Insulin for Hyperglycaemia

Newborn Use Only

2026

Alert	High risk medication in A PINCH Medicines list under New South Wales Clinical Excellence Commission. Different brands of insulin are not bioequivalent. Do not substitute between brands.[13] Actrapid is the ANMF group's recommended short-acting insulin for IV infusion in neonates. International units are hereafter referred to as "units". High risk of hypoglycaemia. Insulin binds to the plastic of giving sets. Flush the plastic tubing with 20 mL of prepared insulin solution into a receptacle prior to connecting to the infant. This is to saturate the binding. Insulin concentrations ≤ 0.05 Unit/mL are not reliably delivered even after preconditioning and flushing.
Indication	Treatment of persistent hyperglycaemia. [For treatment of hyperkalaemia, see Insulin – hyperkalaemia].
Action	Insulin is a polypeptide hormone that acts on cells throughout the body to stimulate uptake, utilisation and storage of glucose resulting in a lowering of blood glucose. Insulin stimulates the liver to store glucose in the form of glycogen and facilitates the entry of glucose into muscle and adipose tissue. It inhibits lipolysis, proteolysis and gluconeogenesis, enhances protein synthesis and conversion of excess glucose into fat.
Drug type	Polypeptide hormone – lowers blood glucose.
Trade name	Actrapid – Contains insulin neutral. NovoRapid® Contains insulin aspart. Note: Both brands are suitable for intravenous preparation. They can be used interchangeably
Presentation	Actrapid - Insulin neutral - 100 units/mL in a 10 mL vial NovoRapid – Insulin aspart – 100 units/mL in 3 mL cartridge and 10 mL vial.
Dose	**IV** Starting dose: 0.05 unit/kg/hour. Dose range: 0.01 to 0.1 unit/kg/hour. Titrate in small increments to blood glucose: Target blood glucose level (BGL) 8 to 10 mmol/L [1, 2].
Dose adjustment	Therapeutic hypothermia: Limited evidence in neonates. Higher dose may be required to maintain euglycemia [3]. ECMO: Data limited in preterm neonates to make recommendation. Renal impairment: Limited data in neonates. Lower doses may be required in severe renal failure. Hepatic impairment: Limited data in neonates. Close monitoring of BGL advised due to lability of BGL [4].
Route	IV
Preparation	**NOTE: Insulin binds to the plastic of giving sets. Flush the plastic tubing with 20 mL of prepared insulin solution into a receptacle prior to connecting to the infant. This is to saturate the binding.** **NOTE: Refer to Appendix for tables to assist with concentration selection.** Use the smallest volume syringe available/suitable for drawing up the drug for the preparation. (e.g. for <1 mL draw up – use 1 mL syringe). For 10 mL syringe - Recommend using syringe that has markings at 0.2mL increments The standard concentrations outlined in this monograph were developed taking into consideration a minimum patient weight of **0.4 kg** and a minimum infusion rate of **0.1 mL/hour**. For patients weighing less than 0.4 kg, the standard concentrations may not permit administration at or above the minimum infusion rate of 0.1 mL/hour. In such cases, the dilution and/or concentration may require individualisation to ensure safe and accurate drug delivery. Weight suggestions for infusion concentrations below are a guide only. Clinicians may choose infusion concentration different to the suggested based on expected dose and the corresponding 24-hour fluid volumes.

Insulin concentration	**0.05 unit/mL**	**0.2 unit/mL**
Infant weight (Guide only)	<3 kg	≥3 kg
0.01 unit/kg/hour	0.2 mL/kg/hour	0.05 mL/kg/hour

NEW RELEASE

20 mL Syringe

Note: Prepare 2 syringes - one for priming the plastic tubing and one for the infusion

It is a 2 step dilution.

Step 1. Draw up insulin and add compatible fluid* to make a diluted solution as per table below:

Insulin concentration	0.05 unit/mL	0.2 unit/mL
Volume of Insulin (100 units/mL)	0.2 mL (20 units)	
Volume of compatible fluid*	9.8 mL	
Total volume	10 mL solution (**2 units/mL**)	

Step 2: Draw up diluted insulin and add compatible fluid* as per table below:

Prepare two separate 20 mL syringes of this solution. Use one syringe to flush the plastic tubing only.

