

**To test or not to test...**

- The value of routine SMBG, especially in patients not on insulin, has come into question, due to uncertain or marginal benefits & significant costs.<sup>1,2,3,4,5,6,7,8,9,10,11</sup> A possible association with depression<sup>12</sup> & lower quality of life<sup>13</sup> has also been noted. (See also: 1) Weighing the Benefits & Risks of Intensive Therapy in the Extras section online & 2) Landmark Trials chart.). **Consider cost of SMBG**, especially where testing may not change tx, not using insulin, or offer net benefit.<sup>14,15</sup>
- Some favour SMBG in most individuals with T2DM. However, SMBG is only worth doing **time & money** if it results in **+ve behaviour change**.<sup>16</sup>

**Highlight Recommendations from the CADTH Review\***

- For most adults with T2DM who are using insulin:**
  - SMBG should be tailored to best guide in fine-tuning insulin therapy to achieve optimal BG control.
  - This should require no more than 14 tests, on average, each week for most patients on basal insulin (≤2x per day). (Some individuals on MDI, may benefit from more frequent testing. See *Consider testing...section*)
- For most adults with T2DM taking BG lowering medication by mouth:**
  - Routine SMBG is **not** required.
  - Periodic testing may be required in some situations, but only if it helps determine a specific course of action. See *Other Considerations: Consider testing more often...section*
- For most adults with T2DM who control their diabetes through diet alone:** Routine SMBG is **not** required.

\*Note: In gestational & pre-gestational DM, SMBG ≥4x/day (pre & post-prandially) recommended.<sup>17</sup>

**CADTH Clinical Analysis**<sup>18</sup>

(From the Report Summary of Systematic Review (SR) of RCTs & observational studies)

**Patients with diabetes using insulin:**

- In general, the COMPUS systematic review identified few studies that explored the optimal frequency of SMBG in patients with either type 1 diabetes, or insulin-treated T2DM. Moreover, the studies that were identified reported mixed results, and were of low quality. In patients with **insulin-treated T2DM**, low-quality evidence suggests that use of SMBG is associated with improvements in glycaemic control.

**Patients with T2DM not using insulin:**

- The COMPUS systematic review elicited more robust studies for patients with non-insulin-treated T2DM (most tx with MF, SU, TZD) including several RCTs.
  - Pooled results from 7 RCTs showed that SMBG is associated with a statistically significant improvement in glycaemic control (**WMD\* in A1C [95% CI] = -0.25%** [-0.36, -0.15]). [However, a change of <0.5% is of questionable clinical significance.]
  - In 1 RCT, performing SMBG was beneficial to ↓ the number of symptomatic hypoglycemic events in patients using sulfonylureas.
  - For patients not using BG lowering drug tx, improvements in control were less pronounced & non-significant statistically. (**WMD\* in A1C [95% CI] = -0.05%** [-0.33, 0.23]).
  - Overall, quality of evidence varied, depending on the patient population.
- \*[CI= confidence interval, WMD=weighted mean difference]

**Other Considerations:**

- SMBG is often used** to provide feedback to new patients ↑ regarding the effects of lifestyle & dietary choices on BG levels. One Cochrane review found that for those **not** on insulin, benefits of SMBG on glycaemic control are small up to 6 months, & subside by 12 months.<sup>Malanda et al 2012</sup>
- Consider factors** such as motivation, comprehension level, age, hypoglycemia risk (e.g. especially when on insulin or secretagogues), exercise, illness, drug dose adjustments.
- Choice of meter** should accommodate individual needs.
  - Vision impairment: consider display size or voice option
  - Size/feel: portability, speed, dexterity & other needs (e.g. arthritis)
  - Alternate site testing: may be useful if significant pain from finger pokes
  - Simple vs many features, remote reading/transmission etc.
  - Test strip cost:** meters often complimentary; **strips = ↑↑ cost over time**
- Annual cost:** \$165 (1test/d) to \$1100-2400 (7test/d). Cost/100strips=\$75-100.

