CARDIO SCOPIE

iCANN LIFE SCIENCES

Cardiovascular risk in type 2 diabetes : time for action

Satellite Symposium Novo Nordisk

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CHU UCL Namur

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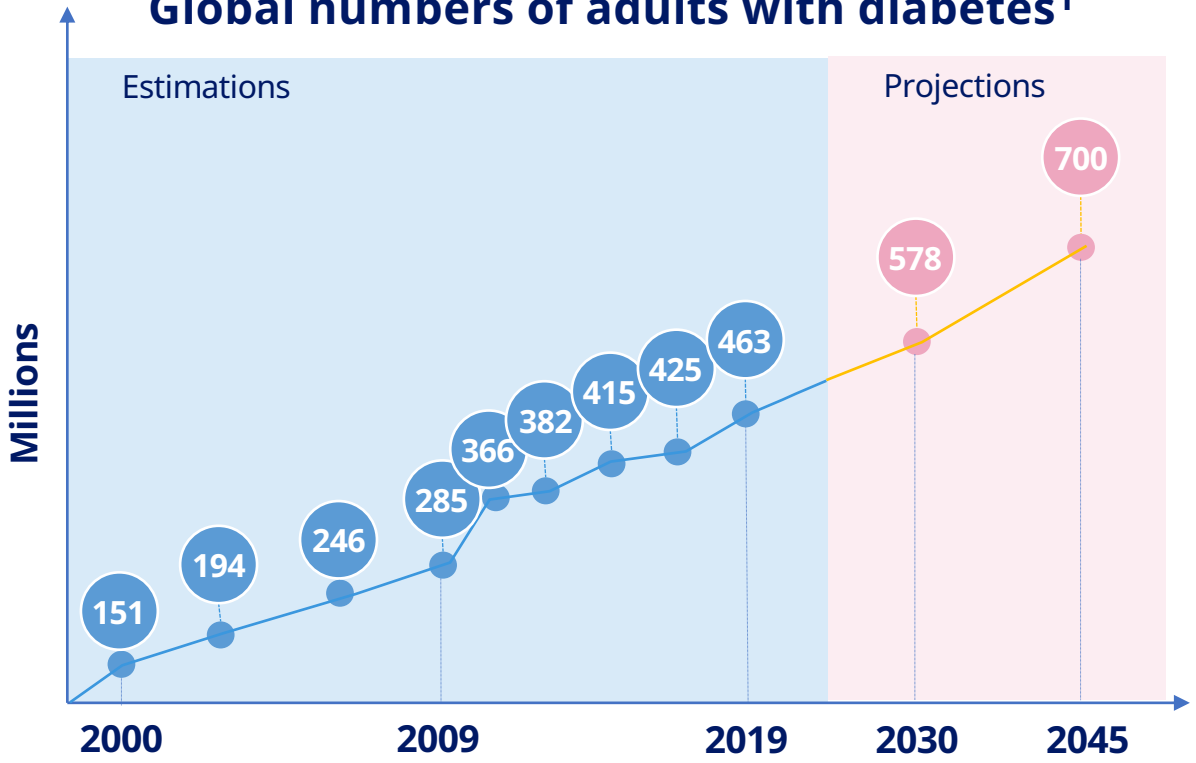
Disclosure

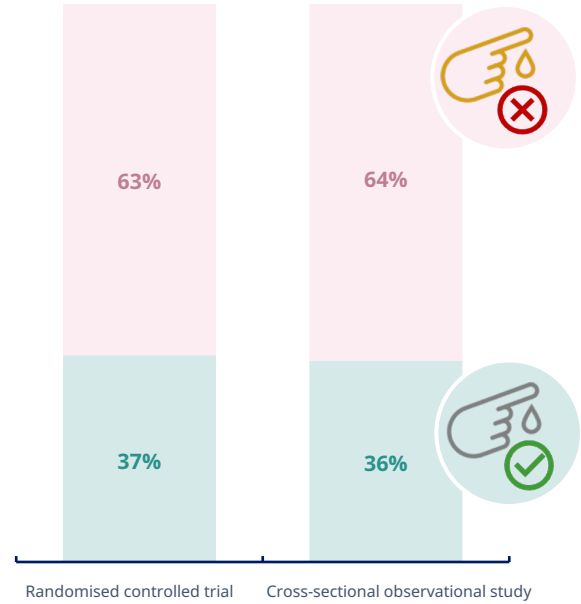
Consulting fees and/or honoraria for delivering lectures and for consultancy/advisory board (payements to CHU UCL Namur) from Novonordisk, Sanofi, Daiichi-Sankyo, Novartis, Servier, Johnson&Johnson, Astra-Zeneca

The global diabetes burden is increasing and remains largely uncontrolled despite current treatments

Global numbers of adults with diabetes[1]



>60% of people with T2D have **poor glucose control** (HbA_{1c} ≥7%) according to a meta-analysis[2]



T2D, type 2 diabetes; HbA1c, glycated haemoglobin

1. International Diabetes Federation, Diabetes Atlas 9th edition 2019. Available at: https://diabetesatlas.org/en/. Accessed October 2021; 2. Mannucci E et al. J Endocrinol Invest 2014;37:477–95.

Atherosclerotic cardiovascular disease is a burden in T2D

Atherosclerosis[1]

The formation of 'fibro-fatty' lesions in the artery wall

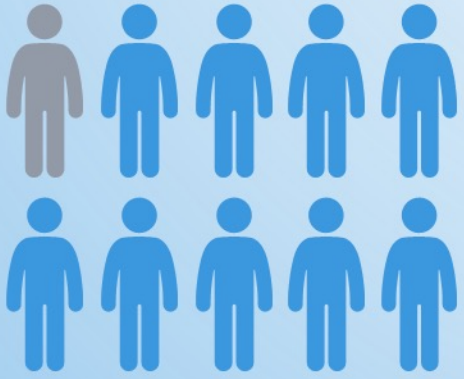
Primary cause of most CVD

- Myocardial infarction
- Stroke
- Peripheral artery disease

CVD accounts for around half of all deaths in T2D[2]

Nearly 1 in 3 people with T2D have CVD[2,3]

of those with established CVD

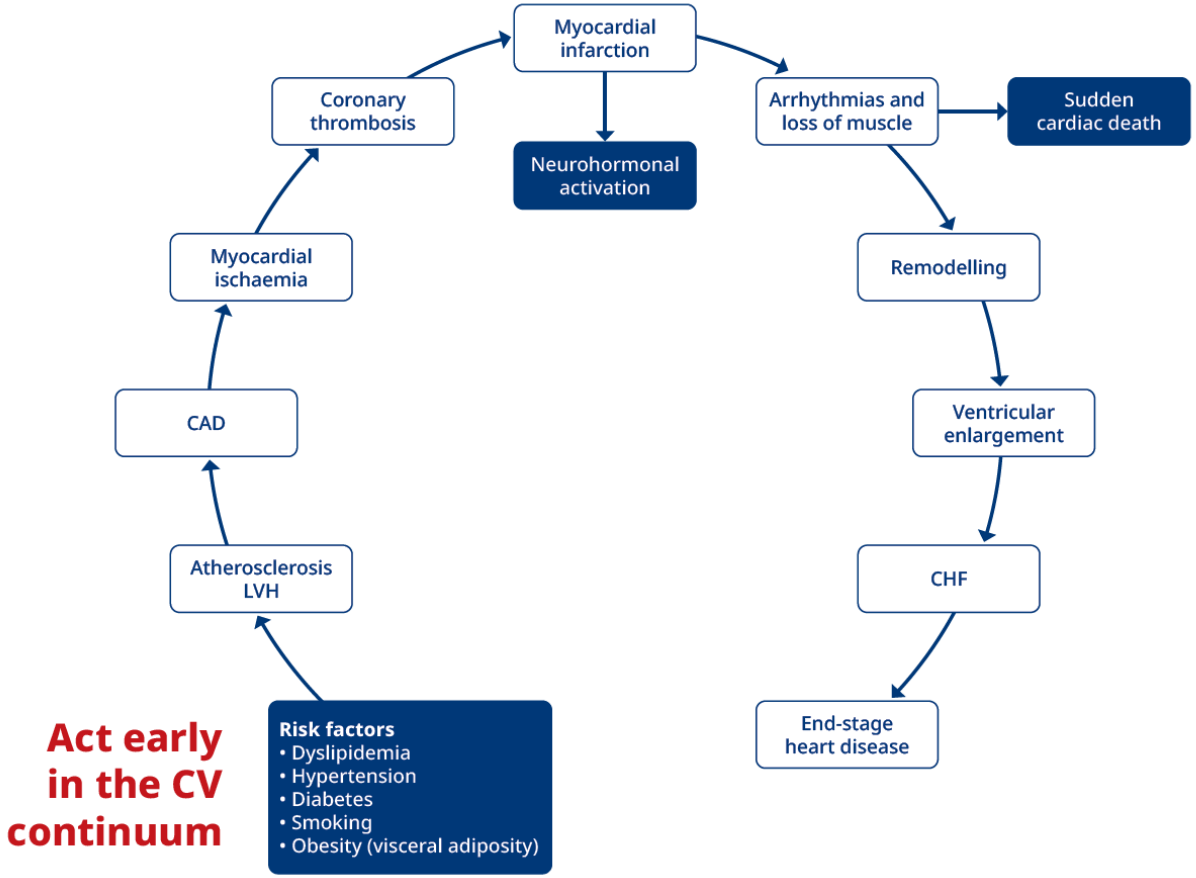


9 out of 10 have ASCVD[2,3]

ASCVD, atherosclerotic cardiovascular disease; CVD, cardiovascular disease; T2D, type 2 diabetes

Adapted from 1. Libby P, et al. Nat Rev Dis Primers 2019;16(1):56:https://doi.org/10.1038/s41572-019-0106-z; 2. Einarson TR, et al. Cardiovasc Diabetol 2018;17(83): https://doi.org/10.1186/s12933-018-0728-6.; 3. McGurnaghan S, et al. Diabet Med 2019;36(6):718–25.

