Mid and South Essex Health and Care Partnership

NHS

MID AND SOUTH ESSEX MEDICINES OPTIMISATION COMMITTEE (MSEMOC)

INSULIN ASPART (FIASP®) FOR THE TREATMENT OF DIABETES MELLITUS

YELLOW - RECOMMENDED FOR RESTRICTED USE - for initiation in Secondary or Community care and continuation in Primary Care

Name: generic (trade)	What it is	Licensed indication	Decision status	NICE/SMC guidance
Insulin aspart (Fiasp®)	Rapid-acting insulin analogue	Treatment of diabetes mellitus in children (aged 1 year and above) and adults.	Final	NICE – no guidance SMC- accepted for use in diabetes mellitus in adults only

MSEMOC recommendation:

Insulin aspart (Fiasp®) is RECOMMENDED FOR RESTRICTED USE in defined patient groups who are not well controlled with current mealtime (bolus) insulin FOLLOWING INITIATION AND STABILISATION BY A DIABETES SPECIALIST:

1. **Type 1 and type 2 diabetes in adults, adolescents, children aged 1 year and above, pregnant women (including gestational diabetes mellitus) on basal bolus insulin needing tight control or has rapid post meal blood glucose (BG) rise**
2. **Type 1 and type 2 diabetes on continuous subcutaneous insulin infusion (CSII) pump**

- **Initiation, titration and stabilisation must be undertaken by consultants or a consultant led diabetes specialist team (for a minimum of 3 months or until patient is stable). Once stabilised and beneficial response demonstrated for continuation in primary care with patient specific information provided by the specialist.**

- **Prescribe BY BRAND to ensure brand/product continuity and minimise the risk of substitution and medication errors.**

This recommendation will be subject to review if biosimilar preparations of insulin aspart become available.

Providers commissioned to provide services on behalf of Mid and South Essex CCGs are reminded that they are required to follow the local joint formulary and prescribing guidance, as detailed in the medicines management service specification of their contract.

Background information:

• Fiasp® is licensed for the management of type 1 and 2 diabetes in adults, adolescents and children aged 1 year and above. It is a fast acting mealtime insulin aspart formulation including nicotinamide (vitamin B3), which results in a faster initial absorption of insulin compared to NovoRapid® (which only contains insulin aspart).
• The summary of product characteristics states that onset of action is 5 minutes earlier with Fiasp® compared to NovoRapid®. It has a half-life of 57 minutes which is comparable to NovoRapid®.
• It is for subcutaneous administration up to 2 minutes before the start of the meal, with the option to administer up to 20 minutes after starting the meal.
• The dose regimen (dose and timing) may vary and is usually between 0.5 and 1.0 unit/kg/day which is adjusted according to individual response.
• Each mL contains 100 units insulin aspart, which is the same active ingredient as in NovoRapid®. It is available in a 3mL cartridge (for penfill), pre-filled pen (FlexTouch pen), and 10 mL vial.
• The formulary application proposes that it is used in T1DM and T2DM as an alternative mealtime (bolus) insulin that may benefit adults, adolescents, children of 1 year and above, pregnancy and continuous subcutaneous insulin infusion (CSII).
• Fiasp® and NovoRapid® are not interchangeable due to differences in bioavailability (Fiasp® has a quicker onset of action and shorter duration) and different release profiles. Patients should be advised of non-interchangeability and to routinely check labels prior to injecting. All insulin should be prescribed by brand on prescriptions in all care settings to avoid dispensing and administration errors.
• The shelf-life is 30 months at 2-8°C, including an in-use period of up to 28 days up to 30°C. Note the shelf life for other short acting insulins is longer (for e.g. 3 years for insulin lispro) while the in-use period information is similar.
• Rapid-acting insulin analogue, insulin lispro (Humalog®) is licensed for use in children aged 2 and above and rapid-acting insulin analogue, insulin glulisine (Apidra®) is licensed for use in children aged 6 and above.

ASSESSMENT AGAINST THE ETHICAL FRAMEWORK

Evidence of Clinical Effectiveness:

Vs NovoRapid (ONSET 1 trial).

