Summary of risk management plan for Tresiba (insulin degludec)

This is a summary of the risk management plan (RMP) for Tresiba. The RMP details important risks of Tresiba, how these risks can be minimised and how more information will be obtained about Tresiba's risks and uncertainties (missing information).

Tresiba's Summary of Product Characteristics (SmPC) and its package leaflet (PL) give essential information to healthcare professionals and patients on how Tresiba should be used.

This summary of the RMP for Tresiba should be read in the context of all this information, including the assessment report of the evaluation and its plain-language summary, all which is part of the EPAR.

Important new concerns or changes to the current ones will be included in updates of Tresiba's RMP

I. The medicine and what it is used for

Tresiba is authorised for the treatment of diabetes mellitus in adults, adolescents and children above 1 year of age (see SmPC for the full indication). It contains insulin degludec as the active substance and it is given intravenously or subcutaneously.

Further information about the evaluation of benefits of Tresiba can be found in the EPAR for Tresiba, including in its plain-language summary, available on the EMA website, under the medicine's webpage: EPAR link.

II. Risks associated with the medicine and activities to minimise or further characterise the risks

Important risks of Tresiba, together with measures to minimise such risks and the proposed studies for learning more about Tresiba 's risks, are outlined below.

Measures to minimise the risks identified for medicinal products can be:

- Specific information, such as warnings, precautions and advice on correct use, in the package leaflet and SmPC addressed to patients and healthcare professionals
- Important advice on the medicine's packaging
- The authorised pack size — the amount of medicine in a pack is chosen so as to ensure that the medicine is used correctly
- The medicine's legal status – the way a medicine is supplied to the public (e.g., with or without prescription) can help minimise its risks.

Together, these measures constitute *routine risk minimisation* measures.

In the case of Tresiba these measures are supplemented with *additional risk minimisation* measures mentioned under relevant risks, below.

In addition to these measures, information about adverse events is collected continuously and regularly analysed, including PSUR assessment, so that immediate action can be taken as necessary. These measures constitute *routine pharmacovigilance activities*. In the case of Tresiba, these measures are supplemented with *additional risk minimisation* measures mentioned under relevant risks, below.

II.A List of important risks and missing information

Important risks of Tresiba are risks that need special risk management activities to further investigate or minimise the risk, so that the medicinal product can be safely administered. Important risks can be regarded as identified or potential. Identified risks are concerns for which there is sufficient proof of a link with the use of Tresiba. Potential risks are concerns for which an association with the use of this medicine

is possible based on available data, but this association has not been established yet and needs further evaluation. Missing information refers to information on the safety of the medicinal product that is currently missing and needs to be collected (e.g., on the long-term use of the medicine).

List of important risks and missing information	
Important identified risks	• Medication errors due to mix-up between basal and bolus insulin • Medication errors due to mix-up between the different strengths of Tresiba
Important potential risks	• None
Missing information	• None

II.B Summary of important risks

The important identified risks for Tresiba are presented below.

Important identified risks

Medication errors due to mix-up between basal and bolus insulin	
Evidence for linking the risk to the medicine	Medication errors are a known risk for many insulin products. The risk has been observed in clinical development programme and confirmed by reports from post-marketing experience. Medication errors in clinical trials are systematically collected and the cases are well documented. However, clinical trials are unrepresentative of clinical practice and the appearance of the device (labelling and cartridge colour) are not the same as the marketed device. Post-marketing data include events from all spontaneous cases (including literature cases), non-interventional studies and other solicited sources. Completed therapeutic confirmatory trials using the marketed device in which IDeg was used as the investigational drug and market experience are the evidence sources of this risk.
Risk factors and risk groups	Diabetic patients treated with basal–bolus insulin therapy, patients living with another person who has diabetes and visually impaired or colour-blind patients may be at a higher risk.

Risk minimisation measures	**<u>Routine risk minimisation measures</u>**
	
	***Routine risk communication*:**
	None.
	
	***Routine risk minimisation activities recommending specific clinical measures to address the risk*:**
	• <u>SmPC</u>
	  • Instructions for avoidance of medication errors are reflected in Section 4.4 of the SmPC.
	  • Special precautions for disposal and handling of the pre-filled pen (FlexTouch) and Penfill are described in Section 6.6 of the SmPC.
	
	• <u>Patient leaflet</u>
	  • Specific information on how to use Tresiba by patients who are blind or have poor eyesight and cannot read the dose counter on the pen has been included in the package leaflet for the patient.