The various stages of the CV continuum



Victor J. Dzau. Circulation. The Cardiovascular Disease Continuum Validated: Clinical Evidence of Improved Patient Outcomes, Volume: 114, Issue: 25, Pages: 2850-2870, DOI: (10.1161/CIRCULATIONAHA.106.655688)

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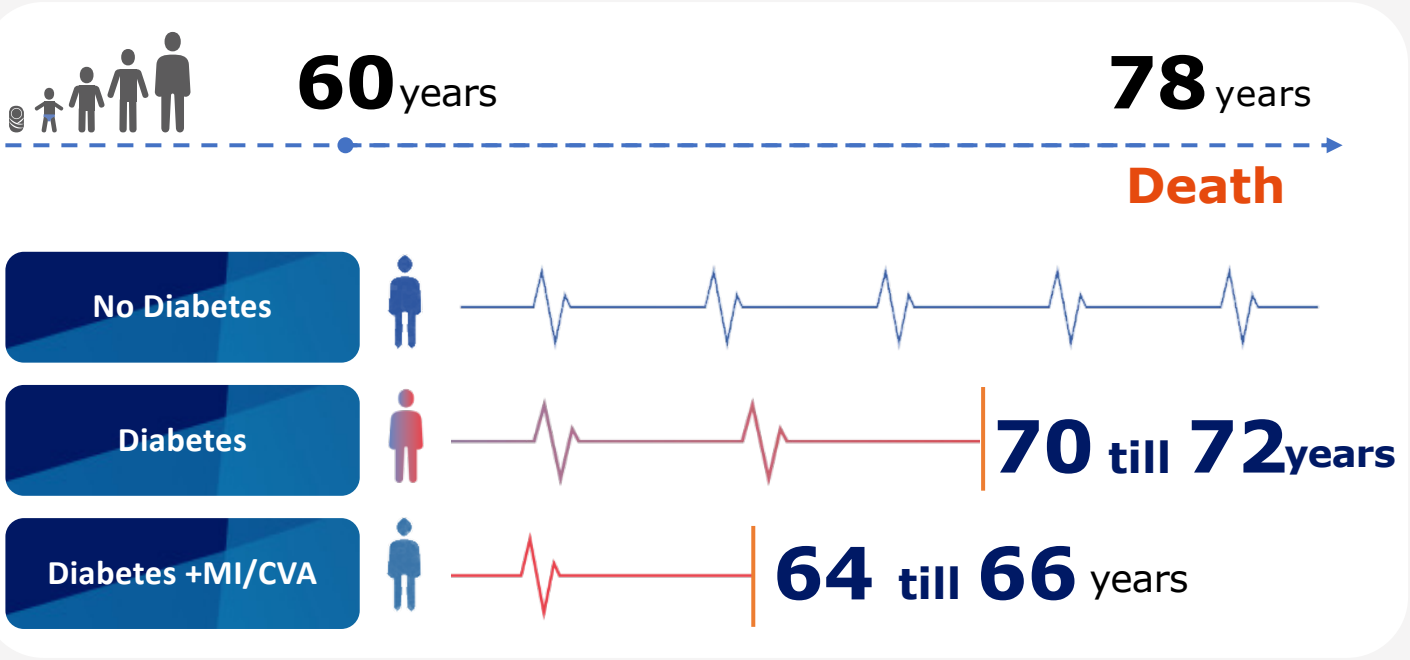
Having type 2 diabetes significantly impacts the life expectancy of your patient



CVA, Cerebrovascular accident; MI, myocardial infarction.
Adapted from: The Emerging Risk Factors Collaboration. *JAMA*. 2015;314:52–60.

Mortality risk and CV disease are increased with diabetes*

Hazard ratio for all-cause mortality:

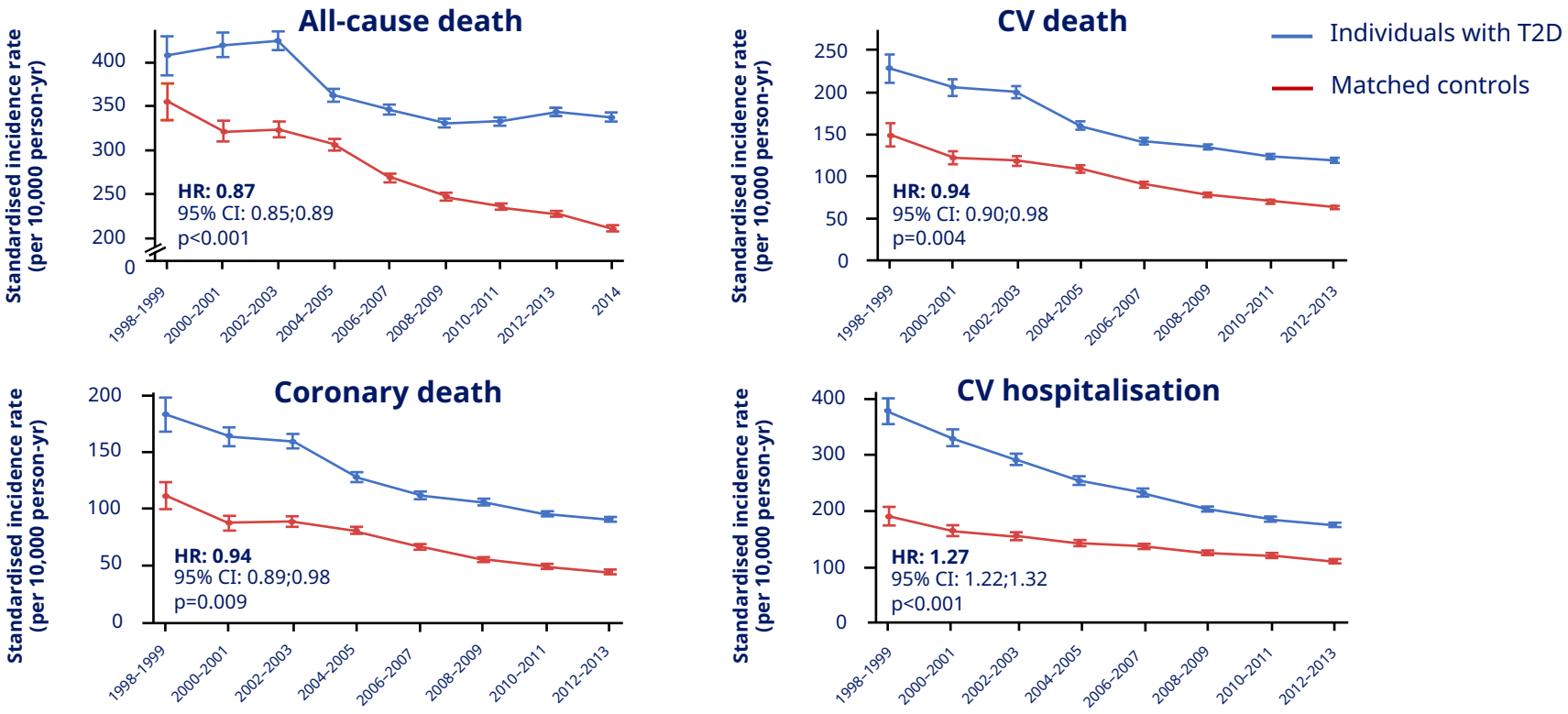
1.80

Hazard ratio for CV death:

2.32

*Mortality risk associated with diabetes vs no diabetes (n=820,900).
CV, cardiovascular.
Rao Kondapally Seshasai S et al. N Engl J Med 2011;364:829–41.

Individuals with T2D are at increased risk of CVD vs those without CVD



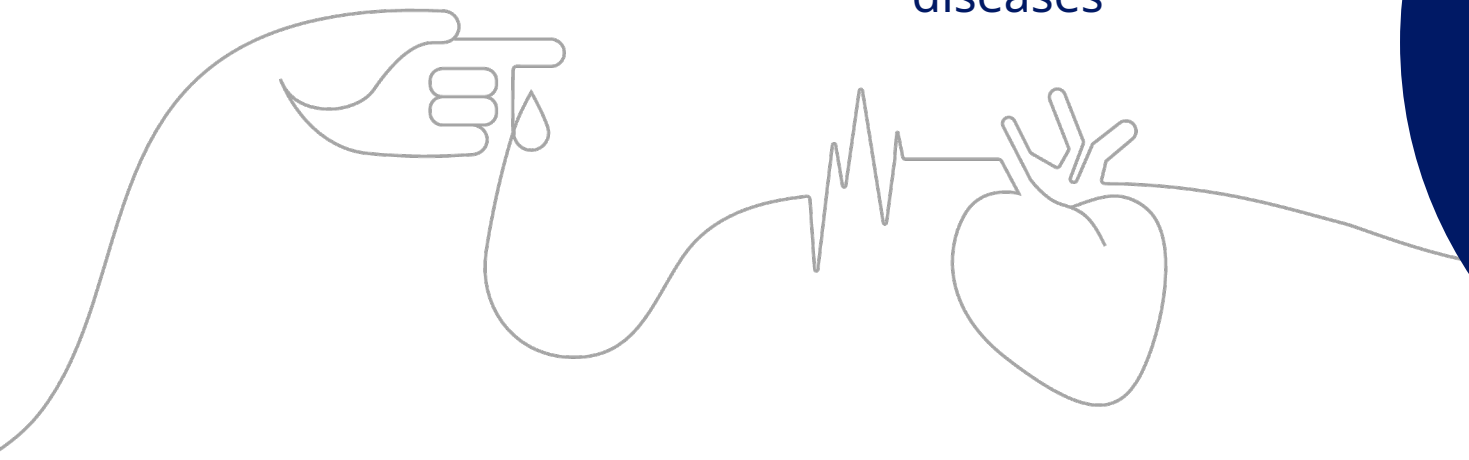
Although CV death rate is declining in general, the difference in CV death between individuals with and without T2D is still evident

Data are mean ± 95% CI; HR (95% CI) are patients with T2D vs matched controls.
CI, confidence interval; CV, cardiovascular; CVD, cardiovascular disease; HR, hazard ratio; yr, years.
Rawshani A et al. N Engl J Med 2017;376:1407–18.

Tackling the CV risk in every type 2 diabetes patient

Diabetes

Cardiovascular diseases



Maximize the cardiovascular protection of your type 2 diabetes patients ALSO in primary prevention

PATIENT PROFILE | GEORGE

Summary

- Male, 56
- Works as an accountant
- Likes to play golf twice a month but recently needs to take more breaks per round
- Comes for a check-up as he wants to discuss his concerns about recent weight gains
- Understands his blood results and starts to worry that his general health is deteriorating – would like to hear further treatment options
- Is starting to worry given his family history for cardiovascular events

Patient Characteristics

CV Risk : **High** [1]

HbA1c	**8.2**	Blood pressure (mmHg)	**140/90**
BMI	**31.5**	LDL level (mg/dl) Triglycerides (mg/dl)	**160** **180**

- 6 years since T2D diagnosis
- Smoker
- No existing CVD

Medical History

- Takes maxim dosage of **daily metformin** along with a **DPP-4i**
- Follows a treatment for his blood pressure (ACE inhibitor) and cholesterol (Statins)
- Father died from a stroke at 65
- No chronic kidney disease

> “I'm worrying about my weight and health; it seems to go for the worst. My father had a stroke, so I want to really be on top of my diabetes to stop its progression before it's too late.”