**If testing, when?** See also: SMBG DECISION TOOLS

- <http://diabetescare.nhs.uk/sites/default/files/files/SMBGDecisionTool.pdf>
- <http://guidelines.diabetes.ca/bloodglucoselowering/smbgtoolpww>
- Diet Only:** occasional testing, esp. of 2 hr post-prandial may be useful to reinforce lifestyle changes. {SK & **NIHB** allows for 3-4 tests/week <sup>200/year</sup>}
- OAHA only:** at staggered times; eg. pre- & 2hr post-prandial, 1 or 2x weekly (↑ or ↓ frequency as necessary; most benefits in 1st 6-12months<sup>11</sup>) {SK & **NIHB** allows for 1 test/day <sup>400/year</sup> for those on DM meds with high-risk of causing hypoglycemia, & 3-4 tests/week <sup>200/year</sup> for low risk.}
- OAHA & HS insulin:** 1-2x/day at variable times (≤14 tests/wk); e.g. fasting, pre- & 2hr post-prandial
- Insulin: multiple daily injections +/-OAHA:** individualize <sup>CADTH</sup>; ≥TID <sup>CDAs</sup>; pre- & 2hr post-prandial; \*\* { **NIHB** allows for ≤5 tests/day <sup>500/100days</sup> if on insulin. SK drug plan reimbursement allows for ≤10 tests/day <sup>3650/year</sup> on insulin. } \*\*Some patients with very intensive regimens may require paired meal testing; up to 7 tests/day.}
- Paired meal testing (AC before & 2hr PC after):** to match regimen to BG patterns; stagger times and days:
  - Day 1: AC & PC breakfast; Day 2: AC & PC lunch; Day 3: AC & PC supper; & HS somewhere. (Provides a good cross-sectional representation of pattern of hypo- & hyperglycemia, with **less testing**.)
  - Analyse after 1-3weeks.
- Paired HS & AM testing:** for a few nights ~ useful to assess basal control
- Consider testing more often:** in pregnancy; illness; exercise; prior to driving if on insulin, to detect & treat hypoglycemia; when diet &/or activity changes; after adjusting insulin/pills over 1-2 weeks; if hypoglycemic unawareness.

**BG Meters**<sup>19, 20, 21, 22, 23, 24</sup> {Note list of meters is not exhaustive.}

Consideration	Nova Max		Oracle	Dario	GE 200	TRUE			Medtronic
	Plus	Link				TRUEtrack	TRUEmetrix Air	Sidekick	
Reagent <b>A,B,C or D</b> (see notes**); Picture									
Impaired Vision	-	-	✓✓ voice (Eng/Fre)	Phone display	✓ large, backlit	✓ large	✓ large	-	Alarms
Drop size mol., Time seconds	0.3, 5 <sup>9u</sup> , 0.8; 10 <sup>ket</sup>	0.3; 5	0.7; 6	0.3; 6	0.75; 5	1; 10	0.5; 4	1; 5	Need ≥2 finger pricks/d to calibrate
Range (glucose): mmol/L	1.1-33.3, 0.1-8 <sup>ket</sup>		1.1-33.3	0.5-33.3		1.1-33.3			0-35U/hr basal, 0-75U bolus
Downloadable (✓), memory	✓, 400		✓, 450	✓	1000	✓, 365	✓, 1000	50	✓, 365
Expiration (strips)	6 months		3 months	As labelled	3 months	4 months			Predictive <b>30 min advance</b> connects to <i>Contour Next Link</i> meter and replaces <i>Guardian</i> . 5 colors available. Not waterproof! <b>Glu suspend for 2hrs</b> , 2 reservoir sizes; Continuous glu monitoring. Can be used without insulin. <i>Medtronic CareLink</i> software to track insulin and glu graphs; allows caregiver access. Wear 6 days at a time. Sensor reads every 5 minutes. 1 x AAA, Rechargeable sensor.
Day Average - Range	≤30		≤90	≤30	≤90	≤30			
Alternative Testing Sites (Glu only)	Palm, forearm		Palm, forearm, upper arm, calf, thigh	Fingertip only	Palm, forearm	Forearm			
Other {Note most strip pkg sizes in 50s & 100s}	Beeps when enough blood on strip. 1 x Li <sup>3V</sup>	Same as <i>Nova Max Plus</i> , but no ketone testing. Connection to IP. 2 x Li <sup>3V</sup>	Simple, large buttons and backlit screen. If BG ≥ 13.3 mmol/L, warns to check ketones. 2 x AAA	All-in-one package, pocket-sized. Connects to Apple/Android. Web portal allows caregiver access. Smart phone provides battery & memory.	Easy-to-handle strips. Large buttons. 2 x Li <sup>3V</sup>	May be hard to use. <sup>21</sup> Low cost strips (~\$60). No auto coding like <i>TRUEread</i> . 1 x Li <sup>3V</sup>	<i>TRUEmetrix</i> available with less fxs. Bluetooth enabled. Low cost strips. Results with time and date, 4 event <b>♫</b> , ketone test reminder. 1 x Li <sup>3V</sup>	All in one disposable system, simple and low cost. Record reading before discarding.	
♫ = reminder function !! = Alarms									