- Objective: To validate the non-inferiority of Fiasp® to NovoRapid®.
- Design: Randomised, double blind non-inferiority study (non-inferiority limit of HbA1c set at 0.4%) which compared NovoRapid® with Fiasp®, patients (n=1,143) for 26 + 26 week extension. Both were taken 0-2 minutes before the start of meals.
- Patients: Adults with T1DM, baseline BMI ≤35.0 kg/m2, already on basal-bolus insulin for ≥ 12 months. HbA1c 7.0-9.5% (53-80 mmol/mol). Note patients were not receiving any other antidiabetic drugs.
- Intervention and Comparison: Patients were randomised 1:1 to receive either NovoRapid® or Fiasp® as part of the Basal-bolus (with once- or twice-daily insulin detemir).
- Primary Outcome: The Change in HbA1c from baseline (primary outcome): Fiasp®: -0.32% NovoRapid®: -0.17% TD: -0.15% (95% CI -0.23 to -0.07) (non-inferiority demonstrated).
- Other Outcomes:
  - (i) Change in HbA1c from baseline (post-meal Fiasp®): post-meal Fiasp®: -0.13 mealtime NovoRapid®: -0.17% TD: 0.04% (-0.04 to 0.12) (non-inferiority demonstrated).
  - (ii) Reduction in 2-hour PPG increment (mmol/L) (baseline post prandial glucose (PPG) not reported) was Fiasp®: -0.3 NovoRapid®: 0.4 TD: 0.67 (95%CI -1.29 to -0.04) (superiority demonstrated).
  - (iii) Change/increase in bodyweight : Fiasp®: 0.7 kg NovoRapid®: 0.6 kg TD: 0.12 kg (95%CI -0.30 to 0.55) (no statistical difference).
- Safety: Observed rate of severe or BG confirmed hypoglycaemic episodes, no difference between treatment groups in mean rates of hypoglycaemia (92.7% vs 97.4%, [Treatment ratio 1.01 (0.88 to 1.15 p=0.54)]. However, the incidence of severe or plasma glucose-confirmed hypoglycaemia within one hour of administration was higher with mealtime Fiasp® than NovoRapid® (33.9% vs. 28.4%).

Vs NovoRapid (ONSET 2 trial)

- Objective: To validate the non-inferiority of Fiasp® to NovoRapid®.
- Design: Randomised, double blind non-inferiority study which compared NovoRapid® with Fiasp®, patients (n=689) for 26 + 26-week extension. Both were taken 0-2 minutes before the start of meals.
- Patients: Adults with T2DM, baseline BMI ≤40.0 kg/m2, already on basal-bolus insulin and oral antidiabetic drugs for ≥ 6 months. HbA1c 7.0-9.5% (53-80 mmol/mol).
- Intervention and Comparison: Patients were randomised 1:1 to receive either NovoRapid® or Fiasp® as part of the Basal-bolus (with insulin glargine).
- Primary Outcome: The Change in HbA1c from baseline (primary outcome): Fiasp® -1.38% NovoRapid®: -1.36% TD -0.02% (95% CI -0.15 to 0.10) (non-inferiority demonstrated).
- Other Outcomes:
  - (i) Reduction in 2-hour PPG increment (mmol/L) (baseline post prandial glucose (PPG) not reported) was Fiasp®: -3.2 NovoRapid®: -2.9 TD: -0.36 (95%CI -0.81 to -0.08).
  - (ii) Change/increase in bodyweight : Fiasp®: 2.7 kg NovoRapid®: 2.7 kg TD: 0kg (95%CI -0.60 to 0.61) (no statistical difference).
- Safety: Observed rate of severe or BG confirmed hypoglycaemic episodes, no significant difference in hypoglycaemia observed (76.8% vs 73.3%, [Treatment ratio 1.09 (0.88 to 1.36)].

Vs Basal Insulin (ONSET 3 trial)

- Objective: To validate superiority of Fiasp® plus Basal Insulin to Basal insulin alone.
- Design: Randomised, open-label, superiority, patients (n=236) for 18 weeks. Both were taken 0-2 minutes before the start of meals.
- Patients: Adults with T2DM, baseline BMI ≤40.0 kg/m2, already on basal-bolus insulin and oral antidiabetic drugs for ≥ 3 months. HbA1c 7.0-9.5% (53-80 mmol/mol).
- Intervention and Comparison: Patients were randomised 1:1 to receive either Fiasp® as part of the Basal-bolus insulin (with detemir, glargine or neutral protamine Hagedorn (NPH) or Basal insulin only.
- Primary Outcome: The change in HbA1c from baseline: Fiasp -1.16% Basal Insulin: -0.22% TD -0.94% (95% CI -1.17 to -0.72) (superiority demonstrated).
- Other Outcomes: None were evaluated.