ESC Guidelines Cardiovascular prevention 2021

Most patients with type 2 diabetes are at high to very high risk of CV events

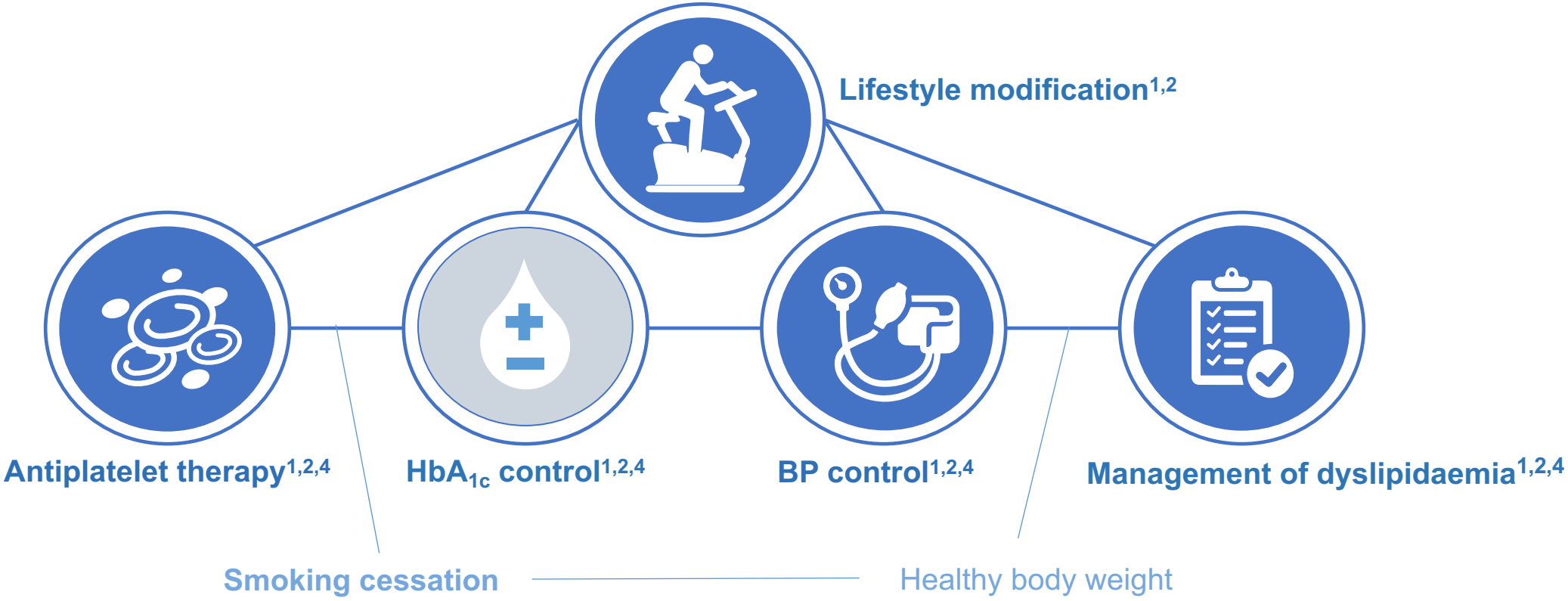
Patients with type 2 diabetes mellitus		
Patients with type 1 DM above 40 years of age may also be classified according to these criteria	Patients with well controlled short-standing DM (e.g. <10 years), no evidence of TOD and no additional ASCVD risk factors	**Moderate-risk**
	Patients with DM without ASCVD and/or severe TOD, and not fulfilling the moderate risk criteria.	**High-risk**
	Patients with DM with established ASCVD and/or severe TOD:[87, 93-95] • eGFR <45 mL/min/1.73 m² irrespective of albuminuria • eGFR 45-59 mL/min/1.73 m² and microalbuminuria (ACR 30 -300 mg/g) • Proteinuria (ACR >300 mg/g) • Presence of microvascular disease in at least 3 different sites (e.g. microalbuminuria plus retinopathy plus neuropathy)	**Very high-risk**

Risk factors George :

- Age = 56 years
- BMI = 31.5 kg/m²
- Hypertension
- Dyslipidemia
- HbA1c = 8.2%

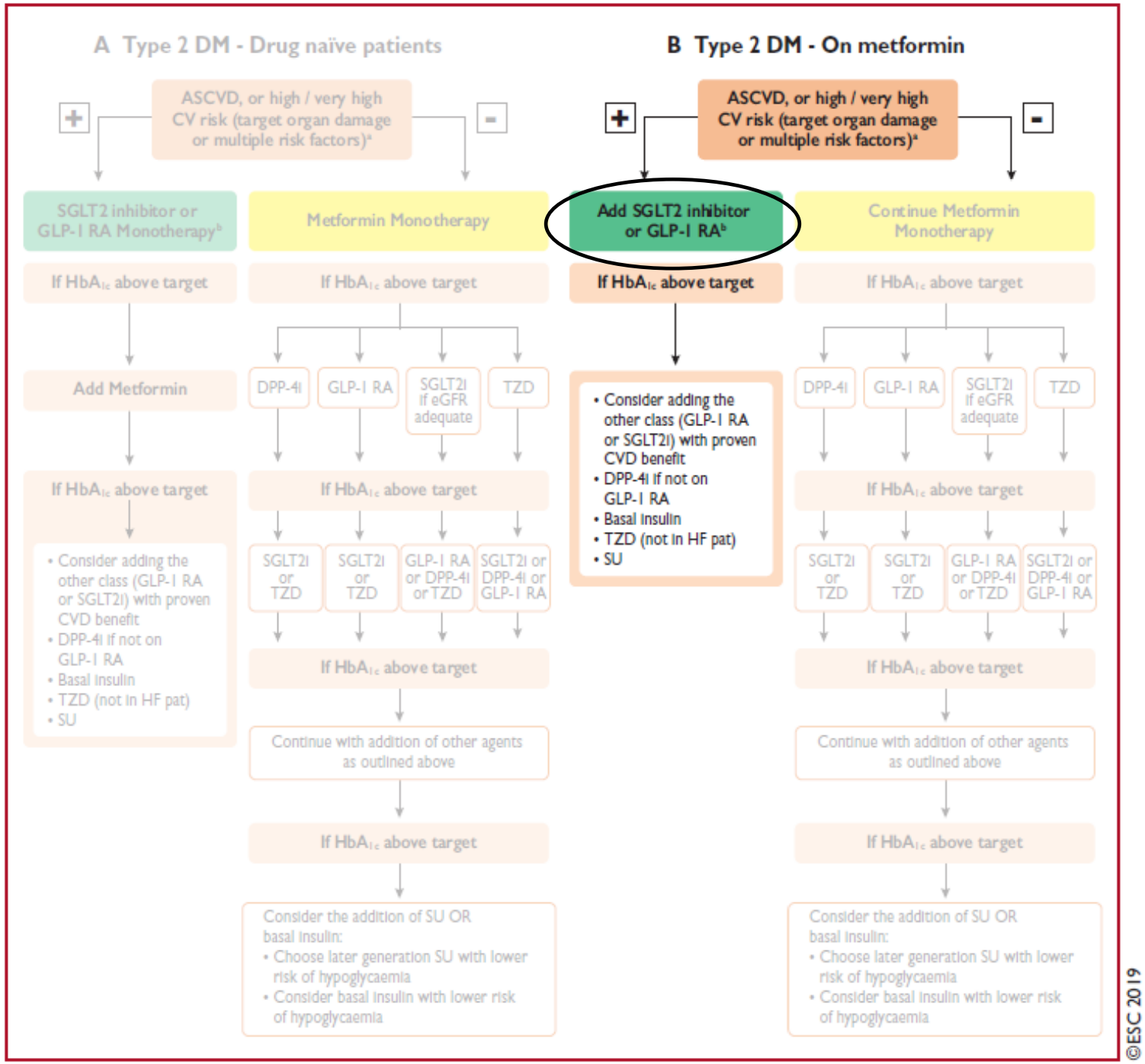
Adapted from Visseren FLJ et al. Eur Heart J. 2021 Sep 7;42(34):3227-3337

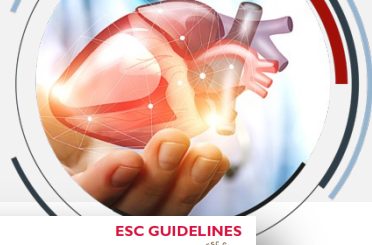
The CV risk approach in a type 2 diabetes patient such as George is multifactorial and individualized[1-4]



CV, cardiovascular; HbA_{1c}, glycosylated haemoglobin; BP, blood pressure

1. American Diabetes Association. *Diabetes Care* 2018;41(Suppl 1):S86–S104; 2. Piepoli MF et al. *Eur Heart J* 2016;37:2315–2381; 3. Rydén L et al. *Eur Heart J* 2013;34:3035–3087; 4. Cosentino F et al. *Eur Heart J* 2019;00:1–69





ESC European Society of Cardiology

European Heart Journal (2019) 00, 1–69
doi:10.1093/eurheartj/ehz486

ESC GUIDELINES

2019 ESC Guidelines on diabetes, pre-diabetes, and cardiovascular diseases developed in collaboration with the EASD

The Task Force for diabetes, pre-diabetes, and cardiovascular diseases of the European Society of Cardiology (ESC) and the European Association for the Study of Diabetes (EASD)

Authors/Task Force Members: Francesco Cosentino* (ESC Chairperson) (Sweden), Peter J. Grant* (EASD Chairperson) (United Kingdom), Victor Aboyans (France), Clifford J. Bailey[1] (United Kingdom), Antonio Ceriello[1] (Italy), Victoria Delgado (Netherlands), Massimo Federici[1] (Italy), Gerasimos Filippatos (Greece), Diederick E. Grobbee (Netherlands), Tina Birgitte Hansen (Denmark), Heikki V. Huikuri (Finland), Isabelle Johansson (Sweden), Peter Jüni (Canada), Maddalena Lettino (Italy), Nikolaus Marx (Germany), Linda G. Mellbin (Sweden), Carl J. Östgren (Sweden), Bianca Rocca (Italy), Marco Roffi (Switzerland), Naveed Sattar[1] (United Kingdom), Petar M. Seferović (Serbia), Miguel Sousa-Uva (Portugal), Paul Valensi (France), David C. Wheeler[1] (United Kingdom)

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Authors/Task Force Member Affiliations: listed in the Appendix.

