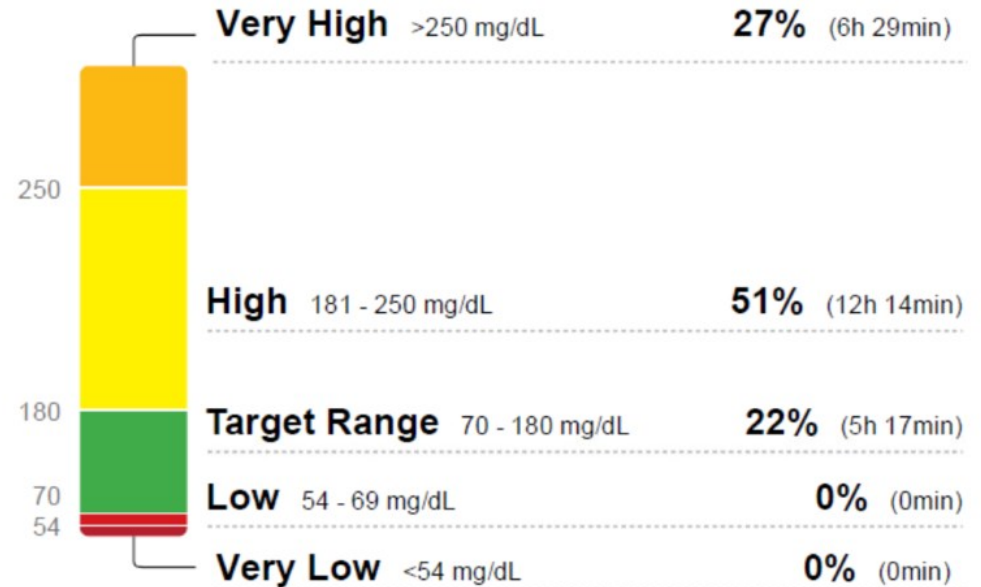
GLUCOSE STATISTICS AND TARGETS

February 2, 2023 - March 1, 2023 **28 Days**
 % Time CGM is Active **99%**

Ranges And Targets For	Type 1 or Type 2 Diabetes
Glucose Ranges	Targets % of Readings (Time/Day)
Target Range 70-180 mg/dL	Greater than 70% (16h 48min)
Below 70 mg/dL	Less than 4% (58min)
Below 54 mg/dL	Less than 1% (14min)
Above 180 mg/dL	Less than 25% (6h)
Above 250 mg/dL	Less than 5% (1h 12min)
Each 5% increase in time in range (70-180 mg/dL) is clinically beneficial.	

Average Glucose **221 mg/dL**
Glucose Management Indicator (GMI) **8.6%**
Glucose Variability **24.0%**
 Defined as percent coefficient of variation (%CV)