Onset 3 was not a head to head study vs NovoRapid®, therefore, benefit vs NovoRapid® cannot be inferred.

Vs NovoRapid (ONSET 4 trial)

- Objective: To evaluate the compatibility and safety of Fiasp® and NovoRapid® with an External Continuous Subcutaneous Insulin Infusion System (microscopically confirm episodes of infusion set occlusions)
- Design: Randomised (2:1), double-blind, multicentre, multi-national parallel-group open-label, patients (n=37) for 6 weeks.
- Patients: Adults with T1DM, baseline BMI 20-35 kg/m2, using an external CSII system for previous 6 months receiving insulin aspart, insulin lispro or insulin gluisine for at least 3 months prior to screening. HbA1c below or equal to 9%.

- Intervention and Comparison: Patients were randomised 2:1 and had their insulin in the CSII switched to either Fiasp® (n=25) or NovoRapid® (n=12).
- Primary Outcome: No microscopically confirmed episodes of infusion set occlusions were observed with treatment with either Fiasp® or NovoRapid® (supporting compatibility with pump system).
- Other outcomes: Evaluating short-term efficacy and safety.
- Safety: Higher frequencies of infusion site reactions were noted (13% vs 8% respectively), no serious adverse events were recorded.

Vs NovoRapid (ONSET 7 trial)

- Objective: To validate non- inferiority of faster-acting insulin aspart compared to NovoRapid® in combination with insulin degludec in children and adolescents with type 1 diabetes.
- Design: Randomised, parallel assignment, multi-national (n = 834) for 26 weeks.
- Patients: Children with T1DM male or female, 1 year to 17 years on ongoing daily treatment with basal-bolus insulin regimen using basal insulin analogue or Neutral Protamine Hagedorn (NPH) insulin for at least 90 days. HbA1c below or equal to 9.5%.
- Intervention and Comparison: Three randomised patient intervention arms: 1) Basal-bolus insulin (insulin degludec) with Fiasp® (at meal time- 0 to 2 minutes before the meal) 2) Basal-bolus insulin (insulin degludec) with NovoRapid® (meal time- 0 to 2 minutes before the meal) and 3) Basal-bolus insulin (insulin degludec) with Fiasp® (post meal- 20 minutes after start of the meal).
- Primary Outcome: The change in HbA1c from baseline: Fiasp® (meal time) vs NovoRapid® (meal time) non-inferiority demonstrated (p<0.001, treatment difference -0.17, 95% CI -0.30 to -0.03). Fiasp® (post meal) vs NovoRapid® (meal time) non-inferiority demonstrated (p<0.001, treatment difference 0.13, 95% CI -0.01 to 0.26).
- Other key outcomes:
  (i) Change in 1-hour & 2-hour PPG: no statistically significant difference between mealtime faster aspart and mealtime IAsp in change from baseline after 26 weeks in 30-min P=0.567; 1-h P=0.461; 2-h, P=0.074 PPG increment.
- Safety: No clinically relevant differences were observed in the adverse event profiles across treatment groups during the 26-week treatment period (supplementary Table 10) or with regard to vital signs, antibody measurements, injection site reactions, body measurements (BMI, body weight, and height), physical examination, Tanner staging, and safety laboratory assessments (biochemistry, haematology, lipids, and urinalysis). Overall rate of severe or BG-confirmed hypoglycaemic episodes was comparable between mealtime faster aspart and mealtime IAsp, and also between postmeal faster aspart and mealtime IAsp (estimated rate ratio for both comparisons 1.11 [95% CI 0.90; 1.37]).