Insulin concentration	0.05 unit/mL	0.2 unit/mL
Volume of diluted insulin from step 1	0.5 mL (1 unit)	2 mL (4 units)
Volume of compatible fluid*	19.5 mL	18 mL
Total volume	20 mL	20 mL

*Compatible fluid: glucose 5%, glucose 10% or sodium chloride 0.9%

50 mL Syringe

It is a 2 step dilution

Step 1: Draw up insulin and add compatible fluid* to make a diluted solution as per table below:

Insulin concentration	0.05 unit/mL	0.2 unit/mL
Volume of Insulin (100 units/mL)	0.2 mL (20 units)	
Volume of compatible fluid*	19.8 mL	
Total volume	20 mL solution (**1 units/mL**)	

Step 2: Draw up diluted insulin and add compatible fluid* as per table below.

Insulin concentration	0.05 unit/mL	0.2 unit/mL
Volume of diluted insulin from step 1	2.5 mL (2.5 units)	10 mL (10 units)
Volume of compatible fluid*	47.5 mL	40 mL
Total volume	50 mL	50 mL
Use 20 mL of this solution to flush the plastic tubing		

*Compatible fluid: glucose 5%, glucose 10% or sodium chloride 0.9%

Administration

Intravenous: **Insulin binds to the plastic of giving sets. Flush the plastic tubing with 20 mL of prepared insulin solution into a receptacle prior to connecting to the infant. This is to saturate the binding.**
Do not filter infusion. Insulin also binds to the filter.
Can be infused with maintenance fluids. Recommend attaching insulin infusion after the filter.
Do not bolus other drugs through this line.

Monitoring

Blood glucose level (BGL)
- After Initiation of infusion: 30 minutes-2 hours based on the infant's risk profile until stabilised.
- On maintenance: 4–6 hourly.
- After cessation of infusion: At 1 hour.
- Alteration of infusion: Within 1 hour.

Serum potassium concentration.

Contraindications

Hypersensitivity to regular insulin or any of its components.
During episodes of hypoglycaemia.

Precautions

Hypoglycaemia is a common adverse effect. Blood glucose must be monitored closely to detect hypoglycaemia.
Do not adjust the rate of the maintenance solution or other infusions when insulin is commenced or the insulin infusion rate is altered. For example, if insulin is commenced or the rate of the insulin infusion is increased, do not turn down the maintenance solution to compensate for the total volume delivered.