TIME IN RANGES

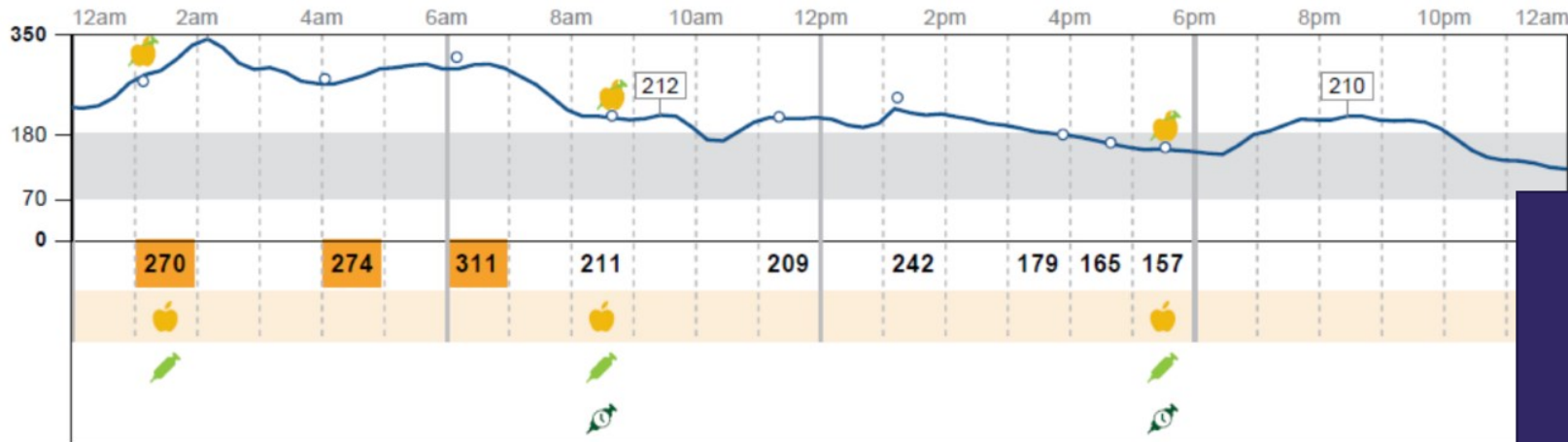


Patient to Follow Up with Pharmacist in 2 Weeks to Assess Glycemic Control

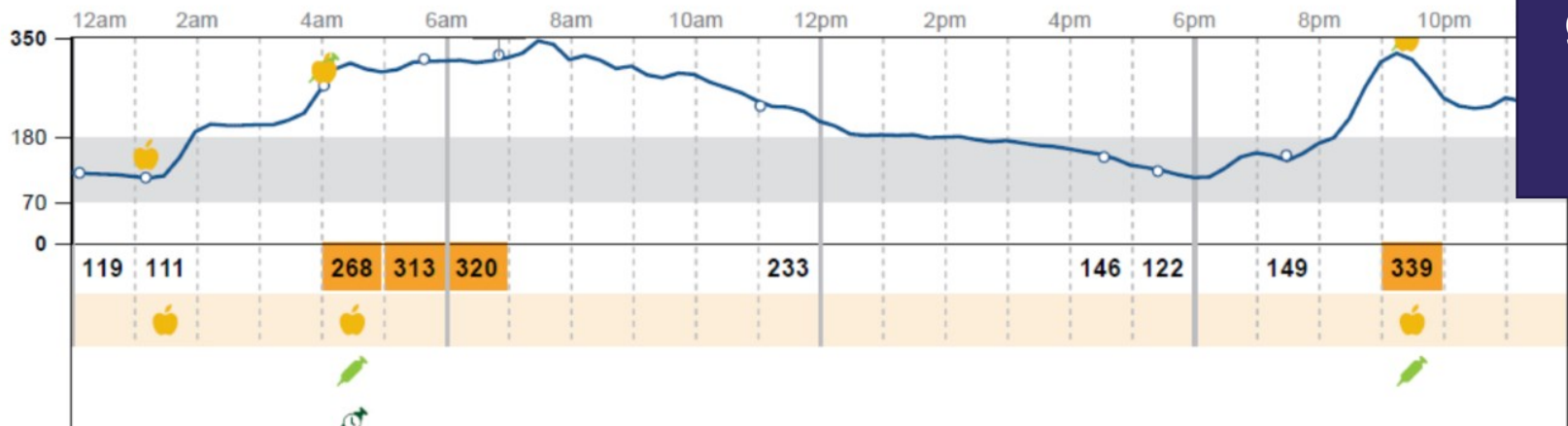


Considerations include the need for wound healing and possible additional surgery in 4-6 weeks for revascularization

