THE DOSE

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Thames Valley Family Health Team's Quarterly Drug Information Newsletter

Thames Valley Family Health Team

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In this issue:

Zepbound (tirzepatide): new option for weight loss

Tirzepatide is indicated for weight management in Canada similarly to Wegovy.[1] **Zepbound has shown greater weight loss (15-21%) than Wegovy (15%).**[2]

Medication	Average weight loss at 1 year[2]	Monthly cost	ODB or NIHB coverage?
Tirzepatide (Zepbound)	**15-21%**	**$400-800**	No. Has patient support program
Semaglutide (Wegovy)	**15%**	**$400-500**	No. Has patient support program
Liraglutide (Saxenda)*	8%	$400-500	No
Naltrexone-bupropion (Contrave)	6%	$250-350	No. Has patient support program
Orlistat (Xenical)	3%	$200	No

Prescribing Zepbound: key details

- **Dosing**: Start at 2.5 mg SC weekly, increase every 4 weeks until reaching maintenance dose (10 mg, 12.5 mg or 15 mg depending on tolerability)
- Five strengths: 2.5 mg, 5 mg, 7.5 mg, 10 mg, 12.5 mg and 15 mg Kwikpens
- **GI side effects in >50% of patients (dose dependent)**. In trials 5% of patients discontinued due to a GI adverse effect (vs. 2.6% in placebo).[1,3]
  - Nausea 24-33%
  - Diarrhea 18-23%
  - Constipation 11-17%
  - Vomiting 8-12%
  - Abdominal pain 5%
- Pancreatitis same as placebo (0.2%). No cases of medullary thyroid cancer.[3]

FREE GROUP: Best Weight is an online group for the public (Thames Valley FHT patients or not) that covers lifestyle approaches to weight loss.

Important update: Dexcom G7 covered, Libre 3 available

Dexcom G7 covered for ODB and NIHB recipients on insulin

The Dexcom G7 is now covered for ODB and NIHB recipients. **Anyone who is qualifies for ODB or NIHB coverage of FreeStyle Libre 2 is eligible for Dexcom**, as criteria are the same:

- Patients **on insulin therapy** for diabetes [type 1 or type 2]. No LU code needed[4]

FreeStyle Libre 3 Plus now available but not ODB-covered

The Libre 3 Plus is the successor to the FreeStyle Libre 2. Libre 3 Plus highlights:

- It is smaller than both Dexcom G7 and Libre 2 – size of 2 stacked pennies
- Libre 3 Plus sensors last for 15 days (Libre 2 sensors last 14 days)
- Data storage for full 15 days – no need to scan every 8 hours to get full data
- **NOT** currently covered by ODB. Covered by NIHB with same criteria as Dexcom

See page 2 for a full comparison of these continuous glucose monitors (CGMs)

CGMs: What you need to know (Dexcom G7, FreeStyle Libre 3 Plus, Libre 2)

Key points:

- ODB currently covers the Dexcom G7[4] and FreeStyle Libre 2 but patients must be on insulin
- NIHB covers Dexcom G7 and FreeStyle Libre 2 and Libre 3 Plus for patients on insulin
- All CGMs can be purchased over the counter, but a prescription is needed for coverage
- All CGMs provide **interstitial** glucose measurements. Capillary blood glucose remains most accurate to verify if a "low" reading on a CGM is a true low (blood glucose <4 mmol/L).[5]

Practical comparison of the Dexcom G7, FreeStyle Libre 3 Plus and FreeStyle Libre 2