NEW RELEASE

	The amount of glucose being delivered to the infant will then be reduced as the insulin is commenced or dose is increased, possibly causing hypoglycaemia in an already unstable infant. If ceasing insulin or changing the strength, be careful to remove and replace the previous line and T-piece to avoid flushing through insulin remaining in the tubing. Administer IV bolus medication via separate IV access to avoid insulin bolus administration.
Drug interactions	The following may reduce insulin requirements: Octreotide, beta-adrenergic blocking agents, angiotensin converting enzyme inhibitors, salicylates, anabolic steroids, alpha-adrenergic blocking agents, quinine, quinidine and sulfonamides. The following may increase insulin requirements: Thiazides, furosemide, ethacrynic acid, glucocorticoids, thyroid hormones, sympathomimetics, octreotide, growth hormone, and diazoxide. Beta blocking agents may mask the symptoms of hypoglycaemia and delay recovery from hypoglycaemia. Hypoglycaemia in the presence of concomitant use of a beta-adrenergic blocking agent may precipitate a hypertensive crisis.
Adverse reactions	Hypoglycaemia; hypokalaemia; and hyponatraemia. Urticaria and anaphylaxis (extremely rare). Insulin resistance may develop resulting in a larger dose requirement.
Overdose	AUSTRALIA: Contact the Poisons Information Centre on 13 11 26 for information on management. NEW ZEALAND: Contact the National Poisons Centre on 0800 764 766 for information on management.
Compatibility	**Fluids:** sodium chloride 0.9%, glucose 5%, glucose 10%, glucose 50%. **PN at Y site:** Variable compatibility results have been reported. **Y-site:**[12,13] Acetaminophen, aciclovir, alfentanil, aminophylline, amphotericin B lipid complex, anidulafungin, atenolol, atropine, azathioprine, aztreonam, caffeine citrate, calcium gluconate, caspofungin, cefazolin, cefepime, cefotaxime, ceftazidime, ceftriaxone, cefuroxime, chloramphenicol, clindamycin, cloxacillin, dexamethasone, dexmedetomidine, enalaprilat, epoetin alfa, erythromycin lactobionate, fentanyl, fluconazole, folic acid, foscarnet, fosfomycin, fosphenytoin, furosemide, ganciclovir, hydrocortisone, ibuprofen, imipenem-cilastatin, indometacin, lidocaine, linezolid, magnesium sulfate, Meropenem, methadone, methylprednisolone, metoclopramide, metoprolol, metronidazole, milrinone, naloxone, nitroglycerin, nitroprusside, octreotide, pamidronate, pancuronium, penicillin G, pentobarbital, pentoxifylline, phenobarbital, potassium acetate, potassium chloride, propofol, pyridoxine, remifentanil, sildenafil, sodium bicarbonate, sodium nitroprusside, streptokinase, tacrolimus, thiamine, ticarcillin –clavulanate, urokinase, vancomycin, vecuronium, verapamil, voriconazole. **Variable compatibility:**[12] amikacin, amiodarone, amphotericin B conventional, ampicillin, cyclosporine, digoxin, dobutamine, dopamine, epinephrine, furosemide, gentamicin, heparin, hydralazine, midazolam, morphine sulfate, multiple vitamin injection, norepinephrine (refer to Micromedex), ondansetron, pantoprazole, tobramycin, vasopressin.
Incompatibility	**Y-site administration:**[12,13] Adrenaline (epinephrine), alprostadil, amikacin, amphotericin B, ampicillin, calcium chloride, cefoxitin, diazepam, diazoxide, digoxin, dobutamine, dopamine, epinephrine, furosemide-undiluted, gentamicin, glycopyrrolate, hydralazine, ketamine, labetalol, morphine, phenytoin, piperacillin -tazobactam, propranolol, protamine, rocuronium, sulfamethoxazole-trimethoprim
Stability	Prepared solutions are stable at room temperature (< 25°C) for 24 hours. (extrapolated from Insulin Human Regular) [12]
Storage	Store human insulin between 2 and 8°C. Do not freeze. Protect from excessive heat and light. Should appear clear and colourless. While it is suggested that insulin vials can be kept for 28 days after the first use, ANMF consensus recommendation is to avoid this practice because of the risk of microbial contamination and increased susceptibility of neonates to sepsis.
Excipients	Actrapid: Glycerol, metacresol, zinc chloride, water for injections. Hydrochloric acid and sodium hydroxide are used to adjust the pH. Contains less than 1 mmol sodium (23 mg) per dose, i.e. is essentially 'sodium-free'. NovoRapid: Glycerol, phenol, metacresol, zinc chloride, dibasic sodium phosphate dihydrate, sodium chloride, sodium hydroxide, hydrochloric acid and water for injections.
Special comments	Insulin is adsorbed to the plastic of intravenous bags, syringes, and tubing which reduces the delivery of insulin [5-7].