MON Feb 13



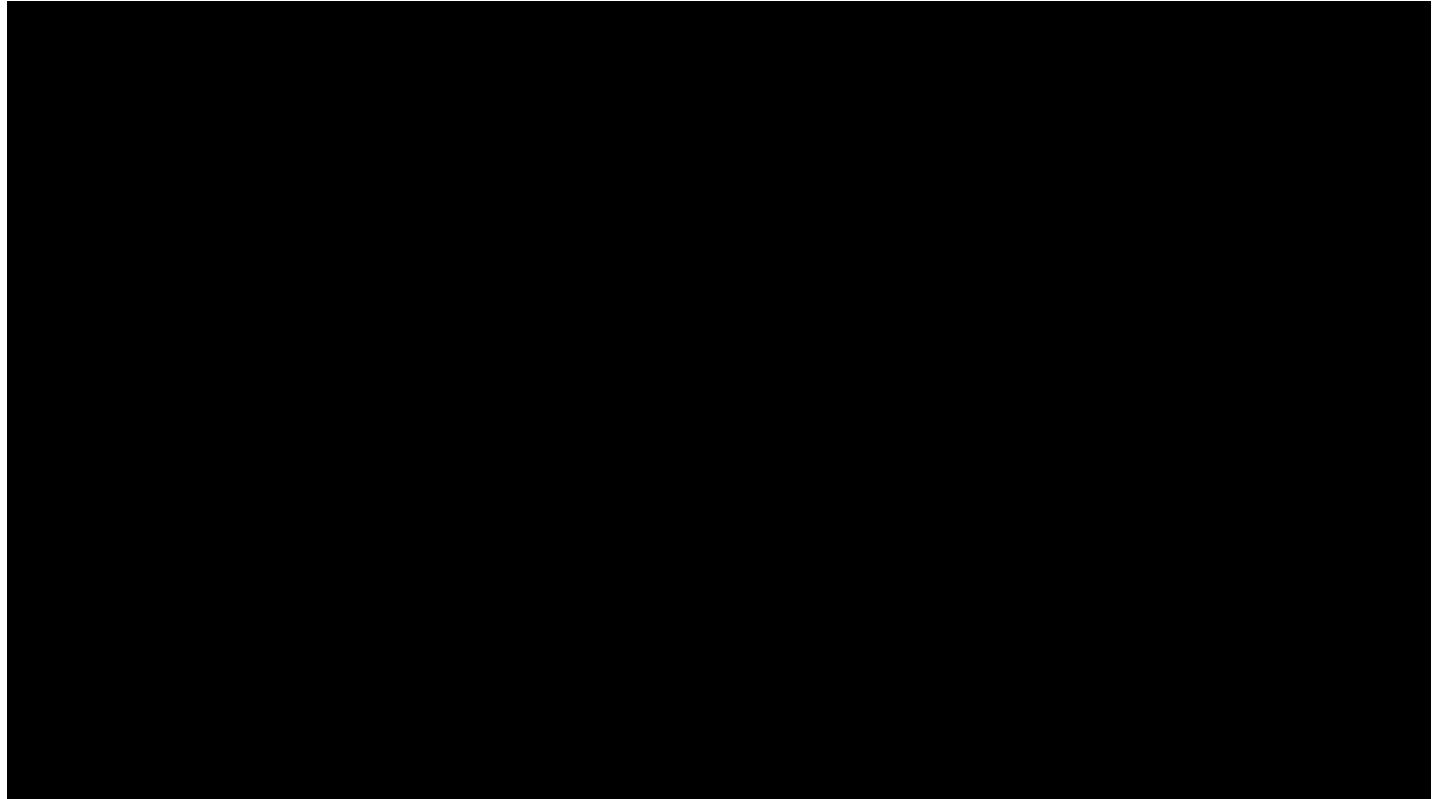
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Basal/bolus will be considered if improvement in glycemic control is inadequate

Patient Video

Zac Harmon
Age 66

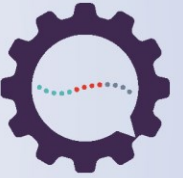




Improving Diabetes Care Quality with Pharmacy Access to CGM

Carly Rodriguez, PharmD, FAMCP
Vice President & Chief Pharmacy Officer
Moda Health

2023 NCQA HEDIS Measures: Hypoglycemia



New Measure Highlights the Potential Role of CGM in Hypoglycemia Prevention

Emergency Department (ED) Visits for Hypoglycemia in Older Adults with Diabetes

- Medicare members aged ≥ 67 years with diabetes (type 1 or type 2)
- Risk-adjusted ratio of observed to expected ED visits for hypoglycemia