	Dexcom G7	**FreeStyle Libre 3 Plus**	**FreeStyle Libre 2**
Duration of one sensor	10 days + 12-hour grace period to replace sensor	**15 days**	14 days
Relative sensor size	Smaller	**Smallest**	Largest
How to see glucose	Phone app (free) OR Dexcom G7 receiver	Libre 3 phone app (free) OR Libre 3 reader	Libre 2 phone app (free) OR Libre 2 reader
Is scanning required?	No	No	Yes, if using reader only must scan every 8 hours. No scanning required if using phone app
Data storage	24 hours	15 days	8 hours
Sensor warmup period	30 minutes	1 hour	1 hour
Coverage	**ODB (new)** and NIHB for people on insulin	NIHB for people on insulin.	ODB and NIHB for people on insulin
Cost per month	~$300 (3 sensors)	~$260 (2 sensors)	~$260 (2 sensors)
Sensor administration	Sensor is preloaded into applicator	Sensor is preloaded into applicator	Must load the sensor into applicator
Approved ages for use	2 years old and up	2 years old and up	4 years old and up

Frequently asked questions about CGMs

Q: Do all patients need to be switched over from Libre 2 to Libre 3 right now?
A: No, the Libre 2 is still available. Patients can switch to Libre 3 when it becomes covered by their plan.

Q: Which CGM is the best?
A: There is no one ideal CGM. Patients may find that one is more accurate for them. Coverage, sensor size, duration, need for a phone and ease of application can guide which CGM is best for a given patient.

Practice tool spotlight: Osteoporosis Canada Calcium Calculator

Case example: While counseling a 67-year-old female patient on vitamin D and calcium supplementation for osteoporosis, she asks you if her daily 500 mg calcium carbonate tablet is sufficient.

What is it? Allows patients to estimate their daily dietary calcium intake.

What does it provide? Adds up calcium content among many different foods to provide a total calcium intake and compares this to the recommended daily calcium intake. If patients are below the recommended amount, it advises them to increase their intake and provides an amount, in mg, to add.

When is it most helpful? Saves time and empowers patients to self-assess and adjust the calcium content of their diet. Patients who eat calcium-rich foods may need only a low-dose supplement or no additional supplement, and this approach helps to better individualize recommendations.

How to access? Free online resource – click here to access

Bottom line: Questions about getting enough calcium from diet or needing a supplement? Send patients this link so they can accurately gauge for themselves!

Rapid fire: quick updates for busy primary care providers

Saxenda discontinuation

Saxenda (liraglutide daily injection for weight loss) will be **unavailable by October 2025** due to an anticipated shortage, and it will be officially discontinued in March 2026.[6]

Victoza (liraglutide daily injection for type 2 diabetes) will remain on the market.

Patients wishing to remain on medications for weight loss should aim to switch before October 2025 to minimize interruptions. Semaglutide (Wegovy) and tirzepatide (Zepbound) are other GLP-1 medications indicated for weight loss.

Stay tuned for further information and guidance on switching patients on GLP-1 and/or GIP/GLP-1 products.

Rupall generic tablets now available

Rupatadine (Rupall) is a second-generation antihistamine available via **prescription only** for allergic rhinitis or chronic spontaneous urticaria.

Place in therapy: Rupatadine may help allergic symptoms not improved with other antihistamines.

Tablets are indicated for patients ≥12 years old. Not recommended in pregnancy due to lack of data and should be used cautiously in lactation as it is excreted into breast milk.

Rupatadine is not covered by ODB. The generic is $45/month compared to the brand $55/month. A brand savings card may make the brand tablets less expensive than the generic tablets.

New Hypertension Canada 2025 guidelines for primary care

Click here to access guideline.

Guideline goals: Aim to provide pragmatic, streamlined recommendations for hypertension management in primary care, in response to requests for a more simplified approach.[7]

Guideline highlights include:

- Defining hypertension as **BP ≥130/80 mmHg** (2020 guideline used ≥135/85 mmHg)
- **Starting pharmacotherapy if BP ≥140/90** mmHg, or if SBP is 130-139 mmHg in patients at high cardiovascular (CV) risk
- Target **SBP <130 mmHg for all adults** (2020 guideline had varied targets based on CV risk)
- **Low-dose combination therapy as first-line**, with high value on reaching targets sooner
- Adding **spironolactone if BP targets not met** with maximal ACE inhibitor or ARB + thiazide or thiazide-like diuretic + long-acting calcium channel blocker.

Bottom line:

- 2025 guidelines have tighter targets and lower threshold for initiating treatment[7,8]
- Shared decision-making remains key

Stay tuned for a more detailed summary in future editions of The Dose!