ESC Committee for Practice Guidelines (CPG) and National Cardiac Societies document reviewers: listed in the Appendix.

[1]**Representing the EASD.**

ESC entities having participated in the development of this document:

Associations: Acute Cardiovascular Care Association (ACCA), Association of Cardiovascular Nursing & Allied Professions (ACNAP), European Association of Cardiovascular Imaging (EACVI), European Association of Preventive Cardiology (EAPC), European Association of Percutaneous Cardiovascular Interventions (EAPCI), European Heart Rhythm Association (EHRA), Heart Failure Association (HFA).

Councils: Council on Cardiovascular Primary Care, Council on Hypertension.

Working Groups: Aorta and Peripheral Vascular Diseases, Cardiovascular Surgery, Thrombosis.

The 2019 ESC guidelines reflect a move towards a more individualised, evidence-based approach to patient management, driven by CVOTs in the diabetes field

Adapted from Cosentino F et al. Eur Heart J. 2020 Jan 7;41(2):255-323

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FIGURE 3: USE OF GLUCOSE-LOWERING MEDICATIONS IN THE MANAGEMENT OF TYPE 2 DIABETES

HEALTHY LIFESTYLE BEHAVIOURS; DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT (DSMES); SOCIAL DETERMINANTS OF HEALTH (SDOH)

TO AVOID THERAPEUTIC INERTIA REASSESS AND MODIFY TREATMENT REGULARLY (3–6 MONTHS)

Goal: Cardiorenal Risk Reduction in High-Risk Patients with Type 2 Diabetes (In addition to comprehensive CV risk management)*

+ASCVD†

Defined differently across CVOTs but all included individuals with established CVD (e.g. MI, stroke, any revascularisation procedure). Variably included: conditions such as transient ischaemic attack, unstable angina, amputation, symptomatic or asymptomatic coronary artery disease.

+Indicators of high risk

While definitions vary, most comprise ≥ 55 years of age with two or more additional risk factors (including obesity, hypertension, smoking dyslipidaemia or albuminuria)

+ASCVD/Indicators of High Risk

GLP-1 RA# with proven CVD benefit — EITHER/OR — SGLT2i§ with proven CVD benefit

If HbA_{1c} above target

- For patients on a GLP-1 RA consider adding SGLT2i with proven CVD benefit or vice versa
- TZD^

+HF

Current or prior symptoms of HF with documented HFrEF or HFpEF

+HF

SGLT2i§ with proven HF benefit in this population

+CKD

eGFR < 60 ml/min per 1.73 m^2 OR albuminuria (ACR ≥ 3.0 mg/mmol (30mg/g)). These measurements may vary over time; thus, a repeat measure is required to document CKD.

+CKD (on maximally tolerated dose of ACEi/ARB)

PREFERABLY

SGLT2i§ with primary evidence of reducing CKD progression

Use SGLT2i in people with an eGFR ≥ 20 ml/min per 1.73 m^2; once initiated should be continued until initiation of dialysis or transplantation

— OR —

GLP-1 RA with proven CVD benefit if SGLT2i not tolerated or contraindicated

If HbA_{1c} above target, for patients on SGLT2i, consider incorporating a GLP-1 RA or vice versa

If additional cardiorenal risk reduction or glycaemic lowering needed

Goal: Achievement and Maintenance of Glycaemic and Weight Management Goals

Glycaemic Management: Choose approaches that provide the efficacy to achieve goals:

Metformin OR Agent(s) including COMBINATION therapy that provide adequate EFFICACY to achieve and maintain treatment goals

Consider avoidance of hypoglycaemia a priority in high-risk individuals

In general, higher efficacy approaches have greater likelihood of achieving glycaemic goals

Efficacy for glucose lowering

Very High:
Dulaglutide (high dose), Semaglutide, Tirzepatide

Insulin

Combination Oral, Combination Injectable (GLP-1 RA/Insulin)

High:
GLP-1 RA (not listed above), Metformin, SGLT2i, Sulfonylurea, TZD

Intermediate:
DPP-4i

Achievement and Maintenance of Weight Management Goals:

Set individualised weight management goals

General lifestyle advice: medical nutrition therapy/eating patterns/ physical activity

Intensive evidence-based structured weight management programme

Consider medication for weight loss

Consider metabolic surgery

When choosing glucose-lowering therapies:

Consider regimen with high-to-very-high dual glucose and weight efficacy

Efficacy for weight loss

Very High:
Semaglutide, Tirzepatide

High:
Dulaglutide, Liraglutide

Intermediate:
GLP-1RA (not listed above), SGLT2i

Neutral:
DPP-4i, Metformin

If HbA_{1c} above target

Identify barriers to goals:

- Consider DSMES referral to support self-efficacy in achievement of goals
- Consider technology (e.g. diagnostic CGM) to identify therapeutic gaps and tailor therapy
- Identify and address SDOH that impact on achievement of goals

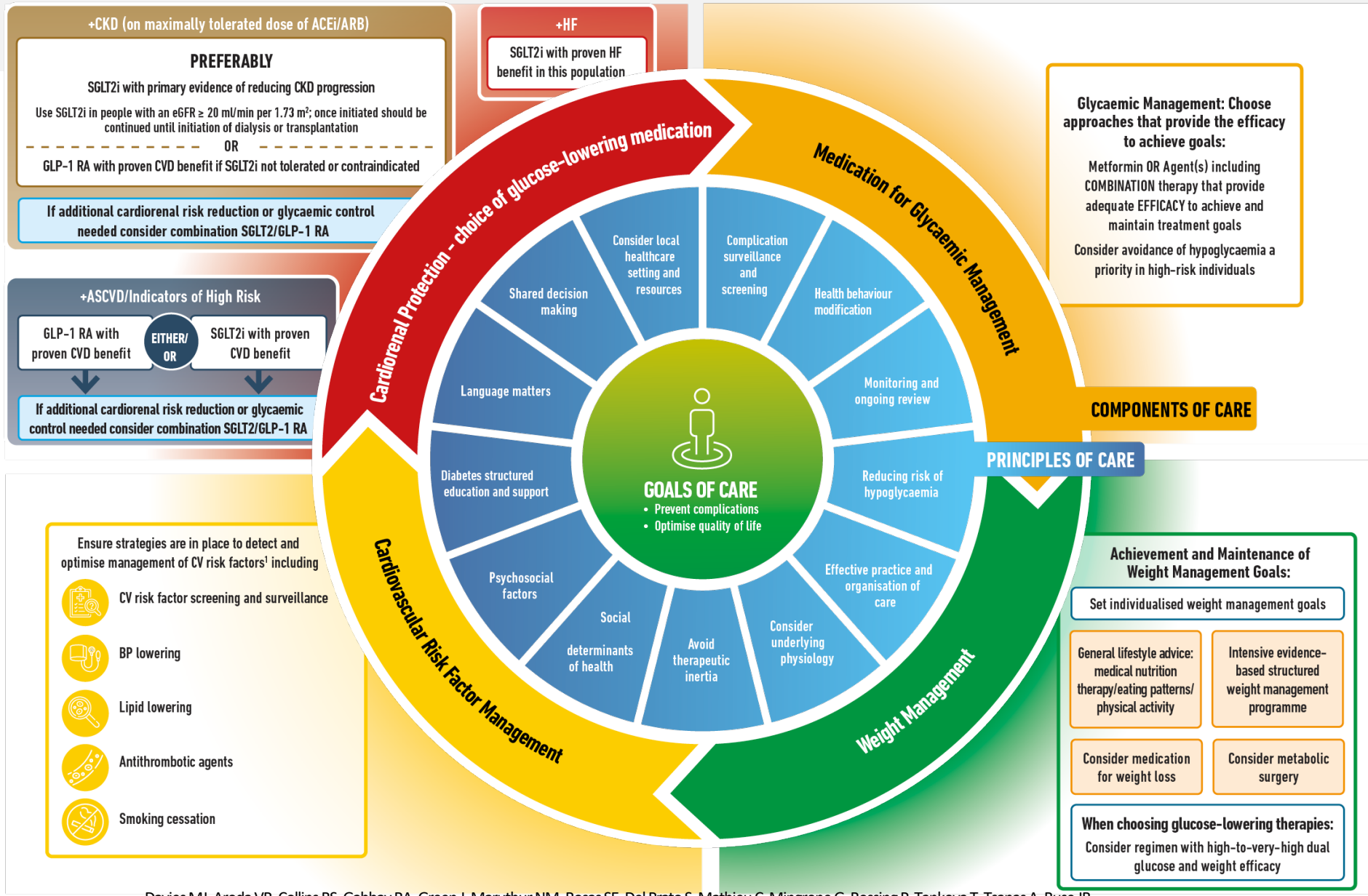
ACEi, Angiotensin-Converting Enzyme Inhibitor; ACR, Albumin/Creatinine Ratio; ARB, Angiotensin Receptor Blocker; ASCVD, Atherosclerotic Cardiovascular Disease; CGM, Continuous Glucose Monitoring; CKD, Chronic Kidney Disease; CV, Cardiovascular; CVD, Cardiovascular Disease; CVOT, Cardiovascular Outcomes Trial; DPP-4i, Dipeptidyl Peptidase-4 Inhibitor; eGFR, Estimated Glomerular Filtration Rate; GLP-1 RA, Glucagon-Like Peptide-1 Receptor Agonist; HF, Heart Failure; HFpEF, Heart Failure with preserved Ejection Fraction; HFrEF, Heart Failure with reduced Ejection Fraction; HHF, Hospitalisation for Heart Failure; MACE, Major Adverse Cardiovascular Events; MI, Myocardial Infarction; SDOH, Social Determinants of Health; SGLT2i, Sodium-Glucose Cotransporter-2 Inhibitor; T2D, Type 2 Diabetes; TZD, Thiazolidinedione.