Consideration	Accu-Chek			Bayer			Freestyle				One-Touch			Sanofi-Aventis	
	Aviva/Aviva Plus, Nano	Aviva Combo	Mobile	Contour Next Link	Contour Next USB	Contour Next EZ (plain)	Precision Neo	Lite; was Mini	InsuLinx	Libre (unreleased) <sup>26,27</sup>	Ping	Verio Flex	Verio IQ	BGStar	
Reagent <b>A,B,C or D</b> (see notes**); Picture															
Impaired Vision	✓ LCD	✓ Colour display	Acoustic mode beeps	Illuminated display & strip port	Lighting Buzzer	✓ Large Buzzer	✓ Large Backlit	Backlit Strip port light	✓ Large TS, backlit	✓ Large TS	High contrast OLED colour	✓ Large	✓ Backlight; colour LCD	✓ Large, backlit	
Drop size mol., Time seconds	0.6; 5			0.3; 5	0.6; 5	0.6-33.3	0.6-33.3	0.6; 5 <sup>9u</sup> , 1.5; 10 <sup>ket</sup>	0.3; 4	0.3; 5	-; 1-3	1; 5	0.4; 5	0.5; 6	
Range: mmol/L	0.6-33.3			1.1-33.3	1.1-33.3	0.6-33.3	1.1-27.8 <sup>9u</sup> , 0-8 <sup>ket</sup>	1.1-27.8 <sup>9u</sup> , 0-8 <sup>ket</sup>	1.1-27.8		2.2-27.8 <sup>9u</sup> , 0-8.0 <sup>ket</sup>	1.1-33.3	1.1-33.3	1.1-33.3	
Downloadable (✓), memory	✓, 500	✓, 1000	✓, 2000	✓, 1000	✓, 2000	✓, 480	✓, 1000	400	✓, 165	✓, 480	✓, 20 000	✓, 500	✓, 750	✓, 1865	
Expiration (strips)	As labelled			3 months	6 months			As labelled				6 months			3 months
Day Average	≤90			≥30	≤90	≤30	≤30	≤30				≤90			≤90
Alternative Testing Sites (Glu only)	Palm, forearm, upper arm	-	Thumb, palm, upper arm, calf, thigh	Palm			-	Forearm, upper arm, thumb	Palm, upper arm, thigh, calf	-	-	Palm, forearm	-	Palm, forearm	Palm, forearm
Other {Note most strip pkg sizes in 50s & 100s}	Ergonomic, easy to hold. <i>Aviva Compact Plus</i> has a 72h back-up battery. Nano similar, except smaller. ♫ x4/d. !!	For insulin use/IP (calc bolus dose). Color graphs, tables ♫ !! 3 x AAA	Large size. 50tests/cassette; 6 lancets/drum. No strip handling. 15 languages, ♫x10/day. 2 x AAA plus backup 1 x Li <sup>3V</sup>	More fx than Contour Next. Sync with Medtronic IP. 2nd-chance sampling of blood. Rechargeable.	Easy to use Similar to <i>Contour Next</i> . 14 languages. Rechargeable.	Good option if not tech savvy. ?claim more accurate lows. 2nd-chance BG sampling. Personalize ♫. 2 x Li <sup>3V</sup>	Suggests insulin dose. 2 x Li <sup>3V</sup>	As per <i>Freedom Lite</i> , but ♫ x4 programmable. 2 x Li <sup>3V</sup>	Bolus insulin dose calculator; ♫ !!; 2 x Li <sup>3V</sup> plus backup. Recall May 13, ↑↑ BG reading.	Scanner used over clothing. Continuous Glu monitoring. USB for computer; graphs with date, time. Rechargeable.	Remote 10ft. Can add Dexcom platinum system. Continuous Glu monitoring. Water proof 12m. IP. 2 x AAA	Good option if tech savvy. Colour bar indicates low, in range, or high levels. Bluetooth enabled. 1 x Li <sup>3V</sup>	Good option if tech savvy !!, Eng/Fre Rechargeable. Recall Mar 13, ↑↑ BG, may shut off.	♫ x7 / day. Record pre/ post, non-slip grip. 2 x Li	