Limitations (ONSET 1, ONSET 2, ONSET 3 and ONSET 4, ONSET 7 trials):

- Fiasp® is a 'black triangle' (▼) product. It is therefore subject to additional monitoring.
- Long term safety data was limited due to the short durations of the trials.
- Trial end points and objectives were in line with EMA guidance on medicines for diabetes.
- There was no significant difference in HbA1c between the groups in ONSET 1 and ONSET 2; however, the duration of the study was short.
- Both ONSET 1 and ONSET 2 demonstrated superior postprandial glucose control at 1 hour for mealtime Fiasp® compared to mealtime NovoRapid®. The improvement in PPG control could possibly be of clinical relevance, but it is uncertain if the effect on PPG is an independent marker of risk considering the limited effect on HbA1c. Further, the effect of improved PPG control decreased over time.
- Superior postprandial control offered by Fiasp® use may benefit pregnant patients trying to achieve tighter postprandial glycaemic control in line with the NICE guideline for pregnancy.
- There was a significant difference in HbA1c between the groups in ONSET 3; however, the duration of the study was short.
- It may be considered that the documented differences in efficacy or safety (i.e. changes in glycaemic control and/or the timing of hypoglycaemias) between Fiasp® and NovoRapid® are not of sufficient clinical relevance to consider Fiasp® a different medicinal product.
- EMA's (European Medicines Agency) assessment report stated that 'no dose-finding study has been performed which is acceptable, considering that the pharmacology program show that the glucose-lowering effect of Fiasp® is comparable to that of NovoRapid®. Furthermore, the insulin dose is titrated based on blood glucose levels.'
- There are no comparative studies of post-meal NovoRapid® versus post-meal Fiasp®.
- In the ONSET 1 and ONSET 2 trials, the rates of hypoglycaemic events at 1 hour and 2 hours post-meal were greater in the Fiasp® patient group than the NovoRapid® patient group.
- The ONSET 3 study supported the use of basal-bolus insulin in patients inadequately controlled on basal insulin, although the study did not provide any additional evidence to support the use of Fiasp® over other bolus insulins.
- There was an apparent increase in the frequency of injection site reactions in the Fiasp® group compared to the NovoRapid® group especially in type 1 diabetic patients.
- The only oral antidiabetic drugs patients received was metformin (ONSET 1, 2 & 3 studies).
- The studies were initiated and sponsored by Novo Nordisk.

Safety

- Fiasp® has similar contraindications, adverse effects & interactions as NovoRapid®.
- Apart from differences in the timing of the hypoglycaemic episodes in ONSET 1 and ONSET 2, no significant differences of clinical importance in the pattern, proportions and rates of adverse events were identified between Fiasp® and NovoRapid® in either type 1 or type 2 diabetes mellitus.
- In ONSET 1 the mealtime Fiasp® had a comparably higher rate of hypoglycaemic episodes (severe or BG confirmed) in the first and second hour after the meal compared to NovoRapid® in patients with type 1 diabetes.
- In ONSET 2 for patients with type 2 diabetes the overall rates of hypoglycaemic episodes two hours after meal was higher for Fiasp® than for NovoRapid® (33.9% vs 28.4%), although not statistically significant (a difference was also seen the first hour after meals whish was also not statistically significant).
- Excluding hypoglycaemia, the sponsor of the trials reported no serious adverse events occurring in ≥1% of subjects.
- Fiasp® and Novorapid® are not interchangeable due to differences in bioavailability (Fiasp® has a quicker onset of action and shorter duration) and different release profiles. Patients should be advised of non-interchangeability and to routinely check labels prior to injecting. All insulin should be prescribed by brand on prescriptions in all care settings to avoid dispensing and administration errors.
- EMA's pooled analysis of ONSET 1, 2 and 3 concluded that of the rates of injection site reactions were higher for Fiasp® (23 events) than for the comparators (10 events) (3.8 and 2.4 events per 100 PYE, respectively). None of these injection site reactions were serious or severe.
  Safety from Summary of Product Characteristics (SPC)
- Fiasp® can be used in pregnancy.
- Adverse reactions listed below (Table 1) are based on 6 completed therapeutic confirmatory trials in adults. Frequency categories are defined according to the following convention: Very common (≥ 1/10); common (≥ 1/100 to < 1/10); uncommon (≥ 1/1,000 to < 1/100); rare (≥ 1/10,000 to < 1/1,000); very rare (< 1/10,000) and not known (cannot be estimated from the available data).

