

CONSIDERATIONS FOR ESTABLISHING A TYPE 1 DIABETES EARLY DETECTION SCREENING AND MONITORING PLAN

This resource outlines how endocrinology practices can develop presymptomatic type 1 diabetes (T1D) screening processes and workflows to expand screening access through outreach. This resource is provided for your reference only. Development of specific screening processes and workflows in your practice will vary depending on your specific circumstances and capabilities.

PHASE 1

Establish T1D screening protocols and processes for your practice

An exemplary process flow for building T1D screening policies and capabilities

1

Build an early detection team with a “champion” to lead it

2

Define patient population to screen

3

Develop screening and monitoring protocols

4

Establish best practices for coding and billing

5

Build EHR workflows

6

Educate internal stakeholders

PHASE 2

Expand screening population through outreach and referral

Considerations on how to scale up to become an inbound referral center

1

Identify target referral population

2

Define intake process and referral pathways

3

Establish clinic scheduling and logistics

4

Scale up capacity

5

Develop communication cascade

6

Educate larger community

PHASE 1

Establish T1D screening protocols and processes for your practice

1 Build an early detection team with a “champion” to lead it

Identify a T1D screening team leader—such as a clinician or administrator—who is knowledgeable about T1D and can help coordinate workflow development. As a next step, organize a cross-disciplinary group, which may include leadership, clinical and administrative stakeholders, and information technology specialists.

NOTES:

2 Define patient population to screen

To start, consider implementing a risk-stratified approach that prioritizes screening children and adults at highest risk for T1D.

- **Starting point for screening pediatric patients:** Family history of T1D AND/OR history of autoimmune disease
- **Starting point for screening adults:** Abnormal glucose. Additional risk factors can be leveraged to enrich screening, including age <35 years, history of autoimmune disease, and/or family history of T1D

NOTES:

3 Develop screening and monitoring protocols

A. Screening

Define a screening process, including

- **How to order islet AAb testing:** Identify testing codes and consider use of AAb panels
- **Lab selection:** Internal lab or external lab (eg, Quest Diagnostics®, Labcorp, or other private labs)

B. Monitoring

Establish a monitoring protocol with follow-up intervals based on patient age and T1D stage and routine glycemic testing using tools such as OGTT, CGM and HbA1c.¹

NOTES:



See page 6 for ADA guidance on presymptomatic T1D screening and page 7 for considerations for risk-stratified screening pathways

Stakeholders to include:

- Health system leadership
- Endocrinology
- Clinical operations
- Diabetes educators
- Health IT
- Pediatricians
- Primary care providers
- Nursing

4 Establish best practices for coding and billing

Review applicable encounter, diagnosis, and reimbursement codes. Create a letter of medical necessity template for AAb testing. Track lab test approvals and denials to determine best practices for reimbursement.

NOTES:

5 Build EHR workflows

Establish order sets for your patients that include screening, AAb panels and reporting. Integrate workflows for AAb screening and early-stage T1D monitoring into EHR platform. Include patient lists, order sets for lab testing, best practice alerts for point-of-care reminders, outreach and results communications, and educational materials for at-risk patients.

NOTES:

6 Educate internal stakeholders

Educate internal staff as well as affiliated primary care and specialty providers on the opportunity and process to screen at-risk patients for T1D. Foster education through lunch-and-learn sessions, EHR communications, email/intranet, lectures, and/or grand rounds.

NOTES:

 Sanofi can provide you with educational tools on T1D risk, screening and monitoring, and EHR integration for internal stakeholders.

AAb = autoantibody; ADA = American Diabetes Association; CGM = continuous glucose monitoring; HbA1c = glycated hemoglobin; OGTT = oral glucose tolerance test.

PHASE 2

Expand screening population through outreach and referral

1 Identify target referral population

Identify area providers—including pediatric, primary care, and specialty practices—who are likely to see patients at risk for T1D and refer them for screening. Establish referral criteria based on targeted risk factors and/or any required prior testing.

NOTES:

2 Define intake process and referral pathways

Consider how you will receive referrals based on established pathways such as provider-to-provider communication, dedicated referral email address and inbox, EHR, fax, and/or direct calls. Supporting information may include patient demographic sheet, relevant prior test results (eg, A1C/other glucose testing and/or islet AAbs), and documentation of family history of T1D and/or personal history of autoimmune disease.