Rationale

- Older adults are more likely to experience severe hypoglycemia, worsening outcomes
- Consensus guidelines for the treatment of older adults emphasize prevention of hypoglycemia
- Payers have an opportunity to identify their older members at highest risk for hypoglycemia and implement preventative interventions

2023 NCQA HEDIS Measures: Care Disparities



New Measures are Aimed at Further Efforts to Identify and Reduce Disparities in Care



HEDIS® MEASURES



- NCQA introduced race and ethnicity stratifications to eight additional HEDIS measures
- Plans in place to continue expanding the race and ethnicity stratifications to HEDIS measures over the next several years to help identify disparities in care among patient populations
- These efforts build on NCQA's existing work dedicated to advancing health equity in data and quality measurement

CGM Outcomes Are Aligned With Current and Future Payer Quality Measures



MOBILE Study

	Optimized BGM [†] (n=59)	CGM (n=116)
Participants with HEDIS-compliant HbA1c (<8%)	39%	63%

Study Population:

- 53% ethnically diverse
- 55% HS diploma or less
- 58% non-private insurance

25.8% absolute change in the number of participants able to meet this metric

Kaiser Claims Analysis

Change in ER/admit hypoglycemia rate associated with CGM initiation:



-2.7% (overall)
P=0.001

-4.0% (T2D)
P=0.04

-2.3% (T1D)
P=0.01

53% reduction in ER/admit rate due to hypoglycemia

[†]Optimized BGM defined as ≥3 fingerstick tests per day

CGM Use Prevents Glycemic Deterioration in Insulin-Treated Patients with Type 2 Diabetes



- 149 people with T2D
- Well-controlled (HbA1c <8% at baseline)
- No history of severe hypoglycemia
- At Kaiser Permanente

	Baseline HbA1c	Follow-Up HbA1c	HbA1c Change
CGM Users	6.98%	6.92%	-0.06%
Non-CGM Users	7.1%	7.42%	+0.32%
			Yielding a weighted adjusted net benefit of -0.30%

T2D=Type 2 diabetes



“The improvement in blood sugar control was comparable to what a patient might experience after starting a new diabetes medication.”

– **Andrew J. Karter, PhD**, Senior Research Scientist with Kaiser Permanente Division of Research

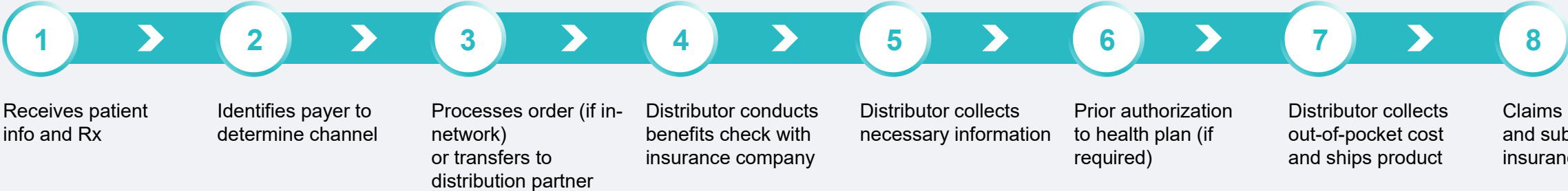


Access Considerations

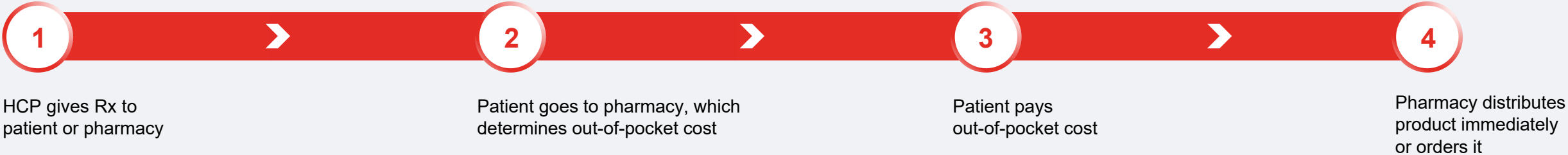
The Pharmacy Channel Improves Efficiencies and Enhances the Member Experience



DME Channel (3-4 Weeks)



Pharmacy Channel (1-2 Days)



Coverage under the pharmacy channel reduces the waiting time by up to 4 weeks.