MedDRA System Organ Class	Very common	Common	Uncommon	Not known
Immune system disorders			Hypersensitivity	Anaphylactic reactions
Metabolism and nutrition disorders	Hypoglycaemia			
Skin and subcutaneous tissue disorders		Allergic skin manifestations	Lipodystrophy	Cutaneous amyloidosis†
General disorders and administration site conditions		Injection/infusion site reactions		

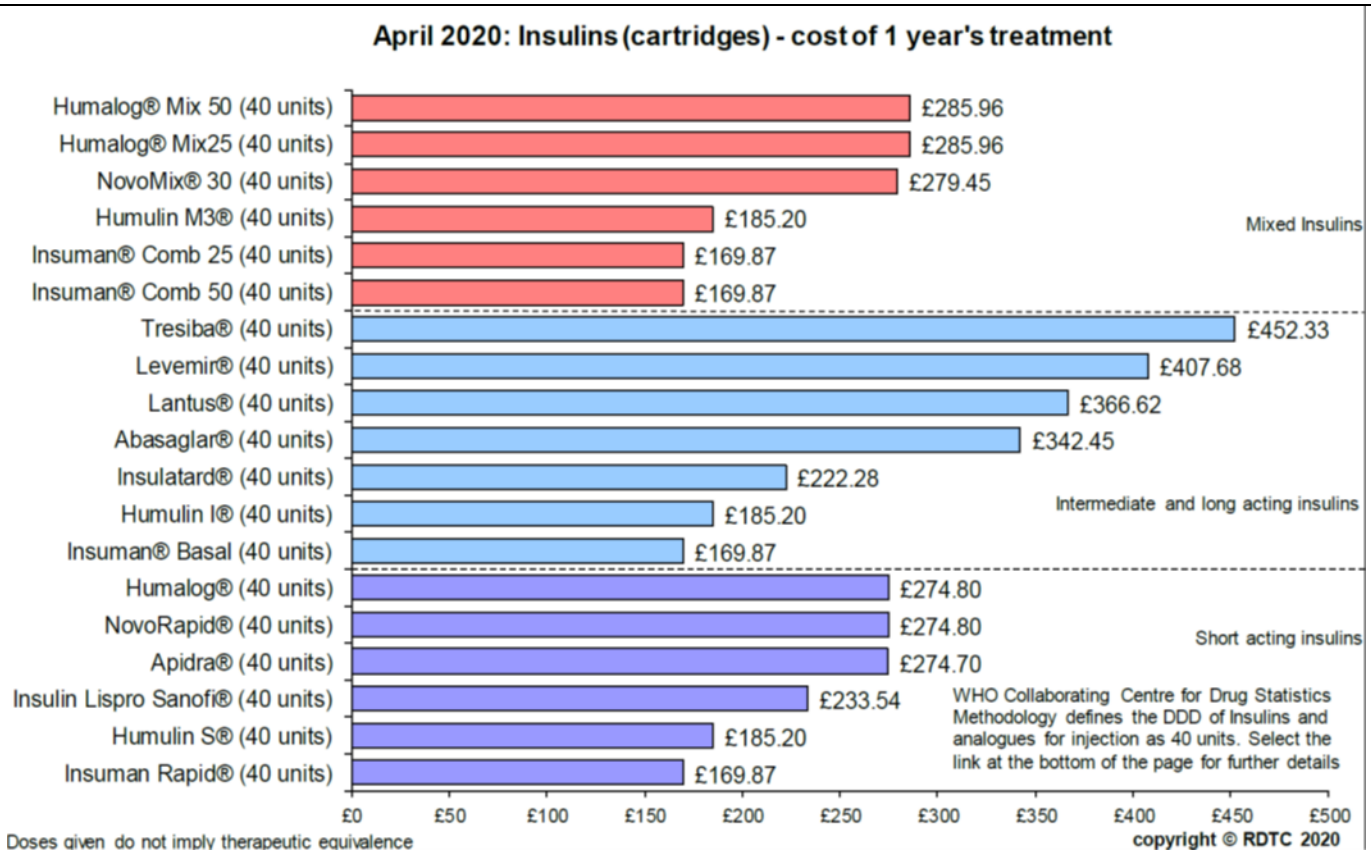
Table 1 Adverse reactions from clinical trials

The SPC warns that the safety profile in patients ≥ 75 years or patients with severe renal/hepatic impairment is limited and Fiasp® should be used with caution in these groups of patients.

Cost of treatment and Cost Effectiveness:

- Scottish Medicines Consortium has accepted Fiasp® for use within NHS Scotland as it is available at an equivalent cost to the other insulin aspart formulations.