* In people with HF, CKD, established CVD or multiple risk factors for CVD, the decision to use a GLP-1 RA or SGLT2i with proven benefit should be independent of background use of metformin; † A strong recommendation is warranted for people with CVD and a weaker recommendation for those with indicators of high CV risk. Moreover, a higher absolute risk reduction and thus lower numbers needed to treat are seen at higher levels of baseline risk and should be factored into the shared decision-making process. See text for details; ^ Low-dose TZD may be better tolerated and similarly effective; § For SGLT2i, CV/renal outcomes trials demonstrate their efficacy in reducing the risk of composite MACE, CV death, all-cause mortality, MI, HHF and renal outcomes in individuals with T2D with established/high risk of CVD; # For GLP-1 RA, CVOTs demonstrate their efficacy in reducing composite MACE, CV death, all-cause mortality, MI, stroke and renal endpoints in individuals with T2D with established/high risk of CVD.

Davies MJ, Aroda VR, Collins BS, Gabbay RA, Green J, Maruthur NM, Rosas SE, Del Prato S, Mathieu C, Mingrone G, Rossing P, Tankova T, Tsapas A, Buse JB

Diabetes Care 2022; https://doi.org/10.2337/dci22-0034. *Diabetologia* 2022; https://doi.org/10.1007/s00125-022-05787-2.

FIGURE 4: HOLISTIC PERSON-CENTRED APPROACH TO T2DM MANAGEMENT



1 = American Diabetes Association Professional Practice Committee. 10. Cardiovascular Disease and Risk Management: Standards of Medical Care in Diabetes-2022. Diabetes Care. 2022 Jan 1;45(Suppl 1):S144–74.

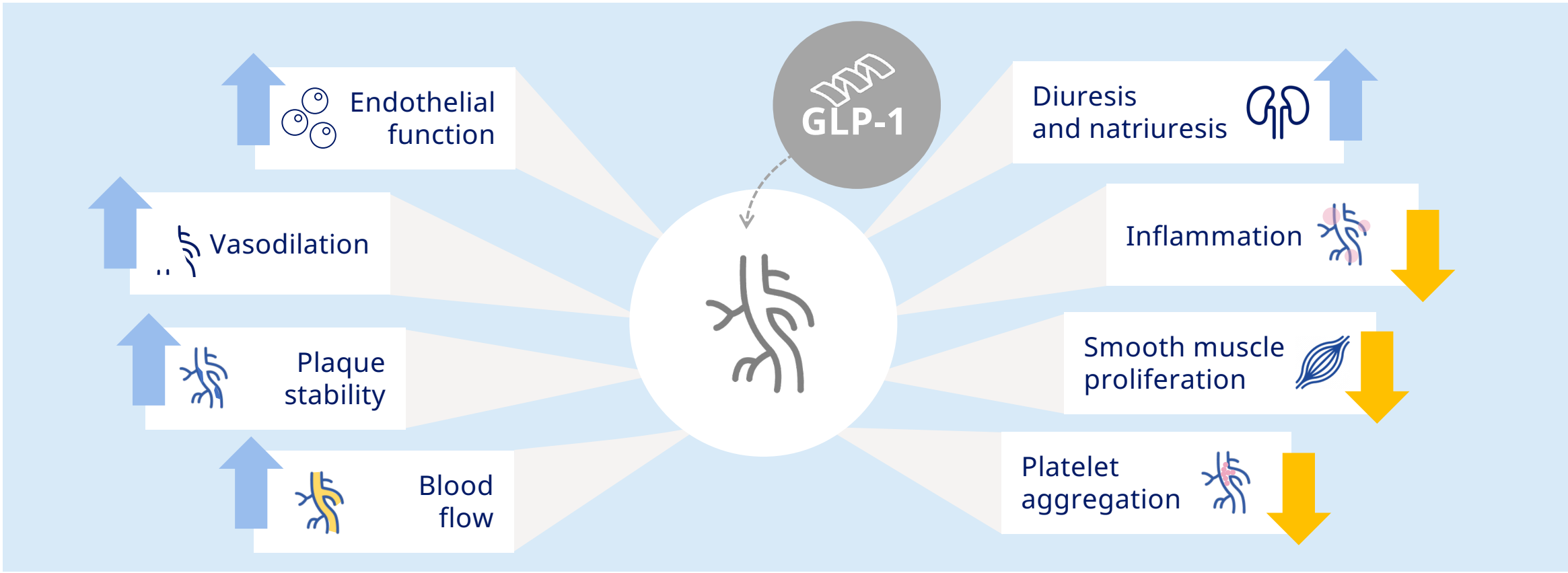
ACEi, Angiotensin-Converting Enzyme Inhibitor; ARB, Angiotensin Receptor Blockers; ASCVD, Atherosclerotic Cardiovascular Disease; BP, Blood Pressure; CKD, Chronic Kidney Disease; CV, Cardiovascular; eGFR, Estimated Glomerular Filtration Rate; GLP-1 RA, Glucagon-Like Peptide-1 Receptor Agonist; HF, Heart Failure; SGLT2i, Sodium-Glucose Cotransporter-2 Inhibitor; T2D, Type 2 Diabetes.

Davies MJ, Aroda VR, Collins BS, Gabbay RA, Green J, Maruthur NM, Rosas SE, Del Prato S, Mathieu C, Mingrone G, Rossing P, Tankova T, Tsapas A, Buse JB

Diabetes Care 2022; https://doi.org/10.2337/dci22-0034. *Diabetologia* 2022; https://doi.org/10.1007/s00125-022-05787-2.

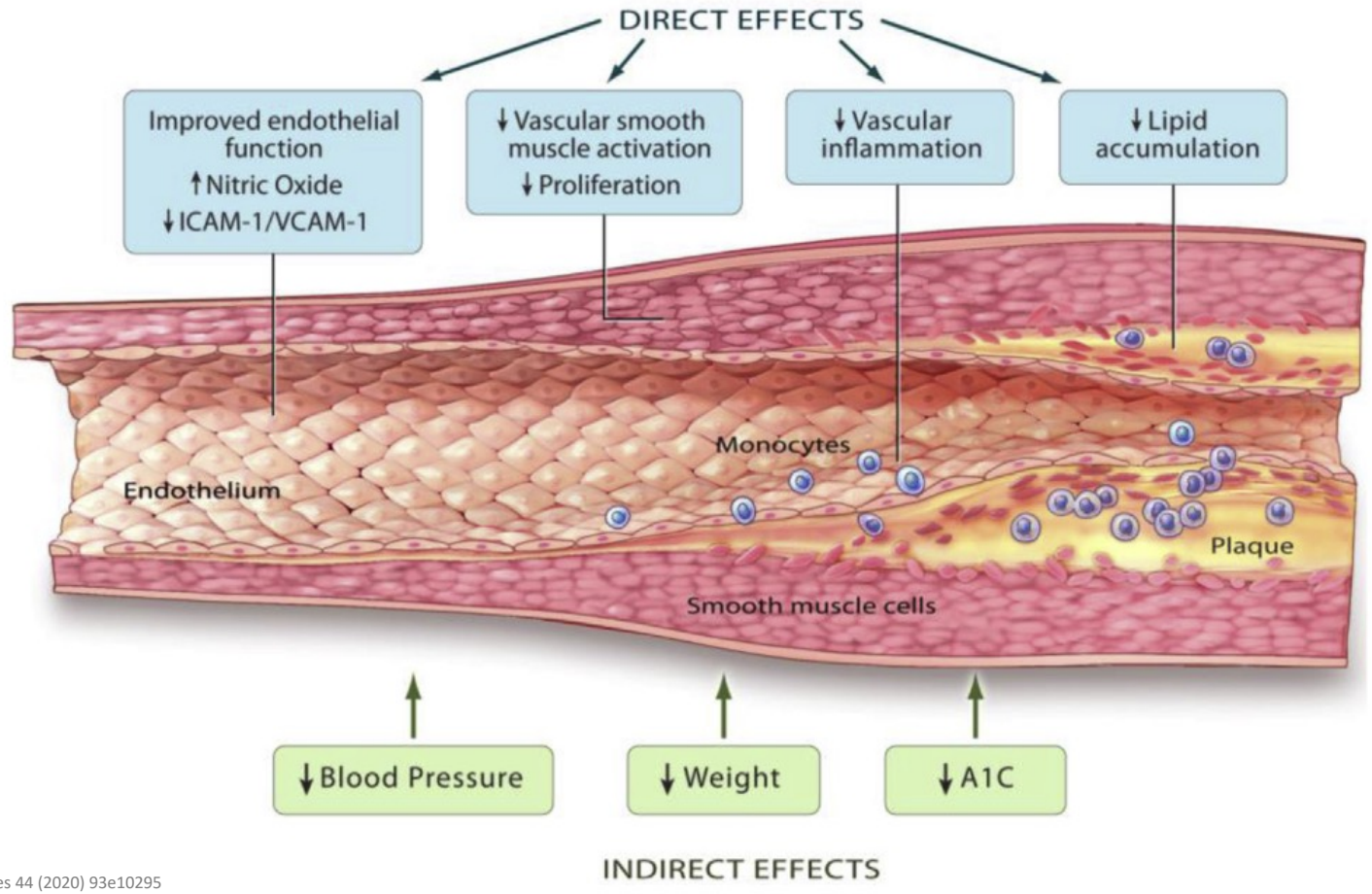
Effects of semaglutide on cardiovascular system

Potential mechanisms for beneficial effect of GLP-1 on cardiovascular risk factors



GLP-1, glucagon-like peptide-1.
Adapted from Drucker DJ. Cell Metab 2016:24:15–30; Muskiet MHA et al. Nat Rev Nephrol 2017;13:605–28.