A1c=hemoglobin A1c ac=before meals Alternate Site Testing (AST): Most newer meters allow for testing from forearm, upper arm, palm, thigh or abdomen as well as usual fingertip. Automatic Coding= all meters are automatically coded unless otherwise specified ave=averaging BG=glucose CADTH=Canadian Agency for Drugs & Technologies in Health CI=confidence interval COMPUS=Canadian Optimal Medication Prescribing and Utilization Service CV=cardiovascular Eng/Fre=English and French Exp=Expiration Fx(s)=Function(s) Glu=glucose IFR=infrared data transfer IP=Insulin Pump Ket=ketones OAHA=oral anti-hyperglycemic agent RCT=randomized controlled trial SMBG=Self-monitor blood glucose pc=after meals T2DM=Type 2 diabetes TS=Touch Screen WMD=weighted mean difference

Reagent Interactions: A Strips with GDH (glucose dehydrogenase) PQQ (pyrroloquinolinequinone): cross react with maltose, galactose or xylose (but not D-glucose); e.g. some immunoglobulins, icodextrin peritoneal dialysis soln, Orenicia, Bexxar; B: GO (glucose oxidase +/- ferricyanide); affect by O2; C: GDH (glucose dehydrogenase) FAD (Flavin adenine dinucleotide); affected by xylose; D: no interaction. <sup>28</sup>

Background considerations:

