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Physician Views: How will US-based endocrinologists use Eli Lilly, Boehringer Ingelheim's newly approved Glyxambi?

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Abstracts

Following a successful launch for the SGLT-2 inhibitor class – led by Johnson & Johnson's Invokana, which was approved by the FDA in March 2013 – the US diabetes market is poised to evolve further following approval of the first fixed-dose SGLT-2 inhibitor and DPP-4 inhibitor combination product: Eli Lilly and Boehringer Ingelheim's Glyxambi (empagliflozin/linagliptin).

Strong uptake of the SGLT-2 class should provide a decent platform for Glyxambi, particularly as key opinion leaders (KOLs) in the diabetes space have also cited the differentiated mechanism of action, and the ability to combine with other oral diabetes classes, as a notable advantage.

Not only did Glyxambi demonstrate a statistically significant reduction in A1C versus both monotherapies at 24 weeks, but versus linagliptin monotherapy provided significant weight loss. The all-oral nature of the combination is another additional benefit, note KOLs.

When FirstWord polled US-based endocrinologists in April 2013, shortly after the approval of Invokana, 40 percent of respondents suggested that a SGLT-2/DPP-4 fixed-dose combination would be a positive development. Subsequent impressive uptake of the SGLT-2 class is likely to have reinforced this view.

Reflecting an initially cautious view among analysts towards the SGLT-2 inhibitor class, consensus forecasts for Johnson & Johnson's market-leading Invokana have risen substantially over the past year: forecast sales of around $2.2 billion in 2018 are approximately double what they were at the beginning of 2014.

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Can Glyxambi ride in this slipstream and what impact will the combination have on both the SGLT-2 and DPP-4 classes? To better understand we are polling US-based endocrinologists, asking them specifically…

To what percentage of type 2 diabetes patients do you currently prescribe both a DPP-4 inhibitor and an SGLT-2 inhibitor?

What is the likelihood that availability of Glyxambi will significantly increase your usage rate of both these drug classes in combination?

Aside from patients already receiving both a DPP-4 inhibitor and an SGLT-2 inhibitor, from what treatment regimen will most patients you prescribe Glyxambi over the next 12 months likely transition from?

To what percentage of eligible type 2 diabetes patients (i.e. pre-insulin) would you expect to be prescribing Glyxambi to 12 months after launch?

What is the likelihood that availability of Glyxambi will play a significant role in slowing the progression of patients to treatment with a GLP-1 agonist?

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