Mechanisms whereby GLP-1 analogues modify the risk of cardiovascular outcomes

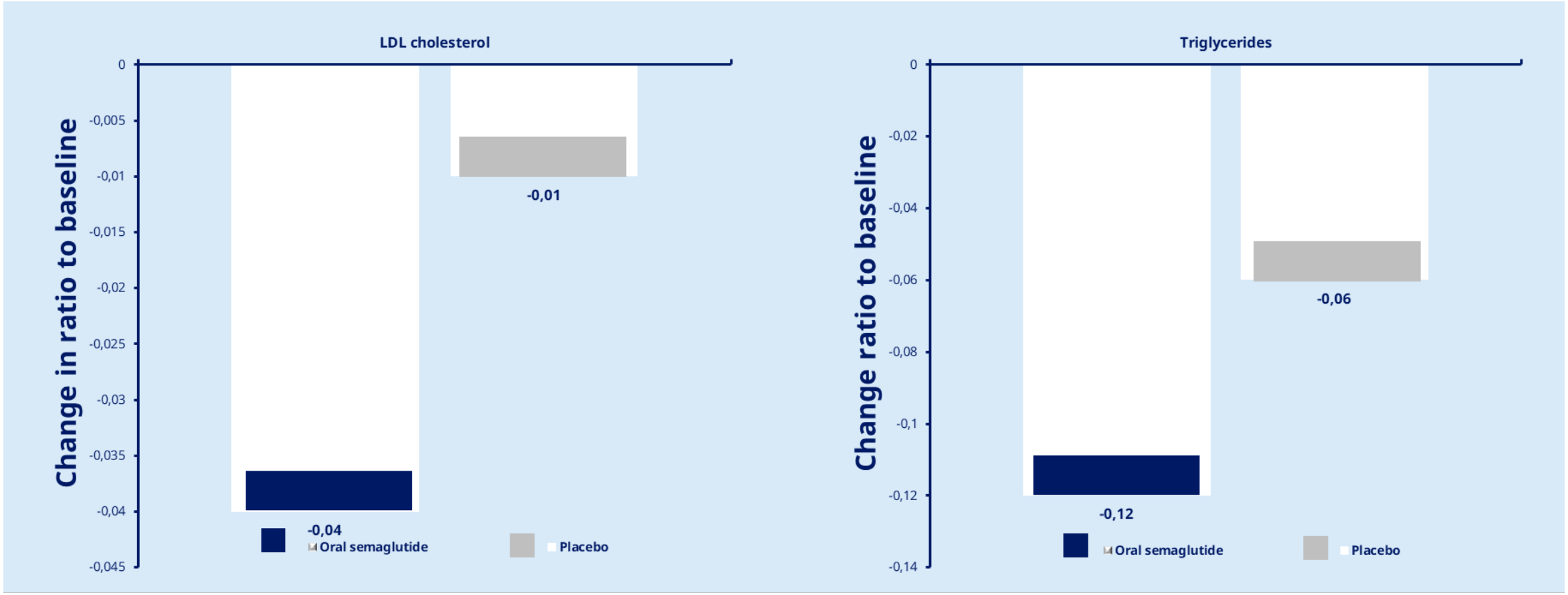


Less atherosclerotic / ischemic events

A. Sharma, S. Verma / Can J Diabetes 44 (2020) 93e10295
A1C,glycated hemoglobin;ICAM-1, intercellular adhesionmolecule 1;VCAM-1, vascular cell adhesion molecule 1

Effects of semaglutide on cardiovascular system

Oral semaglutide improves **blood lipids**



LDL, low-density lipoprotein.
Husain M et al. N Engl J Med 2019;381:841–51.

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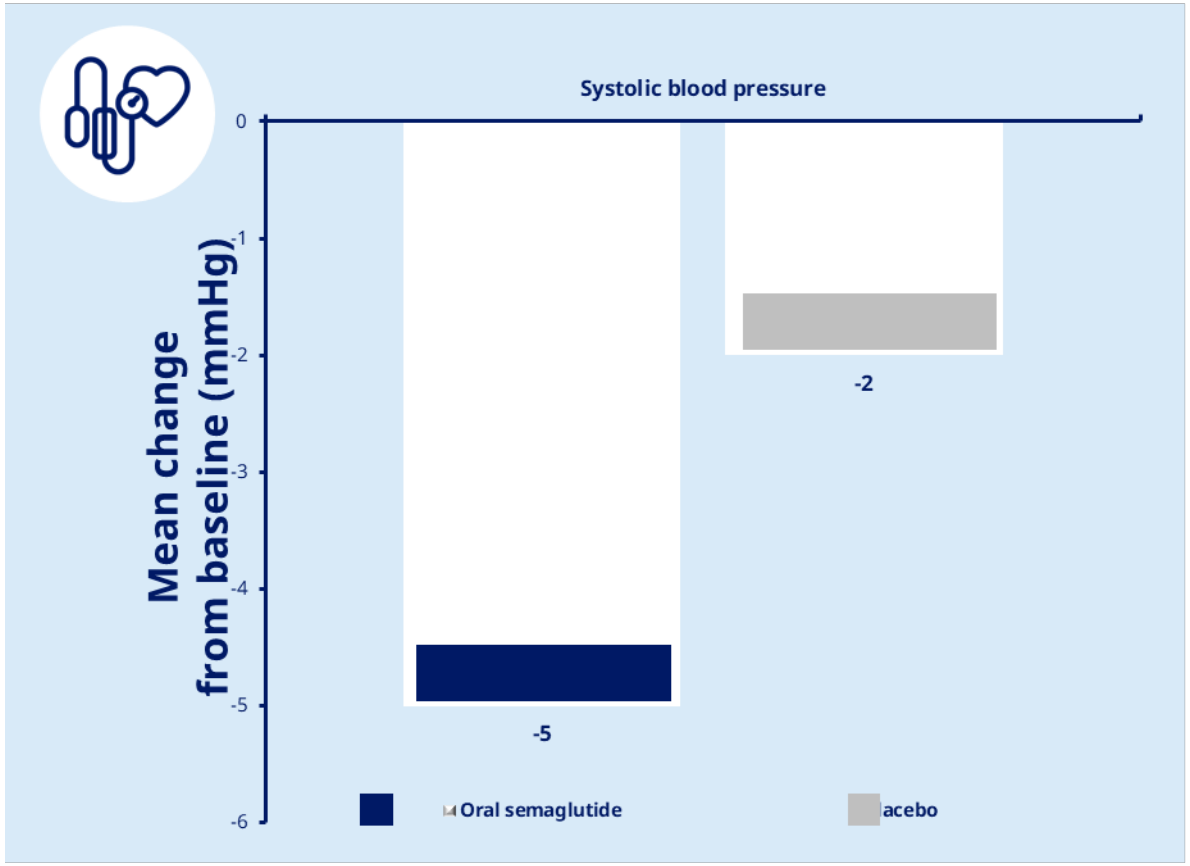
Effects of semaglutide on cardiovascular system

Oral semaglutide reduces systolic blood pressure



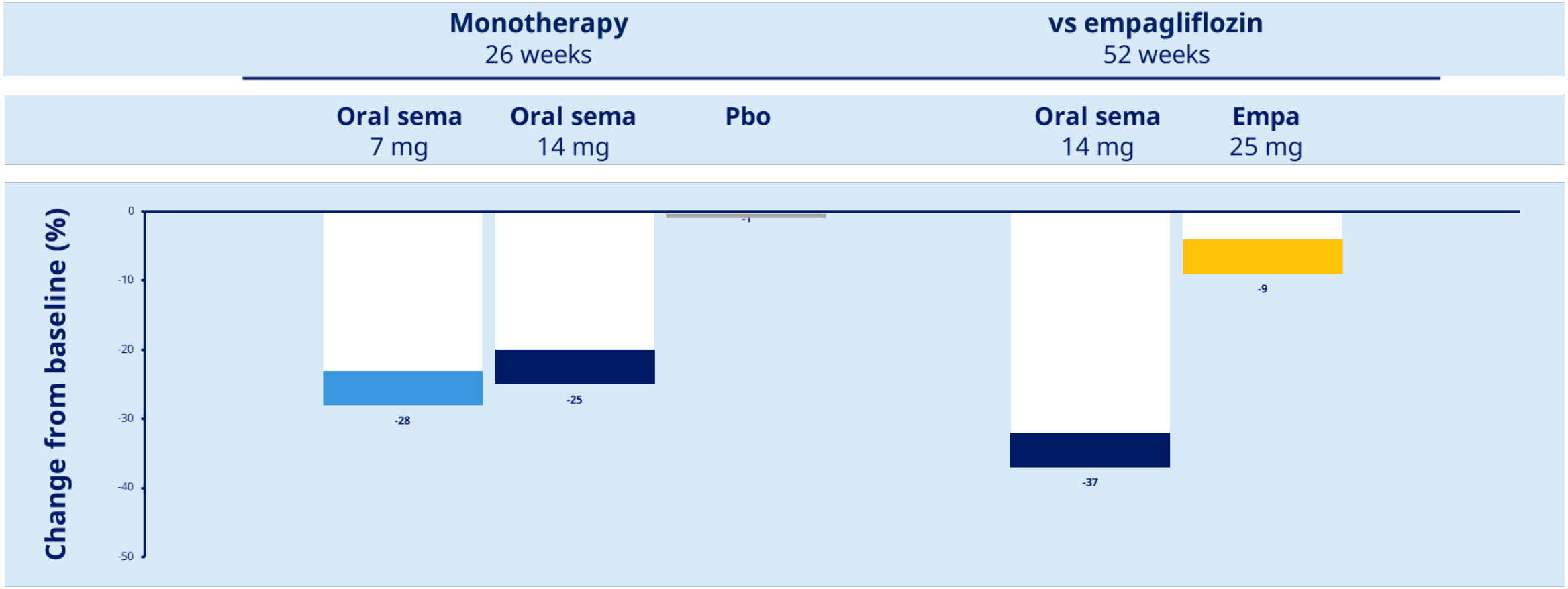
Each 10 mmHg decrease in mean systolic blood pressure is associated with reductions in risk in people with T2D

- **11%** for any complication related to diabetes
- **16%** for deaths related to diabetes
- **11%** for myocardial infarction
- **10%** for microvascular complications

T2D, type 2 diabetes.
Husain M et al. N Engl J Med 2019;381:841–51; Stratton IM et al. Diabetologica 2006;8:1761-9.