- **Weighing the benefits & risks of intensive therapy:** [See also Diabetes - Landmark Outcome Trials Chart<sup>29</sup>]
  - The results of clinical trials evaluating outcomes of intensive glycemic control have been somewhat disappointing. Achieving an A1C of less than 6.5% may ↓ microvascular endpoints, but over 100,000 patient years of RCT data have failed to show a benefit on CV endpoints.<sup>30</sup> {The 10 year observational follow-up to the UKPDS suggests CV benefit of intensive glycemic control (FBG <6; mean baseline A1Cs 7.9% vs 8.5%) especially with metformin.<sup>31</sup>}
  - Individualization of antihyperglycemic therapy has become a common theme<sup>32,33</sup> as some evidence & experience suggests that some patients may do worse with more intensive regimens (e.g. ↑ mortality (NNH=95/3.5yrs) in the ACCORD RCT<sup>n=10,251</sup> in patients randomized to achieve an intensive A1c of 6% vs 7 - 8%; actual A1c achieved was 6.4% vs 7.5%)<sup>34</sup>.
  - Although an A1C of <7% is suggested for most, individual patient & treatment regimen factors may result in acceptance of less aggressive targets. For example the American Geriatric Society<sup>35</sup> noted that an A1C of 8% may be more suitable in frail elderly & those with a life expectancy <5yrs.
  - A recent observational cohort trial found a "U" shaped curve for mortality related to A1C. An A1C of 7.5% was associated with the lowest mortality, with higher mortality seen at higher and lower A1C values.<sup>36</sup>
- **CADTH Exec Summary:** Within the limitations of available evidence, this report concludes:
  - Use of SMBG appears to be associated with improvements in glycemic control among patients with insulin-treated type 2 diabetes. Evidence was limited and of low quality.
  - Few studies compared different frequencies of SMBG for patients with either type 1 or insulin-treated type 2 diabetes, and the evidence from these studies was of low quality. Well-designed studies may prove beneficial in optimizing SMBG frequency for these individuals.
  - Use of SMBG in patients with type 2 diabetes who are not using insulin is associated with a statistically significant, albeit clinically modest, improvement in glycemic control. Performing SMBG may reduce the number of symptomatic hypoglycemic events in patients using sulfonylureas. There was little or no evidence that SMBG provides other benefits, such as improved quality of life, or greater patient satisfaction. Longer-term studies are needed to determine whether or not SMBG reduces diabetes related clinical endpoints (e.g., blindness, reduction in myocardial infarctions, end-stage renal disease) or mortality. Studies of specific subgroups within this population who may be more likely to benefit from SMBG are also warranted.
  - The effect of using SMBG in women with **gestational** diabetes requires further investigation.
- **Estimated 40 year NNTs for SMBG in non-insulin T2DM:** 266 for MI; 500 for stroke; 1,389 for end stage renal disease<sup>15</sup>

Comparison: CADTH & Canadian Diabetes Association (CDA).

- CADTH review includes detailed systematic review of the clinical evidence as well as cost evaluation. Significant effort goes into limiting, minimizing the possible effects of, and acknowledging conflicts of interest.
- CDA guidelines include clinical evidence only. Conflicts of interest are more extensive; however they are acknowledged.

Other Major Meta-analysis Reviews

- Poolsup et al SMBG Meta-analysis: suggests that SMBG in non-insulin T2DM may benefit those with a baseline A1C of >8%, but not < 8%.<sup>37</sup>
- St John meta-analysis: suggests similar ↓ in A1C of -0.22 (95% CI: -0.34—0.11). St John A, Davis WA, Price CP, Davis TM. The value of self-monitoring of blood glucose: a review of recent evidence. J Diabetes Complications. 2009 Feb 19.
- Gomes T, Juurlink DN, Shah BR, Paterson JM, Mamdani MM. Blood Glucose Test Strip Use: Patterns, Costs and Potential Cost Reduction Associated with Reduced Testing. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences; 2009. Accessed Feb 11, 2010 at <http://www.ices.on.ca/fliip-publication/blood-glucose-test-strip-use/index.html#1> Outlines strip costs for elderly in ON; found potential for reduce costs by \$26 million - \$302 million if less testing in low-risk.

Health Canada Related Alerts

- Possible interference of icodextrin, intravenous immunoglobulins, galactose and d-xylose with certain blood glucose meters - Notice to Hospitals [http://www.hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/prof/2008/gluc\\_met\\_nth-aah-eng.php](http://www.hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/prof/2008/gluc_met_nth-aah-eng.php)

Reagents: **NOTE:** (Adapted from Hamilton Family Health Team – Table)

- **Why consideration of reagents in test strips is important** -e.g., peritoneal dialysis - use meters that are not affected by GDH-PQQ  
 Rationale: drug products or therapies that contain certain non-glucose sugars, such as maltose, galactose, and xylose will produce falsely elevated glucose result if measuring your glucose using a GDH-PQQ test strip. This could result in insulin dosing errors or not detecting low (hypoglycemic) readings. Avoid use of these test strips in patients using interfering drug products or therapies. **Glucose oxidase** – may be important at certain altitudes, although very rare.
  - A Strips with glucose dehydrogenase (GDH) pyrroloquinolinequinone (PQQ) will have cross-reactivity with maltose, galactose or xylose but are unaffected by pO2.
  - B Strips with glucose oxidase are affected by pO2 in the blood but not by maltose, galactose and xylose
  - C Strips with glucose dehydrogenase (GDH) Flavin adenine dinucleotide (FAD) can be affected by xylose but unaffected by pO2, maltose and galactose. D: no interaction

