



13 May 2024

## **Medicine Supply Alert Notice**

### **Humalog® (insulin lispro) 100units/ml solution for injection 10ml vials**

**Priority: Level 2\***

**Valid until: late May 2024**

#### **Issue**

1. Humalog® (insulin lispro) 100units/ml 10ml vials are out of stock with an estimated resupply date of late May 2024.
2. NovoRapid® and Trurapi® (insulin aspart) 100units/ml 10ml vials remain available.
3. Admelog® and Lyumjev® (insulin lispro) 100units/ml 10ml vials remain available, however **cannot** support an increase in demand.
4. Fiasp® (insulin aspart) 100units/ml 10ml vials remain available, however **cannot** support an increase in demand.
5. Humalog® 100units/ml 3ml cartridges and Humalog KwikPen® and Junior KwikPen® 100 units/ml 3ml pre-filled pens remain available and can support increased demand.
6. This MSAN is the first of two covering supply issues with insulin vials. The second MSAN for *Humulin® S vials* will be issued shortly but should be noted that as the products have similar sounding names appropriate risk minimisation strategies should be implemented to ensure actions are carried out for specific products

#### **Advice and Actions**

7. Prescribers should:
  - not initiate patients on Humalog® vials during this time;
8. Where patients are insulin pump users and have insufficient supplies to last until the re-supply date, prescribers should:
  - consider prescribing either:
    - NovoRapid® 10ml vials for children and young people in paediatric care and women who are pregnant or in the first 12-months following pregnancy; or
    - Trurapi® or NovoRapid® (insulin aspart) vials for adults (including young people under the care of adult diabetes services):  
after discussion with the patient, ensuring that appropriate education and training is provided (see Additional Information section); and
  - ensure that all insulin pump users have a care plan that clearly documents a back-up Multiple Daily Insulin (MDI) regimen in the event of pump failure. The back-up insulin regimen, whether by prefilled insulin pens, or cartridges with pen device, should remain available on repeat prescription at all times so that the patient can request when needed. All

\*<https://www.nss.nhs.scot/media/1842/medicine-supply-alert-notices-definitions-of-classifications-21-october-2019.pdf>

insulin pump users should ensure they have back-up insulin pens/cartridges/needles available, and within the expiry date.

9. Where an individual is administering insulin from a vial with an insulin syringe, prescribers should:

- consider prescribing Humalog® cartridges or Humalog KwikPens®/Junior KwikPens® where appropriate which can support the market during this time, considering the patient's manual dexterity, vision, ability to use the new device correctly and whether support is required with administering the dose; and
- ensure that all patients initiated on a new device are counselled on the change in device, provided with appropriate reusable pens and/or needles and provided with training on their use, including signposting to training videos (see Additional information section), as well as potential need for closer monitoring of blood glucose levels.

10. If the above options are not considered appropriate, advice should be sought from specialist diabetes team on management options.

11. Pharmacy teams should:

- ensure that all patients initiated on a new device are counselled on the change in device, provided with training on their use, including signposting to training videos, and advised closer monitoring of blood glucose levels may be required (see Additional information section).

## **Additional Information**

### Clinical Information

12. Prescriptions for insulin vials are likely to have been initiated in specialist services. Where primary care clinicians have any concern about making changes to the prescription or issuing an alternative, they should seek advice from the specialist diabetes team.

13. Extracting insulin from prefilled pens and cartridges is considered a **NEVER** event and should not occur in clinical practice. Extracting insulin from prefilled pens and cartridges carries a high-risk of insulin administration errors, and in particular, accidental insulin overdose. The risk of an insulin administration error, and the consequences thereof, have the potential for high risk of harm and catastrophic events.

14. For patients using insulin pumps, Trurapi® and NovoRapid® (insulin aspart) vials are considered like-for-like replacements for Humalog® (insulin lispro) vials. There is no need to alter the insulin infusion rate or bolus insulin doses. As a precaution, the patient should be advised to monitor their glucose levels more closely initially. In the event of concerns with new glucose excursions (high or low glucose readings) the patient should be advised to speak to/seek advice from their specialist diabetes team.

15. For children and young people in paediatric care and women who are pregnant or in the first 12-months following pregnancy consider prescribing:

- NovoRapid® 10ml vials.

16. For adults (including young people under the care of adult diabetes services) consider prescribing:

- Trurapi® 10ml vials or NovoRapid® 10ml vials.

17. Very occasionally an individual may have a recorded allergy to a specific insulin preparation. Where this arises, advice should be sought from the specialist diabetes team.

## Counselling points

18. Patients switched to Humalog KwikPens® or Humalog® Junior KwikPens® will require appropriate education and training for administration technique. Patients should also be counselled on how to administer the correct dose. The [user manual](#) for to Humalog KwikPens® can aid the education and training process.
19. Patients who switch to the Humalog® 3ml cartridges, will require HumaPen SAVVIO® medical device, to aid administration, which can be prescribed on an GP10. Patients will require appropriate education and training for administration technique and correct dosing. The [instructions for use](#) for the HumaPen SAVVIO® can aid the education and training process.

## Links to further information

- [BNF – Insulin](#)
- [SmPC – Humalog® 100 units/ml solution for injection 10ml vials](#)
- [SmPC – Humalog® 100units/ml solution for injection in cartridge](#)
- [Instructions for use – HumaPen SAVVIO® medical device](#)
- [SmPC – Humalog KwikPen® 100units/ml solution for injection in a pre-filled pen](#)
- [SmPC – Humalog Junior KwikPen® 100units/ml solution for injection in a pre-filled pen](#)
- [User manual – Humalog® KwikPen® 100units/ml solution for injection in a pre-filled pen](#)
- [SmPC – Trurapi® 100units/ml solution for injection 10ml vials](#)
- [SmPC – NovoRapid® 100 units/ml solution for injection 10ml vials](#)

## **Specialist Pharmacy Service (SPS) website**

20. The UK Department of Health and Social Care (DHSC) in conjunction with SPS have launched an online Medicines Supply Tool, which provides up to date information about medicine supply issues. To access the online Medicines Supply Tool you need to register with the [SPS website](#). Registration for access to the website is available to UK healthcare professionals and organisations providing NHS healthcare. The tool is located under the Tools tab and then click on the Medicines Supply option.
21. We encourage prescribers, pharmacy professionals, and pharmacy procurement leads in Scotland to register with the SPS website and use its Medicine Supply Tool to stay up to date concerning medicines supply disruptions. Please be aware that while medicines supply issues will appear on the SPS website, some of the recommended actions may not always be appropriate / relevant within the Scottish context.

## **Enquiries**

22. Enquiries from Health Boards or healthcare professionals should be directed in the first instance to [PharmacyTeam@gov.scot](mailto:PharmacyTeam@gov.scot) (primary care) or [NSS.NHSSMedicineShortages@nhs.scot](mailto:NSS.NHSSMedicineShortages@nhs.scot) (secondary care).