Effects of semaglutide on cardiovascular system

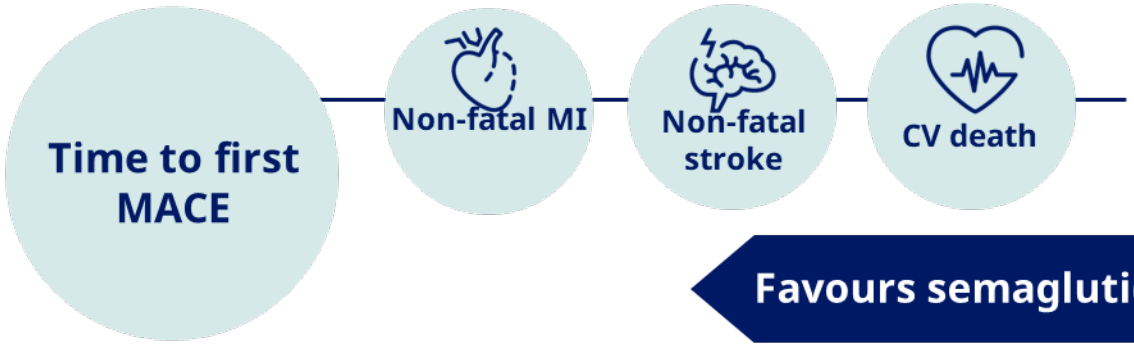
Semaglutide reduced inflammation marker hsCRP levels vs comparators

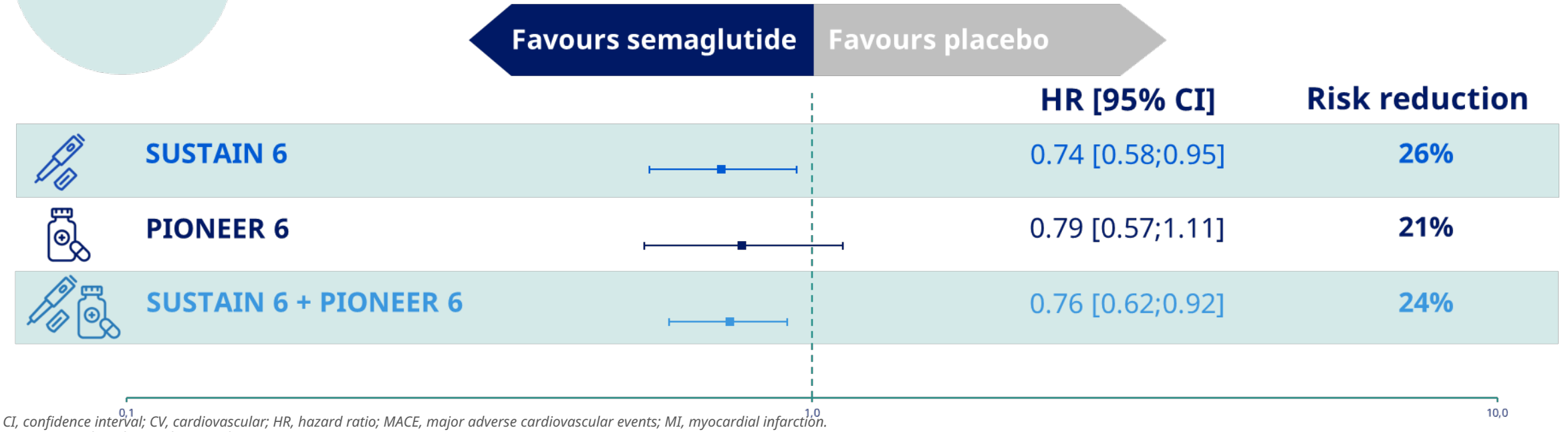


Empa, empagliflozin; hsCRP, high-sensitivity C-reactive protein; Pbo, placebo; sema, semaglutide.
Rosenstock JR et al. Presented at the 70th American College of Cardiology Annual Scientific Session, 15–17 May 2021.

Effects of semaglutide on cardiovascular system

Semaglutide reduced time to first occurrence of MACE when compared with placebo in dedicated cardiovascular outcome studies

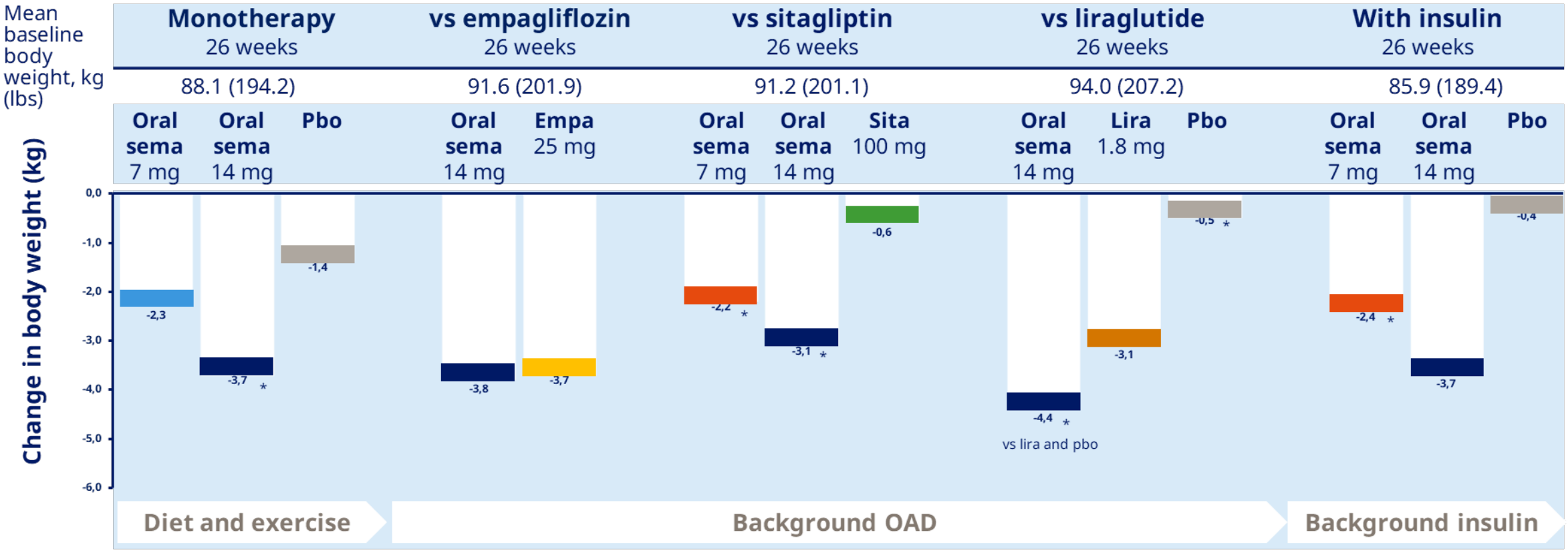




CI, confidence interval; CV, cardiovascular; HR, hazard ratio; MACE, major adverse cardiovascular events; MI, myocardial infarction.
Husain M et al. Diabetes Obes Metab 2020;22:442–51.

Change in body weight with oral semaglutide

The PIONEER programme

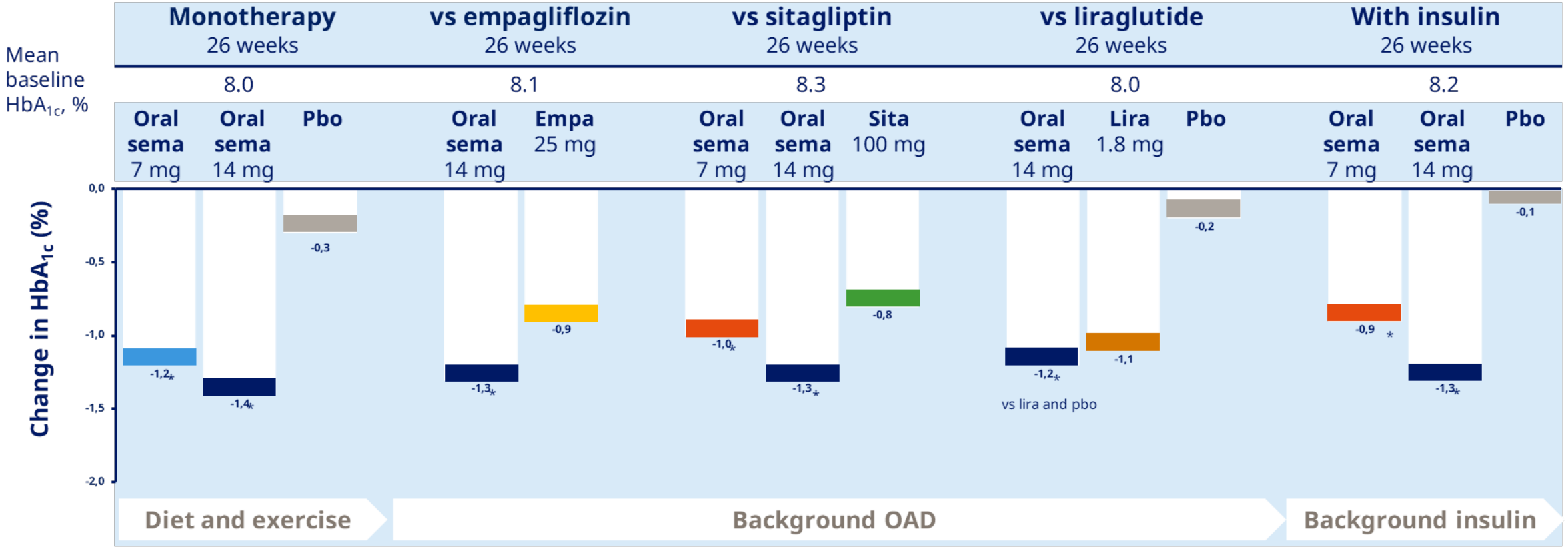


Results for semaglutide 3 mg are not shown, as this is not a treatment dose

**Statistically significantly greater compared with placebo or active comparator. Treatment policy estimand.*
Empa, empagliflozin; Lira, liraglutide; OAD, oral antidiabetes drug; Pbo, placebo; Sema, semaglutide; Sita, sitagliptin.
Aroda VR et al. Diabetes Care 2019;42:1724–32; Rodbard HW et al. Diabetes Care 2019;42:2272–81; Rosenstock J et al. JAMA 2019;321:1466–80; Pratley R et al. Lancet 2019;394:39–50; Zinman B et al. Diabetes Care 2019;42:2262–71.