**Maltose:** found in IV solutions (i.e. immunoglobulin) and other solutions containing dialysate icodextrin  
**Alternate site testing:** not recommended if hypoglycemia suspected, especially if prone to hypoglycemic confusion. In these cases, the finger tip method is the best way to get an accurate result.

If practice changes to reflect the evidence, \$450 million to \$1.2 billion\* could be freed up between 2012 and 2015 for spending on antidiabetes interventions that are proven effective. Patient health would not be affected negatively.

[http://www.cadth.ca/media/compus/pdf/C1109-Prescribing-Aid-Web-e.pdf?utm\\_source=c1109&utm\\_medium=vo2-issue-8&utm\\_campaign=communiqu-03-13-12](http://www.cadth.ca/media/compus/pdf/C1109-Prescribing-Aid-Web-e.pdf?utm_source=c1109&utm_medium=vo2-issue-8&utm_campaign=communiqu-03-13-12) Revised March 2012

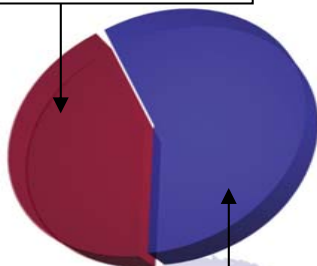
[These results were prepared using data from Brogan Inc., a unit of IMS, PharmaStat®, Public and Private Drug Plans Databases, 2000-2011]

- Cost to drug plans public+private = \$330 million 2006 <sup>Canadian data</sup>
- Cost per QALY (quality adjusted life year) is estimated at \$113,643 for routine use of SMBG (at least 1 strip each day on average).
- Annual cost per patient: \$165 - \$2,400 (see Table below).

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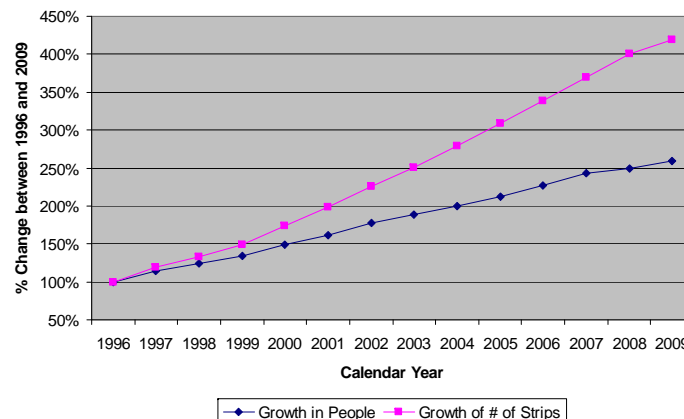


Patients with diabetes who are using insulin  
\$183,000,000

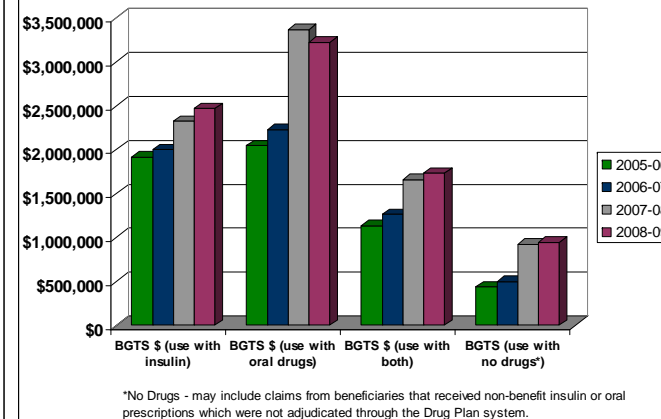


Patients with diabetes who are not using insulin  
\$317,000,000

Growth of Blood Glucose Test Strip Users and Strips Saskatchewan Drug Plan



Cost of Blood Glucose Test Strips (Saskatchewan Drug Plan Paid)



\*No Drugs - may include claims from beneficiaries that received non-benefit insulin or oral prescriptions which were not adjudicated through the Drug Plan system.