NYRDTC Drug Cost comparison chart (April 2020)



Costs are for general comparison only and do not imply therapeutic equivalence. Costs based on a defined daily dose (DDD) of 40 units as recommended by the World Health Organisation. EMA concluded that no dose finding study has been performed and is acceptable.

Costs compared to alternatives (costs based on a DDD of 40 units annual cost)

Insulin	Annual cost per patient vial (£)	Annual cost per patient 5x3ml cartridge (£)	Annual cost per patient 5x3ml pre-filled pen (£)	Annual cost per patient 5x3ml pre-filled pen (£)
NovoRapid® (Insulin aspart 100 units/ml solution)	205.71	275.74	298.04 (FlexPen)	312.95 (FlexTouch)
Fiasp® (Insulin aspart 100 units/ml solution)	205.71	275.74	----------	298.04 (FlexTouch)
Humalog® (Insulin lispro 100 units/ml solution)	242.5	275.74	286.74 (KwikPen)	----------
Biosimilar Humalog® (Insulin lispro Sanofi 100 units/ml solution)	206.15	234.18	243.72 (Pre-filled pen)	----------
Apidra® (Insulin glulisine 100 units/ml solution)	233.6	275.74	275.74 (SoloStar)	----------

The needs of the population:

• The needs of the population may be low as there are alternative bolus insulins available.

• It appears to offer no particular clinical benefits over NovoRapid®, however, would be an option for a cohort of patients with sub-optimal control who may benefit from treatment with a rapid acting bolus insulin, Fiasp® as highlighted by the specialists.

The needs of the community:

• The needs of the community may be low as the estimated patient numbers for treatment are low.

• There would currently be no increased costs if patients prescribed Fiasp® instead of NovoRapid®.

Equity and Equality:

• No impact anticipated. Guidance applies to all relevant patients where indicated. There is no differential impact expected on one or more equality groups differently to others Age, Disability; Gender reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual orientation.

Policy drivers:

• Scottish Medicines Consortium: accepted for use within NHS Scotland for the treatment of diabetes mellitus in adults.

• RDTC New Drug Evaluation: Concluded that Fiasp® appears to be an option for people with diabetes who require a rapid-acting bolus insulin analogue. There are no apparent differences or clinical advantages between Fiasp® and NovoRapid®.

• NICE guideline NG17: Type 1 diabetes in adults – diagnosis and management

1.Offer rapid-acting insulin analogues injected before meals, rather than rapid-acting soluble human or animal insulins, for mealtime insulin replacement for adults with T1DM.

2. Do not advise routine use of rapid-acting insulin analogues after meals for adults with T1DM.

3. If an adult with T1DM has a strong preference for an alternative mealtime insulin, respect their wishes and offer the preferred insulin.

• NICE guideline NG28: Type 2 diabetes in adults – management

1. Start insulin therapy for adults with T2DM from a choice of insulin types and regimens:

Offer NPH insulin injected once or twice daily according to need.

2. Consider starting both NPH and short-acting insulin (particularly if the person's HbA1c is 75 mmol/mol [9.0%] or higher), administered either: separately or as a pre-mixed (biphasic) human insulin preparation.

a. Monitor adults with T2DM who are on a basal insulin regimen (NPH insulin, insulin detemir or insulin glargine) for the need for short-acting insulin before meals (or a pre-mixed [biphasic] insulin preparation).

b. Monitor adults with T2DM who are on pre-mixed (biphasic) insulin for the need for a further injection of short-acting insulin before meals or for a change to a basal bolus regimen with NPH insulin or insulin detemir or insulin glargine, if blood glucose control remains inadequate.

• NICE guideline NG3: Diabetes in pregnancy

The NICE diabetes in pregnancy guidelines recommend that metformin is offered to all women with gestational diabetes if blood glucose targets are not met using changes in diet and exercise within 1-2 weeks.

a. Offer insulin instead of metformin to women with gestational diabetes if metformin is contraindicated or unacceptable to the woman.

b. Offer addition of insulin to the treatments if changes in diet, exercise and metformin for women with gestational diabetes if blood glucose targets are not met.

c. Offer immediate treatment with insulin, with or without metformin, as well as changes in diet and exercise, to women with gestational diabetes who have an FPG glucose level of 7.0 mmol/L or above at diagnosis.

d. Consider immediate treatment with insulin, with or without metformin, as well as changes in diet and exercise, for women with gestational diabetes who have an FPG level of between 6.0 and 6.9 mmol/L if there are complications such as macrosomia or hydramnios.

e. Be aware that the rapid-acting insulin analogues (aspart and lispro) have advantages over soluble insulin during pregnancy and consider their use.

f. Be aware that data from clinical trials and other sources do not suggest that the rapid-acting insulin analogues (aspart and lispro) adversely affect the pregnancy or the health of the foetus or newborn baby.