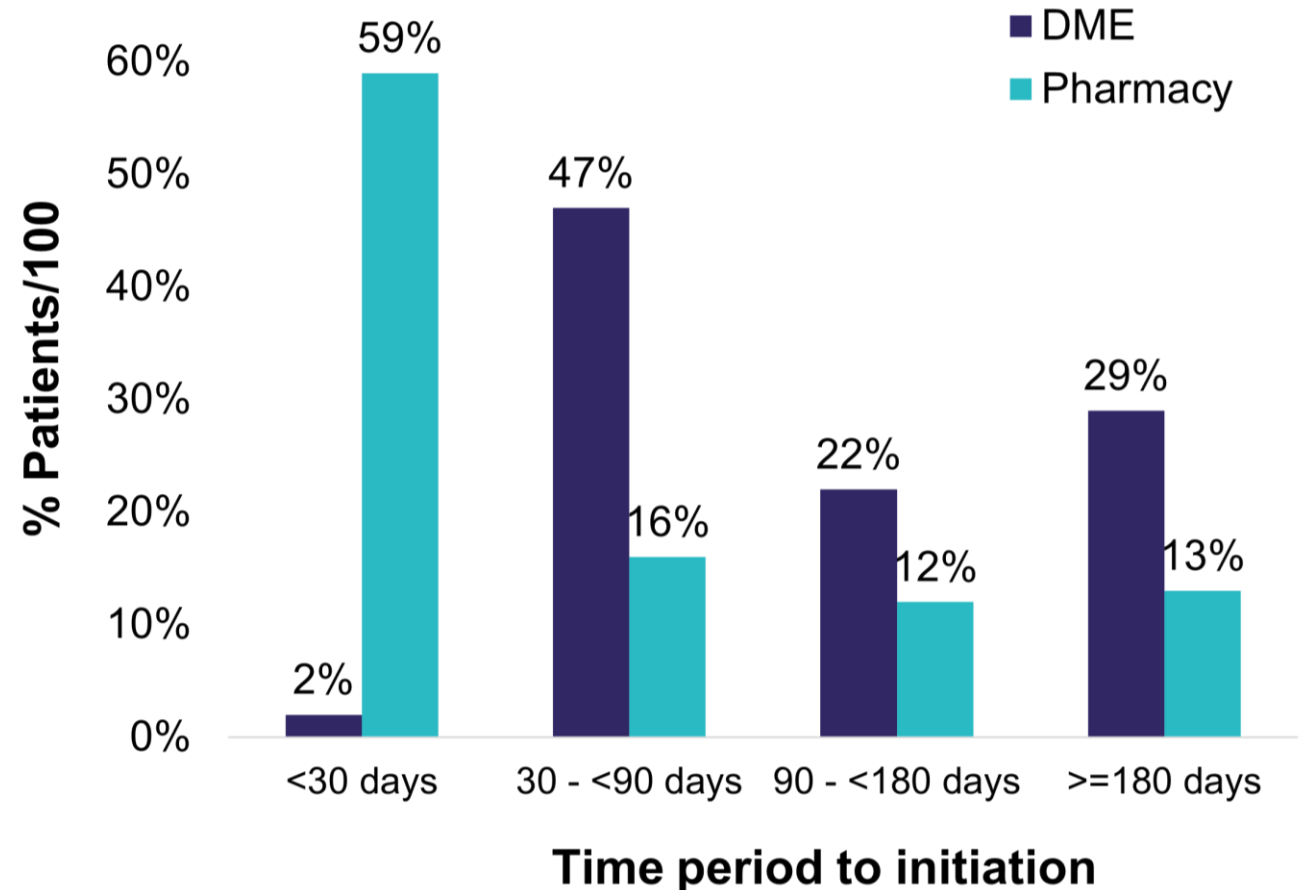
DME = durable medical equipment; HCP = health care provider; Rx = prescription.