CEP academic detailing updates

New topic: ADHD in adults

Are you getting requests for ADHD screening from adult patients? Learn to use a 5-minute, 6-question screener to help in diagnosing ADHD, reducing the need for psychiatry referrals, wait times, and multiple visits to your office. Reach out to your TVFHT pharmacist to schedule a visit, or to CEP if you are not at a TVFHT site.

Did you know? Atomoxetine (brand name Strattera) is marketed as a non-stimulant but acts like a stimulant – it can cause **increased blood pressure (to a greater extent than stimulants in some patients) and insomnia.**

Pharmacotherapy for obesity: Did you know that only six medications have an indication for weight loss in Canada? This topic covers the 4M framework for assessing, initiating, and managing treatment for patients with obesity.

Heart failure: Not sure if it's heart failure? NT-proBNP is covered by OHIP and can help rule out heart failure with a high degree of confidence. This topic also covers the four standard therapies for patients with HFrEF.

New products on the market

Questions about menopausal hormone therapy? Book a **menopause academic detailing visit starting fall 2025**!

Bijuva[9] (estradiol 0.5 or 1 mg / progesterone 100 mg tabs)

A combination product with estrogen and progesterone.

Indication: Treatment of vasomotor symptoms (VMS) of menopause in women with an intact uterus.

Dose: 1 capsule daily with food. 2 strengths: estradiol 0.5 mg or estradiol 1 mg, both with progesterone 100 mg.

Contraindications: Liver disease or dysfunction, personal history of estrogen- or progesterone-dependent cancer, migraine, endometrial hyperplasia, history of thromboembolic disease or venous thromboembolism.

Special populations: Do not use in pregnancy or lactation. Not recommended over 65 years of age.

Adverse effects: Same as for estrogen and progesterone. Most common: breast tenderness, vaginal bleeding, pelvic pain, headache, vaginal discharge. Cardiovascular risks of estrogen include heart attack, stroke, blood clots, hormone-dependent cancers, elevated blood pressure or triglycerides.

Efficacy: Reduced frequency and severity of VMS vs. placebo. Expected to be as efficacious as both components separately.

Place in therapy: Any patient optimized or starting on estradiol 0.5 mg or 1 mg who wishes to reduce pill burden.

Cost: $40 for 30 days. **Covered by ODB**, no LU code.

Pyridium[11] (phenazopyridine hydrochloride 100 mg tablets)

This product was previously unavailable in Canada and has been relaunched in 2025.

Indication: Analgesic for pain, burning, urgency and frequency caused by irritation of lower urinary tract.

Dose: 200 mg 3 times daily after meals. **Limit treatment to 2 days when used with an antibiotic** for treatment of urinary tract infection (UTI).

Contraindications and precautions: Contraindicated in hypersensitivity, renal or any liver disease. Do not use in G-6-PD deficiency due to the risk of hemolytic anemia.

Pregnancy/lactation/special populations: Crosses the placenta. Use only if benefit clearly outweigh risk. No data in lactation. No data in elderly patients.

Adverse effects: Common: Orange to red discolouration of urine and feces. May cause discolouration of body fluids. May stain fabric, clothing and contact lenses if touched after handling tablets. Serious: yellowing skin or sclera, dark urine, nephrotoxicity.

Efficacy: Phenazopyridine may reduce symptoms but **will not cure the underlying cause** of urinary tract discomfort.[8]

Place in therapy: Limited due to short duration of use and limited evidence.[8] Not part of routine care of UTIs.

Cost: $20 per 6 tablets. No ODB coverage.

Accrufer[12] (ferric maltol 30 mg capsules)

A new prescription option for iron deficiency anemia in adults. The complex dissociates in the GI tract and iron is absorbed in the intestine.

Indication: Adult patients with iron deficiency anemia unresponsive or intolerant to other oral irons.

Dose: 30 mg twice daily on an empty stomach.