• NICE TA151: Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus

1.Continuous subcutaneous insulin infusion or insulin pump therapy is recommended as a possible treatment for adults and children 12 years and over with T1DM if:

a. attempts to reach target haemoglobin A1c (HbA1c) levels with multiple daily injections result in the person having ‘disabling hypoglycaemia', or

b.HbA1c levels have remained high (8.5% or above) with multiple daily injections (including using long-acting insulin analogues if appropriate) despite the person and/or their carer carefully trying to manage their diabetes.

2. CSII therapy is not recommended for the treatment of people with T2DM.

Note that there are no specific recommendations for choice of insulin, however, long acting insulins were used as part of the clinical and cost effective analysis model.

• EoE Priorities Advisory Committee Guidance Statement (March 2018): NOT RECOMMENDED for routine prescribing in primary or secondary care in adults and children

EoE CCG decisions:

1. Mid Essex CCG (Jan 2019): Recommended for use in primary care after 3-month stabilisation period by specialist.

2. Bedfordshire and Luton Joint Prescribing Committee, BLMK CCGs (Nov 2018): Do not recommend the use of faster acting insulin aspart (Fiasp®) for routine prescribing in primary or secondary care in adults and children

3.Cambridgeshire and Peterborough CCG (accessed October 2020):

Restricted to endocrine specialist initiation for:

-Type 1 Diabetes mellitus patients (including pregnant patients), using either basal bolus therapy (long-acting insulin with current fast acting analogues) or continuous subcutaneous insulin infusion (CSII) (current fast acting analogues) where there is a * *clinical suspicion that post meal hyperglycaemia is contributing to sub-optimal control of blood glucose.

*a.regular postprandial glucose “spikes” 1 to 3 hours after eating of 8>mmol/mol.

b.spikes are occurring despite optimisation of all other factors such as correct background insulin delivery (whether background insulin injections or basal infusion rates in insulin pumps), correct timing of bolus injections, optimised carbohydrate counting, injection technique/site.

c.the spikes are a problem-either because people feel unwell and/or because their HbA1c is sub-optimal. There are no other insulin regimens that could be trialled for this indication.

4.Medicines Optimisation Programme Board, West Essex CCG, Herts and West Essex Integrated Care Partnership (Dec 2017): Fiasp® Initiated and monitored by an endocrinologist for 3 months, if beneficial, GP can take over prescribing in primary care.

5. HMMC, ENHCCG & HVCCG, Herts and West Essex Integrated Care Partnership (Dec 2017): Recommended for restricted use in defined patient groups who are not well controlled with current mealtime (bolus) insulin following initiation by a specialist:

1. Type 1 diabetes on continuous subcutaneous insulin infusion (CSII) pump

2. Type 1 diabetes on basal bolus needing tight control or has rapid post-meal blood glucose (BG) rise

3. Pregnant women with diabetes mellitus (Type 1 diabetes; Type 2 diabetes including gestational diabetes Mellitus (GDM))

Other decisions include:

1. Greater Manchester Medicines Management Group (GMMG) (accessed October 2020):
Recommended for restricted use only in:
- Are pregnant or planning a pregnancy
- Have postprandial glucose >10 mmol at 2 hours

2. South East London Area Prescribing Committee (January 2020):
Restricted for use as a second-line fast acting insulin option in patients with diabetes mellitus where the first line rapid acting insulin analogue does not provide adequate postprandial plasma glucose (PPG) control. Use of Fiasp® as a second line option is approved in the following patient cohorts only:
- Adult patients with Type 1 diabetes mellitus (T1DM) or cystic fibrosis related diabetes with sub-optimal control of PPG excursions that is impairing ability to achieve target glycaemic control.
- Pregnant women with diabetes (T1DM or Type 2 DM) or gestational diabetes where postprandial control is of particular importance for foetal health.
- Where a post-meal insulin injection would be of benefit to PPG control due to social, physiological or psychological reasons (Fiasp® can be administered up to 20 minutes after starting the meal versus Novorapid® and Humalog® which are to be administered pre-meal only).