NEW RELEASE

	Twenty mL of insulin priming solution at concentrations of 0.1 unit/mL and 0.05 unit/mL were found to deliver 80% and 26.5% of the expected insulin. Insulin concentrations ≤ 0.05 unit/mL are not reliably delivered even after preconditioning and flushing [5, 6].
Evidence	**Efficacy** **Treatment of hyperglycaemia in very low birth weight infants:** Systematic review [2] of trials of insulin infusion for treatment of neonatal hyperglycaemia found that use of an insulin infusion obviates the need to decrease the concentration of glucose prescribed and optimised the utilisation of calories by the infant resulting in significant increases in non-protein energy intake, glucose intake and short-term weight gain. However, insulin infusion had no significant effect on death, severe intraventricular haemorrhage, retinopathy of prematurity, bacterial sepsis, fungal sepsis or necrotising enterocolitis; effects on other major morbidities were not assessed. These trials did not report an excess of hypoglycaemia, possibly due to the more liberal target BSLs: 4.4–9.9 mmol/L [8] and 5.5–9.9 mmol/L [9]. Conclusion: Evidence from randomised trials in hyperglycaemic VLBW neonates is insufficient to determine the effects of treatment on death or major morbidities. [2] [LOE I GOR D] **Prevention of neonatal hyperglycaemia in very low birth weight infants:** Systematic review [10] of trials of early insulin infusion for prevention of neonatal hyperglycaemia found that use of an insulin infusion reduced hyperglycaemia but increased death before 28 days and increased the risk of hypoglycaemia. The reduction in hyperglycaemia was not accompanied by significant effects on major morbidities; effects on neurodevelopment are awaited. The evidence does not support the routine use of insulin infusions to prevent hyperglycaemia in VLBW neonates. [10][LOE I GOR B] **Tight glycaemic control with insulin in hyperglycaemic very low birth weight infants:** RCT in infants born at < 30 weeks' gestation or < 1500 g with hyperglycaemia (2 consecutive BGL > 8.5 mmol/L 4 hours apart) randomly assigned to tight glycaemic control with insulin (target BGL 4–6 mmol/L) or restrictive guidelines for starting insulin (target BGL 8–10 mmol/L). Infants in the tight group had a lesser lower leg growth rate ($P < 0.05$), but greater head circumference growth ($P < 0.0005$) and greater weight gain ($P < 0.001$) to 36 weeks' postmenstrual age than control infants. Tight group infants had lower daily BGL and greater incidence of hypoglycaemia (BGL <2.6 mmol/L) (25/43 vs 12/45; $P < 0.01$) than controls. There were no significant differences in nutritional intake or in the incidences of mortality or morbidity. The balance of risks and benefits of insulin treatment in hyperglycaemic pre-term neonates remains uncertain. [1] [LOE II GOR D]. Guidelines: ESPGHAN 2005 recommended the use of insulin should be restricted to conditions where reasonable changes in glucose infusion rate do not control marked hyperglycaemia. [11] Although this recommendation is now out of date, current evidence is consistent with this recommendation. **Pharmacokinetics** Following IV administration, the observed half-life of insulin ranges from 5 to 15 minutes.[12]
References	1. Alsweiler JM, Harding JE, Bloomfield FH. Tight glycemic control with insulin in hyperglycemic preterm babies: a randomized controlled trial. Pediatrics. 2012;129:639-47. 2. Bottino M, Cowett RM, Sinclair JC. Interventions for treatment of neonatal hyperglycemia in very low birth weight infants. Cochrane Database Syst Rev. 2011:CD007453. 3. Cueni-Villoz N, Devigili A, et al. Increased blood glucose variability during therapeutic hypothermia and outcome after cardiac arrest. Crit Care Med. 2011 Oct; 39(10):2225-31. 4. Scheen AJ. Pharmacokinetic and toxicological considerations for the treatment of diabetes in patients with liver disease. Expert Opin Drug Metab Toxicol. 2014; 10:839-857. 5. Hewson M, Nawadra V, Oliver J, Odgers C, Plummer J, Simmer K. Insulin infusions in the neonatal unit: delivery variation due to adsorption. J Paediatr Child Health. 2000; 36:216-20. 6. Thompson CD, Vital-Carona J, Faustino EV. The effect of tubing dwell time on insulin adsorption during intravenous insulin infusions. Diabetes Technol Ther. 2012;14:912-6. 7. Simeon PS, Geffner ME, Levin SR, et al. Continuous insulin infusions in neonates: pharmacologic availability of insulin in intravenous solutions. Journal of Pediatrics. 1994; 124:818-20. 8. Collins JW, Jr., Hoppe M, Brown K, Edidin DV, Padbury J, Ogata ES. A controlled trial of insulin infusion and parenteral nutrition in extremely low birth weight infants with glucose intolerance. J Pediatr. 1991; 118:921-7. 9. Meetze W, Bowsher R, Compton J, Moorehead H. Hyperglycemia in extremely- low-birthweight infants. Biol Neonate. 1998;74:214-21.

NEW RELEASE

10. Sinclair JC, Bottino M, Cowett RM. Interventions for prevention of neonatal hyperglycemia in very low birth weight infants. Cochrane Database Syst Rev. 2011:CD007615.
11. Koletzko B, Goulet O, Hunt J, Krohn K, Shamir. Guidelines on Paediatric Parenteral Nutrition of the European Society of Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) and the European Society for Clinical Nutrition and Metabolism (ESPEN), Supported by the European Society of Paediatric Research (ESPR). J Pediatr Gastroenterol Nutr. 2005; 41 Suppl 2:S1-87.
12. Micromedex. Insulin Human Regular. Accessed on 26 Sep 2025.
13. Australian Injectable Drugs Handbook, 8th Edition. Accessed on 28 October 2020. https://aidh.hcn.com.au/browse/i/insulin_for_subcutaneous_or_iv_use
14. HUMULIN - TGA product information or eMIMs accessed 16/07/2026.
15. Humulin Preparations. Product Information. Accessed on 28 October 2020.