NOTES:

3 Establish clinic scheduling and logistics

Define clinic schedule, including visit duration and patient risk stratification. Consider reserving time slots for high-priority referrals, such as individuals who have already tested positive for 1 or more islet AAb(s).

NOTES:



See page 6 for ADA guidance on presymptomatic T1D screening and page 7 for considerations for risk-stratified screening pathways

Stakeholders to include:

- Health system leadership
- Clinical operations
- Health IT
- Medical education
- Nursing education
- Physician relations
- Community outreach

4 Scale up capacity

Increase capacity for screening clinics to be held 1/2 day, 1 day, or 2 days per month depending upon demand. Identify staffing for screening clinic, which may include diabetes educators and/or advanced practice providers.

NOTES:

5 Develop communication cascade

Integrate communication tools for referring providers, to include education around why and who to screen for T1D, the screening process, timeline, and follow-up.

NOTES:

6 Educate larger community

Expand outreach through broader educational initiatives on the benefits of early T1D screening, targeting area pediatricians and primary care and specialty providers.

Build partnerships with diabetes and advocacy organizations, school nurses, and community health workers and navigators to further expand awareness around the importance of identifying T1D early and the opportunity to screen individuals at risk.

NOTES:

ADA guidelines recommend presymptomatic T1D screening for patients at risk

Per ADA guidelines,
screening should be offered to patients with a family history of T1D
or otherwise known elevated genetic risk¹

What to test^{1,*}

- Glutamic acid decarboxylase 65 AAb (GADA)
- Insulinoma-associated antigen 2 AAb (IA-2A)
- Insulin AAb (IAA)
- Zinc transporter-8 AAb (ZnT8A)

Who is at risk¹

- Age (<35 years)
- Autoimmunity (personal or family history of autoimmune disease)
- Family history of T1D
- BMI <25 kg/m²
- Control (level of glucose control on noninsulin therapies)
- Comorbidities (eg, treatment with immune checkpoint inhibitors for cancer can cause acute autoimmune diabetes)

Risk-based screening may increase detection and diagnostic accuracy

Apply targeted population filters to maximize diagnostic yield and guide appropriate care

Screening Triggers for T1D



Pediatric Screening Pathway

Family history of T1D^{1,2}

Represents up to **15X increased risk for T1D**

Personal or family history of autoimmune disease^{1,3}

Represents up to **3X increased risk for T1D**

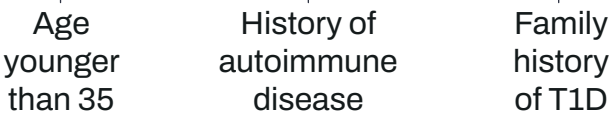


Adult Screening Pathway

Abnormal glucose^{1,4,5,†}

Up to 40% of adults with T1D are initially misclassified as prediabetes or T2D, leading to delays in appropriate care¹

+ Layer additional risk factors to optimize yield²⁻⁶



To facilitate implementation, consider a risk-stratified approach to T1D screening

^{*}The American Diabetes Association recommends testing at-risk individuals for GADA, IA-2A, IAA, and ZnT8A.¹

[†]Abnormal glucose defined as fasting plasma glucose 100-125 mg/dL, 2-hour plasma glucose level 140-199 mg/dL, or A1C 5.7%-6.4% OR ≥10% increase in A1C.¹

BMI = body mass index; T2D = type 2 diabetes.

Sanofi can provide educational resources on why early detection of T1D matters and share best practices on how to build a T1D screening program.

To learn more about T1D screening and access educational resources:

**Contact your
Sanofi representative**

OR

**Visit screenfortype1.com/hcp
or scan the QR code on the right**



References: **1.** American Diabetes Association Professional Practice Committee. *Diabetes Care*. 2026;49(suppl 1):S27-S49. **2.** Primavera M, et al. *Front Endocrinol (Lausanne)*. 2020;11:248. doi:10.3389/fendo.2020.00248. **3.** Edelman SV, et al. Presentation 114 presented at: EASD 2024; September 9-13, 2024; Madrid, Spain. **4.** Templeman EL, et al. *Diabetes Care*. 2025;48(9):1–10. **5.** Wagner R, et al. *Diabetes Res Clin Pract*. 2026;231:113047. doi:10.1016/j.diabres.2025.113047. **6.** Pauley ME, et al. *J Endocrine Soc*. 2025;9(8):bvaf095. doi:10.1210/jendso/bvaf095.