Implementability:

- Prescribers should consult the summary of product characteristics and any MHRA safety advice when commencing treatment.
- Prescribe **BY BRAND** to ensure brand/product continuity and minimise risk of substitution at the point of dispensing.
- Patients need to understand the differences between Fiasp® and NovoRapid® to minimise the risk of medication error.
- Patients must be able to use the available insulin pen i.e. FlexTouch® pen.

References	• European Public Assessment Report. Fiasp. 10 November 2016. Procedure No. EMEA/H/C/004046/0000. http://www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Public_assessment_report/human/004046/WC500220940.pdf •Regional Drug and Therapeutics Centre RDTC: Fast-acting insulin aspart for treatment of diabetes mellitus (July 2017) http://rdtc.nhs.uk/sites/default/files/publications/nde-152-fast-acting-insulin-aspart-01.pdf • Scottish Medicines Consortium (Advice April 2017) https://www.scottishmedicines.org.uk/SMC_Advice/Advice/1227_17_insulin_aspart_Fiasp/insulin_aspart_Fiasp • NICE guideline NG17. Type 1 diabetes in adults: diagnosis and management (Updated July 2016). https://www.nice.org.uk/guidance/conditions-and-diseases/diabetes-and-other-endocrinal--nutritional-and-metabolic-conditions/diabetes • NICE guideline NG28. Type 2 diabetes in adult (Updated August 2019). https://www.nice.org.uk/guidance/conditions-and-diseases/diabetes-and-other-endocrinal--nutritional-and-metabolic-conditions/diabetes • NICE TA151 Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus https://www.nice.org.uk/guidance/conditions-and-diseases/diabetes-and-other-endocrinal--nutritional-and-metabolic-conditions/diabetes • Medicines Optimisation Programme Board, West Essex CCG (Accessed October 2020): https://westessexccg.nhs.uk/your-health/medicines-optimisation-and-pharmacy/clinical-guidelines-and-prescribing-formularies/06-endocrine-system/2521-prescribing-formulary-endocrine/file • HMMC, Herts and West Essex Integrated Care Partnership (Accessed October 2020): https://hertsvalleysccg.nhs.uk/application/files/9215/3633/4418/Insulin_aspart_Fiasp_for_diabetes_201712_HMMC.pdf • Greater Manchester Medicines Management Group (GMMG) (Accessed October 2020): http://gmmmg.nhs.uk/docs/formulary/ch/Ch6-complete.pdf • Bedfordshire and Luton Joint Prescribing Committee (Accessed October 2020): https://medicines.blmkccg.nhs.uk/guideline/faster-acting-insulin-aspart-fiasp-new-formulation-bulletin-269/ • Novo Nordisk Ltd. Summary of product characteristics. Fiasp 100 units/mL solution for injection. (Accessed October 2020): https://www.medicines.org.uk/emc/medicine/33022 Date of revision of the text 09/2020 • Specialist Pharmacy Service. Accessed (Accessed October 2020): https://www.sps.nhs.uk/wp-content/uploads/2020/03/Fiasp-product-safety-assessments-Jan-2020.pdf • East of England Priorities Advisory Committee: Guidance Statement Faster acting insulin aspart (Fiasp®): New formulation (March 2018): https://www.prescqipp.info/umbraco/surface/authorisedmediasurface/index?url=%2fmedia%2f3251%2ffaster-acting-insulin-aspart-fiasp-10.pdf • South East London Area Prescribing Committee (Accessed October 2020): www.lambethccg.nhs.uk/news-and-publications/meeting-papers/south-east-london-area-prescribing-committee • Cambridgeshire and Peterborough Joint Prescribing Group (Accessed October 2020): www.cambridgeshireandpeterboroughformulary.nhs.uk/
Acknowledgements	Mid and South Essex CCGs Medicines Management Teams
Version	1.0
Author	HCPMSEMOC working group
Approved by	MSEMOC; MSE Joint Committee
Date Approved	December 2020
Review Date	December 2025 or sooner if subject to any new updates nationally