	Other risk minimisation measures beyond the Product Information: Product differentiation strategy; includes trade names, label text, colour branding of the carton, container label and cartridge holder. **<u>Additional risk minimisation measures</u>** None.

Abbreviations: SmPC = Summary of Product Characteristics.

Medication errors due to mix-up between different strengths of Tresiba	
Evidence for linking the risk to the medicine	Medication errors are a known risk for many insulin products. The risk has been observed in clinical development programme and confirmed by reports from post-marketing experience. Medication errors in clinical trials are systematically collected and the cases are well documented. However, clinical trials are unrepresentative of clinical practice and the appearance of the device (labelling and cartridge colour) are not the same as the marketed device. Post-marketing data include events from all spontaneous cases (including literature cases), non-interventional studies and other solicited sources. Completed therapeutic confirmatory trials using the marketed device in which IDeg was used as the investigational drug and market experience are the evidence sources of this risk.
Risk factors and risk groups	*Visually impaired patients with diabetes who are erroneously prescribed or dispensed the wrong concentration of Tresiba in the FlexTouch device* The device is not intended for self-injection by patients with poor eyesight. The other risk factor is patients with '*pseudo awareness*' who think they should re-calculate the dose. *Colour-blind patients with diabetes who are erroneously prescribed or dispensed the wrong concentration of Tresiba in the FlexTouch device.* These patients may not notice the different colour and have to rely on other features to identify the concentration.

Risk minimisation measures	**<u>Routine risk minimisation measures</u>**
	
	Routine risk communication:
	None
	
	***Routine risk minimisation activities recommending specific clinical measures to address the risk*:**
	• <u>SmPC</u>
	  • Instructions for avoidance of medication errors are reflected in Section 4.4 of the SmPC.
	  • Special precautions for disposal and handling of the pre-filled pen (FlexTouch) and Penfill is described in Section 6.6 of the SmPC.
	• <u>Patient leaflet</u>
	  • Instruction for patients to check the name and strength on the label of the pen to make sure it is Tresiba 100 units/mL or Tresiba 200 units/mL.
	  • Specific information on how to use Tresiba by patients who are blind or have poor eyesight and cannot read the dose counter on the pen has been included in the package leaflet for the patient.
	  • Instructions on how to use Tresiba 100 units/mL and 200 units/mL solution for injection in pre-filled pen (FlexTouch) is included in the package leaflet for the patient.

	Other risk minimisation measures beyond the Product Information: • Product differentiation strategy; includes trade names, label text, colour branding of the carton, container label and cartridge holder. • Distinct colour coding, coloured side panels (only on Tresiba 200 units/mL packaging) and different packaging sizes. • For patients who are colour blind, a tactile element has been added to the push-button to help differentiate the two formulations. This step is in addition to reading the formulation information on the packaging and pen. • Concentration included on red background on all faces of the outer carton except bottom and additionally on the pen (Tresiba 200 units/mL). • Cautionary text on the carton 'Caution – One step equals 2 units – The pen shows the dose' added in box with red borders on the front panel (only on Tresiba 200 units/mL packaging). **<u>Additional risk minimisation measures:</u>** Additional risk minimisation activities are distributed when Tresiba 200 units/mL dose strength is newly launched and on a yearly basis for the first 2 years to help mitigate the medication errors due to mix-up between different strengths of Tresiba, including a direct healthcare professional communication, a poster for display in pharmacies/diabetic units and a patient education leaflet. The information will describe: • The distinct colour coding, coloured side panels (only on Tresiba 200 units/mL packaging), different packaging sizes. • Concentration prominently included on red background on all faces of the outer carton except bottom and additionally on the pen. • For patients who are colour blind, a tactile element has been added to the push-button to help differentiate the two formulations. This step is in addition to reading the formulation information on the packaging and pen. • Cautionary text on the carton 'Caution – One step equals 2 units – The pen shows the dose' added in box with red borders on the front panel (only on Tresiba 200 units/mL packaging).

Abbreviations: SmPC = Summary of Product Characteristics.

Important potential risks

There are no important potential risks in the safety specification for Tresiba.

II.C Post-authorisation development plan

II.C.1 Studies which are conditions of the marketing authorisation

There are no studies which are conditions of the marketing authorisation or specific obligation of Tresiba.

II.C.2 Other studies in post-authorisation development plan

There are no studies required for Tresiba.