## References (SMBG)

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- Note: see Diabetes and Pregnancy Recommendations, page s170 and s174*
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## Extras:

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FDA Aug/10 and CDC have noted a progressive increase in the reports of bloodborne infection transmission over the past 10 to 15 years (**primarily hepatitis B virus**), resulting from shared use of fingerstick and point-of-care [POC] blood testing devices.

FDA Aug/13 Nova Diabetes Care initiated a voluntary **recall of 21 lots of the Nova Max Glucose Test Strips** distributed both in the USA and outside the continental USA.

FDA Jan/14 Nipro Diagnostics initiated a voluntary recall and replacement of a limited number of **TRUEbalance and TRUEtrack Blood Glucose Meters** distributed both in the United States and outside the United States. The company determined that certain isolated TRUEbalance and TRUEtrack Blood Glucose Meters have an incorrect factory-set unit of measure that displays the glucose result in mmol/L rather than mg/dL. If a consumer were not to notice the incorrect unit of measure, it is possible that the meter result could be read as a lower than expected blood glucose result.

BACKGROUND: There are 501 affected TRUEbalance meters and 105 affected TRUEtrack meters that were distributed in the United States from September 2008 to May 2013. The company is sending notifications to pharmacies, durable medical equipment providers, mail order companies and distributors where the TRUEbalance and TRUEtrack meters are recommended or sold in the United States.

FDA Mar/14 Abbott is conducting a recall for the **FreeStyle Blood Glucose Meter and the FreeStyle Flash Blood Glucose Meter**. When used with the Abbott FreeStyle test strips, the FreeStyle Blood Glucose Meter and the FreeStyle Flash Blood Glucose Meter may produce mistakenly low blood glucose results.

FDA Apr/14 is advising people with diabetes and health care professionals to stop using **GenStrip Blood Glucose Test Strips** because the strips may report incorrect blood glucose levels.

FDA Jun/14 Diabetic Supply of Suncoast, Inc. initiated a nationwide voluntary recall of all **BMB-BA006A Advocate Redi-Code+ blood glucose test strip** lots manufactured by BroadMaster Bio-Tech Corp due to a labeling error which could result in confusion about which meter models the Redi-Code+ BMB-BA006A blood glucose test strips are designed to be used with. In the incorrect labeling, the test strips model (BMB-BA006A) was omitted.

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MHRA June/16 TRUEyou blood glucose test strips - certain lots of test strips may give incorrect low blood glucose results that could lead to undetected hyperglycaemia.

Ontario Aug 2013: introducing limitations in funding for diabetes test strips. And these new restrictions are okay with the Canadian Diabetes Association, which worked with the government to ensure that new self-management of diabetes reflects the best evidence and clinical experience available. According to a notice posted on the Ontario Public Drug Programs (OPDP) website, research indicates that Blood Glucose Test Strips (BGTS) have a limited clinical benefit for many patients who don't take insulin. Based on this evidence, Ontario will restrict the number of BGTS allowed in a 365-day period, while ensuring continued access to those who need test strips to manage their blood sugar. The province's Health Network System (HNS) will track and determine the reimbursement level based on each patient's diabetes treatment. Under the new rules, patients managing diabetes with insulin will be allowed 3,000 BGTS a year, while patients managing diabetes with anti-diabetes medication with high risk of causing hypoglycemia will get 400 BGTS. Patients managing diabetes using anti-diabetes medication with low risk of causing hypoglycemia and those who are managing diabetes through diet/lifestyle therapy only will be allowed 200 BGTS.

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