National Patient Safety Alert

Department of Health & Social Care

NHS

Levemir® (insulin detemir) FlexPen® 100units/ml solution for injection 3ml pre-filled pens and Levemir® (insulin detemir) Penfill® 100units/ml solution for injection 3ml cartridges

Date of issue:	1-Oct-26	Reference no:	NatPSA/2026/006/DHSC

This alert is for action by: All organisations involved in prescribing and dispensing Levemir® (insulin detemir) products.

This is a safety critical and complex National Patient Safety Alert. Implementation should be led by an executive lead (or equivalent role in organisations without executive boards) and supported by clinical leaders in Diabetes and Endocrinology, GP Practices, and Pharmacy.

Explanation of identified safety issue:

This alert is to supplement previous communications issued:

Medicine Supply Notification (MSN/2025/036) – issued on 16th June 2025;
Medicine Supply Notification (MSN/2025/036U) – issued on 14th August 2025; and
Medicine Supply Notification (MSN/2025/036U2) – issued on 15th April 2026.

Levemir® (insulin detemir) FlexPen® 100units/ml solution for injection 3ml pre-filled pens and Levemir® (insulin detemir) Penfill® 100units/ml solution for injection 3ml cartridges are being discontinued from end of December 2026 with stocks anticipated to be exhausted by this date.

Levemir® is a long-acting insulin analogue with a prolonged duration of effect used as a basal insulin. It is licensed for the treatment of diabetes mellitus in adults, adolescents and children aged 1 year and above. It can be used alone as the basal insulin or in combination with bolus insulin. It can also be used in combination with oral antidiabetic medicinal products and/or GLP-1 receptor agonists.

A range of alternative insulins from other suppliers are available. NOTE A

Please refer to the SPS Medicines Supply Tool entry for the discontinuation of Levemir® products for an overview of the supply situation and up to date supply stock overview of recommended insulins. The Medicines Supply Tool should be monitored regularly, as supply capabilities of alternative options remain subject to change.

Actions required

From immediate effect:

Clinicians and prescribers of Levemir® must:

- Not initiate patients on any Levemir® product.

Community pharmacists must:

- When presented with prescriptions for Levemir® products, after ensuring the patient has sufficient insulin, refer patients back to their prescriber, highlighting the need to switch to an alternative insulin due to the imminent Levemir® discontinuation.

As soon as possible and no later than 30/11/2026:

Clinicians and prescribers of Levemir® must:

- In line with locally agreed plans, implement insulin switches for all existing Levemir® patients in line with the clinical guidance (see Additional information below).
- Local teams should ensure that they have checked the current supply overview NOTE A of alternative insulins and aim to diversify prescribing across available alternatives to reduce the risk of precipitating a supply disruption of alternative products (see Additional information)
- In addition to consulting the clinical guidance, when prescribing alternatives, consider manual dexterity, vision, and whether additional support is required for administration, and:
  - ensure that all patients/carers are counselled on dose to be administered, provided with training on the use of their new device, as well as appropriate ancillaries, including signposting to training videos; and
  - advise patients that closer monitoring of blood glucose levels is required initially, and their insulin dose may need to be adjusted.
- Seek advice from specialist diabetes teams where required.

For further detail, resources and supporting materials see: Enter specific webpage provided by alert issuer

For any enquiries about this alert contact: DHSCmedicinesupplyteam@dhsc.gov.uk

Failure to take the actions required under this National Patient Safety Alert may lead to CQC taking regulatory action

Additional information:

For advice on switching patients on Levemir® to a suitable alternative, please refer to the clinical guidance that has been produced by clinical experts.

Alternative insulins NOTE A:

Insulin glargine U100 (Long acting):

- Abasaglar® KwikPen® and Abasaglar® cartridges. Please note: these cannot support increased demand.
- Lantus® SoloStar® and Lantus® cartridges
- Semglee® pre-filled pens (biosimilar)

Insulin glargine U300 (Ultralong acting):

- Toujeo® SoloStar® and Toujeo® DoubleStar®

Please note: as insulin glargine is available in two strengths, these products must be prescribed by brand to minimise the risk of product mis-selection.

Insulin degludec (Ultralong acting):

- Tresiba® U100 cartridges and Tresiba® U200 FlexTouch®

Human isophane insulin (intermediate acting):

- Humulin® I KwikPen® and Humulin® I cartridges. Please note: these cannot support increased demand.

Notes:

NOTE A: Refer to the Levemir® discontinuation entry on the SPS website for an up-to-date supply stock overview.

References:

1. Clinical Guideline: Discontinuation of Levemir®
2. BNF Insulin detemir
3. BNF Insulin preparations
4. NICE guidance: Type 1 diabetes in adults (insulin therapy)
5. NICE CKS- Insulin therapy in type 1 diabetes
6. NICE CKS- Insulin therapy in type 2 diabetes
7. SmPC Levemir®
8. SmPC Lantus®
9. SmPC Toujeo®
10. SmPC Abasaglar®
11. SmPC Semglee®
12. SmPC Tresiba®
13. SmPC Humulin® I
14. SPS Medicines Supply Tool entry for the discontinuation Levemir® products

Stakeholder engagement:

Advice for Central Alerting System (CAS) officers and risk managers
This is a safety critical and straightforward National Patient Safety Alert. In response to CHT/2019/001 your organisation should have developed new processes to ensure appropriate oversight and co-ordination of all National Patient Safety Alerts. CAS officers should send this Alert to a clinical lead, or equivalent role, to co-ordinate the implementation of this National Patient Safety Alert, copying in their nominated executive leader (or equivalent role in organisations without executive boards).