Pharmacy Coverage of CGM Ensures Timely Access for Plan Members

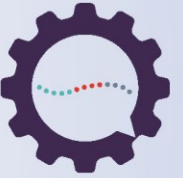


Retrospective cohort study of 271 patients prescribed CGM and seen over a 3-year period from 2017-2020 at Boston Medical Center

- CGM through pharmacy benefit was significantly faster than DME ($P < 0.0001$)
- Factors associated with initiation of CGM were younger age, *private insurance*, and education with a clinical diabetes educator
- *Identifying as Black or Hispanic was significantly associated with decreased initiation of CGM*
- A1C improved in patients initiated on CGM from 9.06% to 8.22% ($P < 0.001$)



Pharmacy Access to CGM is Crucial for Underserved Populations



Compared to people with commercial insurance, Medicaid beneficiaries have...

- ...higher rates of poor diabetes management
- ...worse glycemic control
- ...experience more barriers to care (including access to and coverage of CGM and other diabetes technologies)
- ...experience more acute- and long-term complications related to diabetes

Pharmacy access benefits those who are...

- ...unable to take delivery from DME
- ...in transient housing situations
- ...affected by limited access due to the pandemic, natural disasters, etc.

Expanding Medicaid Access to Continuous Glucose Monitors

January 2022

By Greg Howe and Jennie Chavis, Center for Health Care Strategies

Made possible through support from The Leona M. and Harry B. Helmsley Charitable Trust.

“Cover CGMs as a pharmacy benefit rather than a DME benefit. Patients report that accessing a CGM and its components is more convenient through a pharmacy than through a DME supplier.”

Best Practice: BCBS North Carolina



Removing Access Barriers to CGM Promotes Clinically Appropriate Utilization

BCBS of NC expanded access to CGM through the pharmacy benefit and implemented insulin point-of-sale edits, **reducing need for manual prior authorization.**

- In partnership with UNC, a study evaluated CGM use before and after the Dec 2018 policy change. Study authors concluded:
 - “Increasing access to these systems through policy options such as adding CGM to the pharmacy benefit may be an **important part of promoting equitable uptake of evidence-based technology by reducing barriers to access that lower income or lower health literacy patients may face.**”
 - “Given the UM criteria implemented along with this policy change restricted use of CGM to patients with diabetes who used insulin, the increase in **CGM use reflects those that would benefit from the use of CGM devices and aligns with clinical guidelines.**”

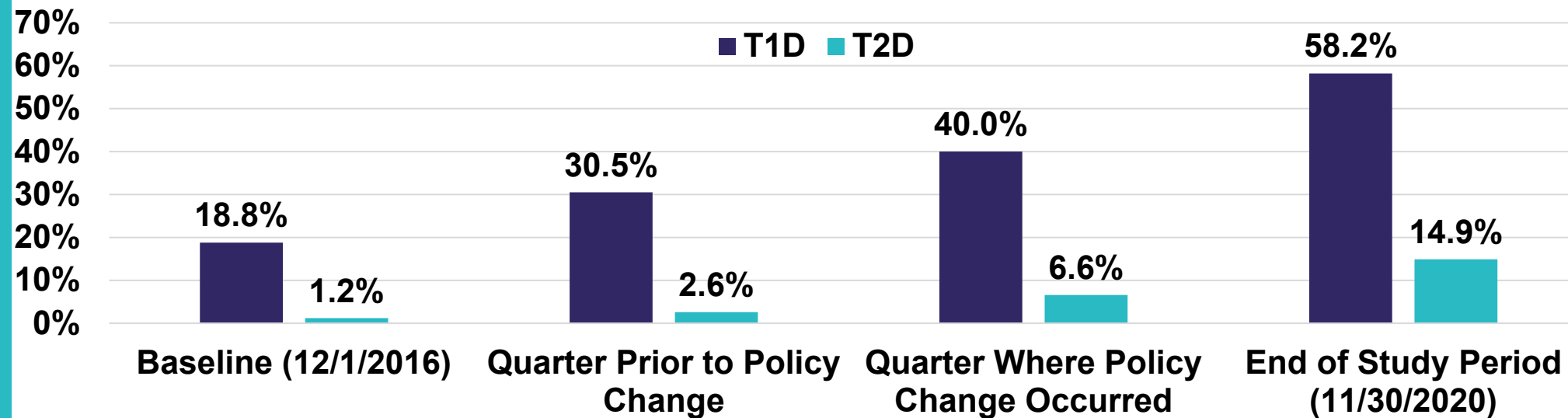
Expanding CGM Coverage Results in Increased CGM Use for Patients Likely to Benefit Per Clinical Guidelines