Contraindications and precautions: Contraindicated in hypersensitivity, hemochromatosis and other iron overload syndromes and patients receiving repeated blood transfusions. Avoid in inflammatory bowel disease (IBD) due to risk of increased GI tract inflammation. Contains lactose. Not indicated in paedatrics.

Pregnancy/lactation: Maternal use not expected to result in fetal exposure. Avoid iron overdose in pregnancy due to risk of adverse fetal outcomes. No data in lactation but it is unlikely to pass into breast milk.

Adverse effects: Gastrointestinal symptoms, including flatulence (4.6%), diarrhea (4%), constipation (4%), discoloured feces (4%), and abdominal pain (2.9%). No serious adverse events in clinical trials.

Drug interactions: Like iron salts, ferric maltol absorption may be reduced by calcium and magnesium salts and antibiotics (tetracyclines, quinolones, penicillin). Separate administration of these products by 2-3 hours.

Efficacy: Improved hemoglobin levels compared to placebo in patients with IBD and CKD not on dialysis.

Place in therapy: An oral iron option that was **not compared to other iron salts with evidence limited to specific populations only.**

Cost: $120/month. No ODB coverage.

Treating lice in primary care

The following article was originally written by Saira Baboolal, UWaterloo PharmD Student, Rx2025. Full reference list is available on page 8.

Lice Treatment Guidelines – Comprehensive Chart for Primary Care Providers

See the following pages for treatment charts.

Bottom line

- There is **increasing resistance and treatment failure** to pyrethrin (R & C Shampoo) and pyrethroid treatments in Canada.
    - 97.1% of head lice tested in Canada were found to have potential resistant alleles.
- European studies and practice demonstrate superior efficacy of non-insecticidal physically acting agents (e.g. agents that suffocate or dissolve lice exoskeletons) vs. topical insecticides (with lice-killing action).
- **Due to increasing insecticidal resistance, it is reasonable to use a non-insecticidal physically acting agent (Resultz, NYDA) as first-line. Resistance to physically acting agents is unlikely.**
    - Use a non-insecticidal physically acting agent in the case of treatment failure with an insecticidal method.
    - In Canada, insecticide-based products (Kwellada, R & C Shampoo) are still considered first-line options but there is not clear data on prevalence of resistance.

Post-treatment recommendations

- Nits can remain attached to the hair shaft after treatment after 7-10 days, especially since the agents are not 100% ovicidal.
    - Mechanical removal of nits with a fine-tooth comb is recommended. Conditioner can be used during the removal process to loosen louse nits from the hair.
- “No nit policies” put in place which require children to be nit free prior to returning to school/childcare has not shown to reduce outbreaks and is not supported by medical rationale.
    - Full course of treatment is recommended and avoidance of close head-to-head activities.
- Guardians of the affected individuals' classmates or child-care mates should be promptly notified.
- In cases of treatment failure (live lice detected after treatment), it is recommended to try a full course of another medication from a different class. E.g. If two permethrin 1% applications done 7-days apart does not eradicate live lice, treatment with a non-insecticidal method could be considered.
- Patient may experience mild burning or itchiness during and/or after application of a topical insecticide; this does not indicate treatment failure or reinfestation.

Definitions

- Lice: Tiny, blood-sucking insects that are specific parasites of humans. Head lice are classified as Pediculus humanus capitis.
- Nit: Lice eggs; typically seen “glued” to hair shaft near the scalp (scalp has warmer conditions suitable for hatching). Typically hatch after 9-10 days.
- Nymph: After egg hatches and before becoming “adult” lice, they are classified as nymphs.
- Pediculicide: Agents used to treat head lice.
- Ovicidal Activity: The ability of an agent to kill insect eggs.
- Cure Rate: No detection of live lice after full treatment course (typically measured 2-weeks post treatment).