Appendix

Infusion tables to assist concentration selection

Table 1: Infusion rates when using insulin concentration **0.05 unit/mL**

Rate (mL/hr)	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
Weight (kg)	**Approximate unit/kg/hour**									
0.5	0.01	0.02	0.03	0.04	0.05	0.06	0.07	0.08	0.09	0.1
1	0.01	0.01	0.02	0.02	0.03	0.03	0.04	0.04	0.05	0.05
1.5	<0.00	0.01	0.01	0.01	0.02	0.02	0.02	0.03	0.03	0.03
2	<0.00	0.01	0.01	0.01	0.01	0.02	0.02	0.02	0.02	0.03
2.5	<0.00	<0.00	0.01	0.01	0.01	0.01	0.01	0.02	0.02	0.02
3	<0.00	<0.00	0.01	0.01	0.01	0.01	0.01	0.01	0.02	0.02
3.5	<0.00	<0.00	<0.00	0.01	0.01	0.01	0.01	0.01	0.01	0.01
4	<0.00	<0.00	<0.00	0.01	0.01	0.01	0.01	0.01	0.01	0.01
4.5	<0.00	<0.00	<0.00	<0.00	0.01	0.01	0.01	0.01	0.01	0.01
5	<0.00	<0.00	<0.00	<0.00	0.01	0.01	0.01	0.01	0.01	0.01

Table 2: Infusion rates when using insulin concentration **0.2 unit/mL**

Rate (mL/hr)	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
Weight (kg)	**Approximate unit /kg/hour**									
0.5	0.04	0.08	0.12	0.16	0.2	0.24	0.28	0.32	0.36	0.4
1	0.02	0.04	0.06	0.08	0.1	0.12	0.14	0.16	0.18	0.2
1.5	0.01	0.03	0.04	0.05	0.07	0.08	0.09	0.11	0.12	0.13
2	0.01	0.02	0.03	0.04	0.05	0.06	0.07	0.08	0.09	0.1
2.5	0.01	0.02	0.02	0.03	0.04	0.05	0.06	0.06	0.07	0.08
3	0.01	0.01	0.02	0.03	0.03	0.04	0.05	0.05	0.06	0.07
3.5	0.01	0.01	0.02	0.02	0.03	0.03	0.04	0.05	0.05	0.06
4	0.01	0.01	0.02	0.02	0.03	0.03	0.04	0.04	0.05	0.05
4.5	<0.01	0.01	0.01	0.02	0.02	0.03	0.03	0.04	0.04	0.04
5	<0.01	0.01	0.01	0.02	0.02	0.02	0.03	0.03	0.04	0.04

$$\text{Rate (mL/hr)} = \frac{\text{Dose (unit/kg/hour) x Weight (kg)}}{\text{Concentration (unit/mL)}}$$

$$\text{Dose (unit/kg/hour)} = \frac{\text{Rate (mL/hr) x Concentration (unit/mL)}}{\text{Weight (kg)}}$$

NEURSE

VERSION/NUMBER	DATE
Original	3/05/2017
Revised 1.1 Revised 1.2 Revised 2.0 Revised 3.0	19/05/2017 20/06/2017 18/03/2021 24/06/2022
Version 4.0	26/09/2025
Version 4.1	16/04/2026
Version 4.2	30/07/2026
Current 5.0	5/11/2026
REVIEW	5/11/2031

Authors Contribution

Original author/s	Srinivas Bolisetty
Evidence Review	David Osborn
Expert review	Charles Verge, Shihab Hameed, Uma Visser
Nursing Review	Ruth Jackson, Celia Cunha da Silva
Pharmacy Review	Rebecca O'Grady, Kerrie Knox, Thao Tran, Michelle Jenkins, Susanah Brew
ANMF Group contributors	Nilkant Phad, Bhavesh Mehta, Amber Seigel, Rebecca Barzegar, Jutta van den Boom, Mohammed Irfan Azeem, Michelle Jenkins, Kerrie Knox, Cindy Chen, Thao Tran, Celia Cunha da Silva, Benjamin Emerson-Parker, Simarjit Kaur, Renae Gengaroli, Bryony Malloy, Gloria Yoo, Marguerite Mason-Elliott
Final editing	Srinivas Bolisetty
Facilitator	Srinivas Bolisetty

NEW RELEASE