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Provider Prescribing Habits And Use Of Newer Agents For Type 2 Diabetes In A Large Multicenter Health Care System

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**Introduction:** Type 2 diabetes (T2D) management approaches have evolved, with current algorithms recommending early use of newer agents such as glucagon-like peptide-1 receptor agonists (GLP-1 RA) and sodium-glucose cotransporter-2 inhibitors (SGLT-2i) when cardiovascular (CV) and renal disease are present. National prescribing data indicate stable metformin use and a decline in sulfonylurea use; prescriptions for newer agents have increased but remain low. High cost, difficulty with prior authorization, and insufficient experience have been proposed as reasons why newer agents are not prescribed more often. Our aims were to determine providers’ prescribing habits and use of newer agents for T2D in our health care system and to identify the factors influencing prescribers’ choice of medications and the barriers to prescribing GLP-1 RAs and SGLT2i.

**Methods:** This study was conducted at a large multicenter health care system. Health care providers were asked to complete an anonymous online survey. The survey was sent to 515 providers (357 primary care physicians, 26 nephrologists, 113 cardiologists, and 19 endocrinologists).

**Results:** There were 125 respondents (24%): 81 (64.8%) in primary care, 22 (17.6%) in cardiology, 13 (10.4%) in endocrinology, and 9 (7.2%) in nephrology. All respondents in endocrinology and primary care, 45.5% in cardiology, and 66.7% in nephrology prescribed T2D medications. Metformin, SGLT-2i, and insulin were prescribed most frequently (76.8%, 78.4%, and 73.4%, respectively), followed by GLP-1 RAs (66.9%), DPP-4 inhibitors (43.9%), sulfonylureas (35.5%), and thiazolidinediones (8.9%). After metformin, SGLT-2i (57.6%) and GLP-1 RAs (55.2%) were most frequently chosen as second-line T2D medications. The top perceived benefits of using GLP-1 RAs and SGLT2i were improvement of hemoglobin A1c and decreased comorbidity risks. Most respondents also chose “to minimize weight gain/promote weight loss” as a benefit of GLP-1 RA use and "mortality benefit" as a benefit of SGLT-2i use. High cost and problems with prior authorization were the primary perceived barriers to prescribing GLP-1 RAs and SGLT-2i. Over half felt that the need to inject was a barrier to GLP-1 RA use, and concern for adverse reactions was a barrier to SGLT-2i use. Cardiology and nephrology specialists viewed limited experience as a barrier to prescribing GLP-1RAs.

**Conclusions:** At our health system, practices for prescribing T2D therapies were in accordance with published algorithms that recommend early use of GLP-1 RAs and SGLT-2i. High cost and need for prior authorization were the main perceived barriers to prescribing newer agents. Limited experience with newer agents was a barrier for nephrologists and cardiologists. Education on patient assistance programs, insurance formularies, and how to incorporate GLP-1RAs and SGLT-2i for CV and renal benefits may increase the use of these agents.

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