Lice Treatment Guidelines – Comprehensive Chart for Primary Care Providers				
Drug	**Population**	**Cost**	**Efficacy / Safety**	**Cure Rate**
Non-Insecticidal Methods				
Isopropyl myristate 50% and ST-cyclomethicone 50% (Resultz)	Safety and breastfeeding: No safety data. Not recommended for infants or children younger than 2 years; not recommended for children younger than 4 years.	**Covered by ODB** Resultz ≈ $20.00 for 120 mL	Physically acting agent: dissolves exoskeleton and dehydrates louse. **Resistance not likely due to physical mechanism of action.** Adverse effects include local irritation with mild erythema and scalp pruritus.	**Cure rate: 57–93%** Not considered to have ovicidal activity (retreatment recommended).
Dimeticone 50% (NYDA)	Containing 92% concentration of silicone oil dimeticone. Safety and breastfeeding: No safety data. Not recommended for use in children less than 2 years of age.	**Covered by ODB** NYDA ≈ $20–30	Physically acting agent that affects insects breathing – effective against lice, nymphs and egg embryos. **Toxicity or resistance not likely.** Adverse effects include mild, ocular irritation itching (flush well with water immediately).	**Cure rate: 97%.** Ovicidal activity: 100% (second treatment still recommended after 8-10 days in case of application errors)
Benzyl alcohol 5% lotion (Ulesfia Lotion)	Approved for use in Canada but not yet marketed. Intended for use on persons six months of age and older; safety for people > 60 years is unknown.	**Not covered by ODB** Quite expensive in comparison to alternative lice agents	Physically acting aromatic alcohol agent against live lice but is not ovicidal. Adverse effects include skin irritation.	**More effective at increasing lice eradication rates at 14 days compared to placebo** (second treatment 9 days after the first treatment required for a full treatment course)

Continued on next page.

Lice Treatment Guidelines – Comprehensive Chart for Primary Care Providers continued				
Drug	**Population**	**Cost**	**Efficacy / Safety**	**Cure Rate**
Topical Insecticides				
Permethrin 1% (Kwellada-P Creme Rinse, Nix Creme Rinse)	Current drug of choice for most patients. 1% formulation is drug of choice during pregnancy/breastfeeding. Acceptable treatment in children ≥2 months of age. Do not use in patients with chrysanthemum allergy.	**Covered by ODB** Kwellada-P Creme Rinse ≈ $17.00 for 50 mL Nix Creme Rinse ≈ $20.00 for 59mL	First line choice in Canada (exact resistance prevalence is unknown); resistance growing elsewhere. Minimal percutaneous absorption, favourable safety profile. Not 100% ovicidal, retreatment recommended. Neurotoxic to live lice – does not kill unhatched eggs.	**Cure rate: 96-100%*** Ovicidal activity after full treatment: 70–80% (retreatment recommended)
Pyrethrins with piperonyl butoxide (R & C Shampoo with Conditioner 0.33% & 3%)	Safe in pregnancy and breastfeeding. Approved for use in children ≥2 years of age; acceptable treatment in children ≥2 months of age. Contraindicated in patients with ragweed, chrysanthemums, pyrethrin allergy.	**Covered by ODB** R & C ≈ $14-24	First line choice in Canada (exact resistance prevalence is unknown); resistance growing elsewhere. Minimal percutaneous absorption, favourable safety profile. Not 100% ovicidal, retreatment recommended. Neurotoxic to live lice – does not kill unhatched eggs. May cause contact dermatitis due to the petroleum distillates.	**Cure rate: 94% after 2 applications*** Ovicidal activity: 25–50%.
Alternative Agents (Non-Pediculicides)				
Suffocation-Based Treatments (e.g. Vaseline, Cetaphil Cleanser, mayonnaise, thick hair gel) Manual Removal	Occlusive agents which are meant to “suffocate” the louse, limited efficacy data. Choice for families if reluctant about pediculicides, patient is too young for evidence-based therapies or resistance to FDA-approved products. If selected it is important to use careful manual removal technique for minimum 3-weeks (louse life cycle) and closely watch for treatment failure.	Varies based on product	May only partially impede lice ventilation since lice have alternative mechanisms of oxygen diffusion. Limited evidence to cause louse mortality; no ovicidal activity.	**Should ideally be avoided because of lack of evidence of efficacy.**

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