Change in HbA1c with oral semaglutide

The PIONEER programme



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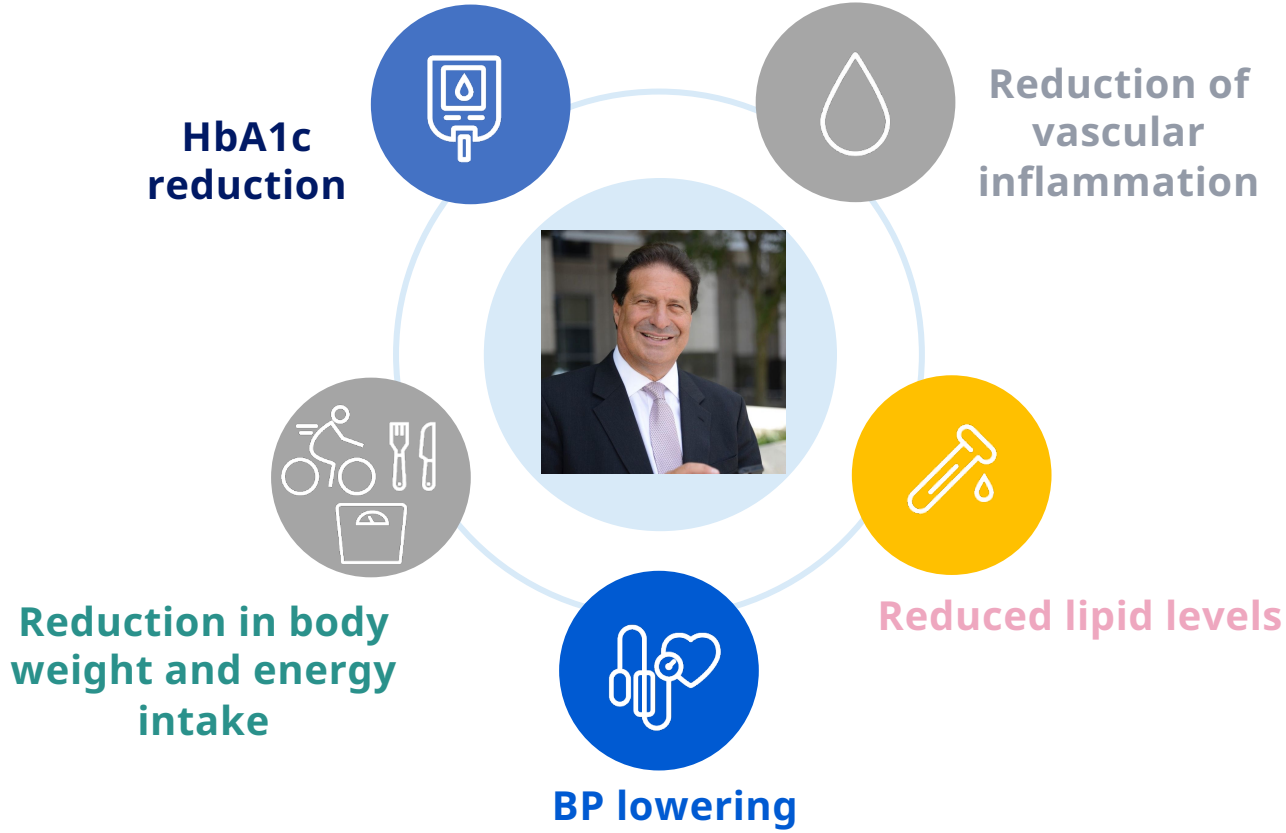
Aroda VR et al. Diabetes Care 2019;42:1724–32; Rodbard HW et al. Diabetes Care 2019;42:2272–81; Rosenstock J et al. JAMA 2019;321:1466–80; Pratley R et al. Lancet 2019;394:39–50; Zinman B et al. Diabetes Care 2019;42:2262–71.

Improving the cardiometabolic risk profile of George with semaglutide

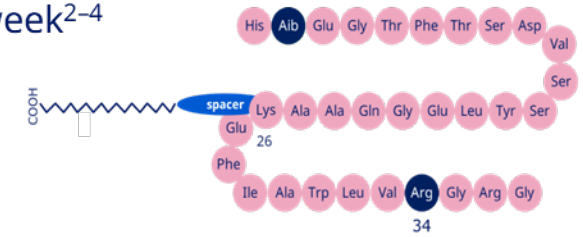


BP, blood pressure; CVD, cardiovascular disease; T2D, type 2 diabetes.

Oral semaglutide (Rybelsus®)

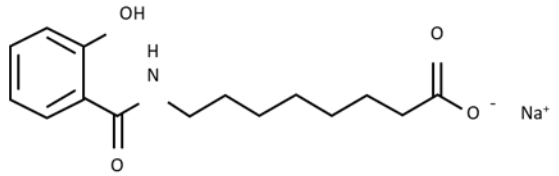
Semaglutide

- 94% homology to human GLP-1[1]
- t½ of approximately 1 week[2–4]
- Amino acid substitution protects against DPP-4 degradation[1]



SNAC (Sodium N-(8-(2-hydroxybenzoyl) Amino) Caprylate)

- SNAC causes a local increase of pH that protects against proteolytic degradation and facilitates absorption across the gastric epithelium[5]



- Absorption enhancer
- Increase bioavailability of oral administration[5]

Once-weekly s.c. semaglutide

Once-daily oral semaglutide

Effective reductions in HbA_{1c}, bodyweight and CV risk factors[6-11]

CV, cardiovascular; DPP-4, dipeptidyl peptidase-4; GLP-1, glucagon-like peptide-1; HbA1c, glycated haemoglobin; OD, once daily; OW, once weekly; s.c. subcutaneous; SNAC, Sodium N-(8-(2-hydroxybenzoyl) amino) caprylate; t½, half-life.

1. Lau J et al. J Med Chem 2015;58:7370-80; 2. Kapitza C et al. J Clin Pharmacol 2015;55:497-504; 3. Marbury TC et al. Diabetologia 2014;57:S358; 4. Connor et al. Poster 1195–P. ADA 77th Scientific Sessions. June 9–13, 2017; 5. Buckley ST et al. Sci Transl Med 2018;10:eaar7047; 6. Thethi et al. Diabetes Obes Metab 2020;22:1263–77; 7. Sorli et al. Lancet Diabetes Endocrinol 2017;5:251–60; 8. Ahrén et al. Lancet Diabetes Endocrinol 2017;5:341–54; 9. Pratley et al. Lancet Diabetes Endocrinol 2018;6:275–86; 10. Husain et al. N Engl J Med 2019;381:841–51; 11. Marso et al. N Engl J Med 2016;375:1834–44

Practical use of oral semaglutide (Rybelsus®)

Dose escalation is recommended to mitigate gastrointestinal adverse events

START

3 mg OD
1 month

Starting dose

MAINTENANCE

7 mg OD
At least 1 month

14 mg OD
For further improvement of glycaemic control

Therapeutic doses for individual treatment needs

Additional strategies for mitigation of gastrointestinal adverse events

Educate and set the expectations for patients

Decrease food intake and avoid fatty meals

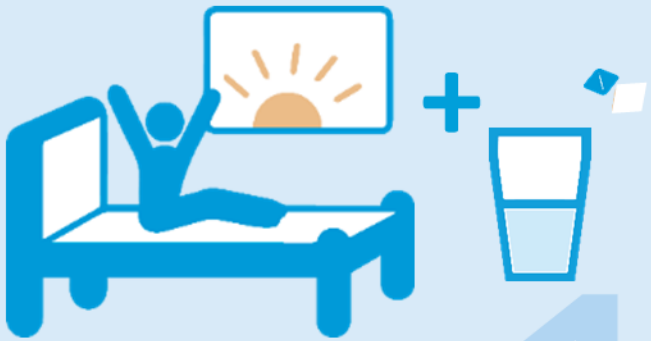
Keep a food diary to identify foods that worsen nausea

OD, once daily.

Oral semaglutide summary of product characteristics. Available at: https://www.medicines.org.uk/emc/product/11507/smpc. Accessed August 2021.

Dosing instructions for oral semaglutide (Rybelsus®)

Wake up fasting and take your semaglutide tablet with up to half a glass of water (approximately 120 mL/4 fl oz)



1

Wait at least **30 minutes** before eating, drinking or taking any other oral medication

2

Have your first meal and drink of the day and take any other medications you need

3

Used in Phase 2 and Phase 3a (PIONEER) programme.
Adapted from 1. Buckley ST et al. Sci Transl Med 2018;10(467); 2. Bækdal TA et al. Clin Pharmacokinet 2019;58:1193–1203.

Practical use of oral semaglutide (Rybelsus®)

No dose adjustment of oral semaglutide is required in special populations

Patients with mild, moderate, or severe renal impairment[a]

Patients with hepatic impairment[b]

65+

Elderly patients[c]

[a]Experience with use of semaglutide in patients with severe renal impairment is limited. Semaglutide is not recommended in patients with end-stage renal disease. [b]Experience with use of semaglutide in patients with severe hepatic impairment is limited. Caution should be exercised when treating these patients with semaglutide. [c]Therapeutic experience in patients ≥75 years of age is limited. Oral semaglutide summary of product characteristics. Available at: https://www.medicines.org.uk/emc/product/11507/smpc. Accessed August 2021.

Reimbursement of GLP-1 analogues in Belgium

Voor uw type 2 diabetespatiënten

- Onvoldoende gecontroleerd (HbA_{1c} > 7,5 %)

EN

- Met een body mass index (BMI) ≥30 kg/m²

EN

- Voorafgaande behandeling gedurende minstens 3 maanden met **tenminste** metformine

In het zorgtraject	Buiten het zorgtraject
↓	↓
Zonder attest	Met attest: • 1ste Aanvraag voor 12 maanden • 2de Aanvraag voor 12 maanden HbA_{1c} < 7% of een daling van ≥ 1%

Het is niet nodig een nieuwe aanvraag in te dienen bij aanpassing van de dosis.

Pour vos patients diabétiques de type 2

- Insuffisamment contrôlés (HbA_{1c} > 7,5 %)

ET

- Avec un indice de masse corporel (IMC) ≥30 kg/m²

ET

- Sous un traitement préalable d'au moins 3 mois sous au **minimum** de la metformine

Dans le trajet de soin	Hors trajet de soin
↓	↓
Sans attestation	Avec attestation : • 1ère demande pour 1 an • Prolongation pour 1 an si l'HbA_{1c} < 7% ou en cas de diminution de ≥ 1%

Il n'est pas nécessaire d'introduire une nouvelle demande en cas de changement de dosage.

GLP-1: glucagon-like peptide 1
www.riziv.fgov.be. Accessed on Aug 2020.

Rybelsus® : the opportunity for an early treatment with a GLP-1 RA in T2D patients

Benefits on cardiometabolic risk factors[1-2]

Reduction in body weight and energy intake[3,4]

Significant HbA_{1c} reduction superior to all comparators[3]

1. Husain M et al. *N Engl J Med.* 2019;381:841–51; 2. Husain M et al. Diabetes Obes Metab 2020;22:442–51; 3. Thethi et al., Diabetes Obes Metab. 2020;22:1263–1277;
4. Gibbons C et al. Diabetes Obes Metab. 2021;23(2):581-588

CARDIO
SCOPIE

THANK YOU