BCBS NC

- Policy change reducing PA requirements
- Coverage for CGM through the pharmacy benefit for nearly all insulin-using members
- CGM automatically approved with a record of a diabetes-related diagnosis code and insulin use*

CGM Utilization Across All Insurance Types in Insulin-Treated* Members



Benefits Observed:

- Enabled real-time billing for CGM devices
- Reduced average cost-sharing for patients
- Reduced barriers such as requiring stable address for mail-order DME and navigating unfamiliar brick and mortar DME providers
- Reduced need for preauthorization by automating approval process for CGM products for any patient with a history of diabetes-related diagnosis code and insulin use

T1D, n=10,925; T2D, n=32,566.

*Insulin was categorized as rapid-acting only, long-acting only, or both rapid-acting, and long-acting based on prescription fill history.

BCBS NC=Blue Cross Blue Shield of North Carolina; T1D=type 1 diabetes; T2D=type 2 diabetes

Reference: 1. Pathak S, et al. *Diabetes Technol Ther.* 2023. Published online ahead of print January 4, 2023. doi:10.1089/dia2022.0418



Health Plan Blueprint

Increasing Access to CGM

Receive input from other parts of organization; complete clinical discovery

Work with PBM and manufacturers to obtain additional clinical data & contracted rates

Analyze and compare historic utilization and spend data with projected data

Finalize recommendation; receive input from P&T committee

Operationalizing: standardize benefit, implement with PBM, communicate to providers, track utilization

Collaborative discussions & input from provider teams, diabetes educators, medical directors, product experts, and other SMEs.



Panel Discussion

Omar Daoud, PharmD

Senior Director of Pharmacy
Community Health Plan of Washington

Nicole Ehrhardt, MD

Assistant Professor of Medicine
UW Medicine Diabetes Institute

Carly Rodriguez, PharmD, FAMCP

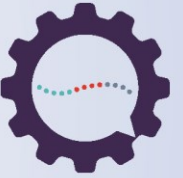
Vice President & Chief Pharmacy Officer
Moda Health

John Watkins, PharmD, MPh, BCPS

Residency Program Director
Premera Blue Cross



Q&A



How to Claim Credit

- **Option 1:** Complete the paper-based evaluation and turn it in at the end of the meeting.
 - A certificate will be emailed to you within 3 weeks
- **Option 2:** OR, complete the evaluation online. **Please do NOT do both.**
 - Go to www.impactedu.net/cgmevaluation
 - Enter code **41323**.
 - Once you complete the evaluation and click "Submit" you will receive instructions to claim your credit. Please be sure to follow these instructions or your credit will not be processed. Pharmacists will be prompted to submit their credit to CPE Monitor which will require an ImpactEdu account complete with your NABP information. You will be prompted to login or create an account during this process.

****Pharmacist have up to 30 days to complete the evaluation and claim credit for participation so that information can be submitted to CPE Monitor as required.***



Closing Comments