



Pharmacologic Approaches to Glycemic Management

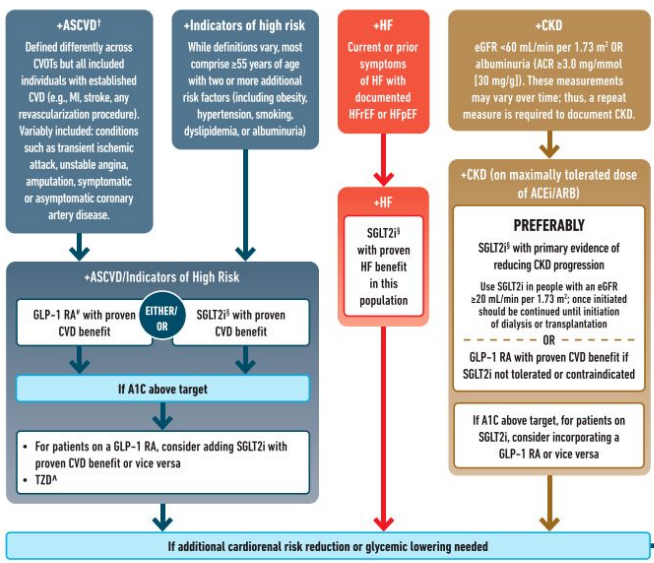
Pharmacologic Approaches to Glycemic
Treatment: Standards of Care in Diabetes. 2024
Diabetes Care 2024; 47(Suppl. 1):S158–S178

Use of Glucose-Lowering Medications

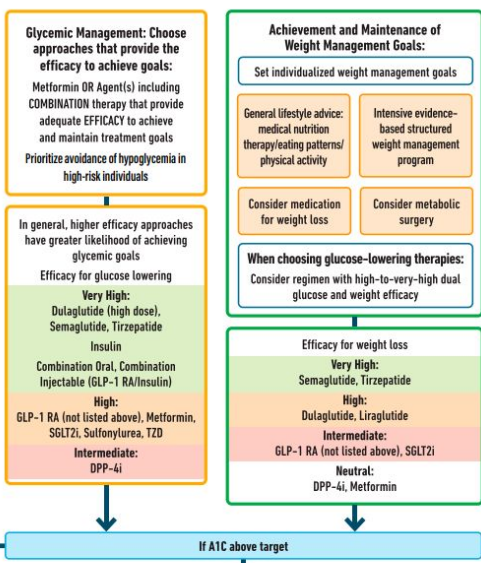


HEALTHY LIFESTYLE BEHAVIORS; DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT (DSMES); SOCIAL DETERMINANTS OF HEALTH (SDOH)

Goal: Cardiorenal Risk Reduction in High-Risk Individuals with Type 2 Diabetes (in addition to comprehensive CV risk management)*



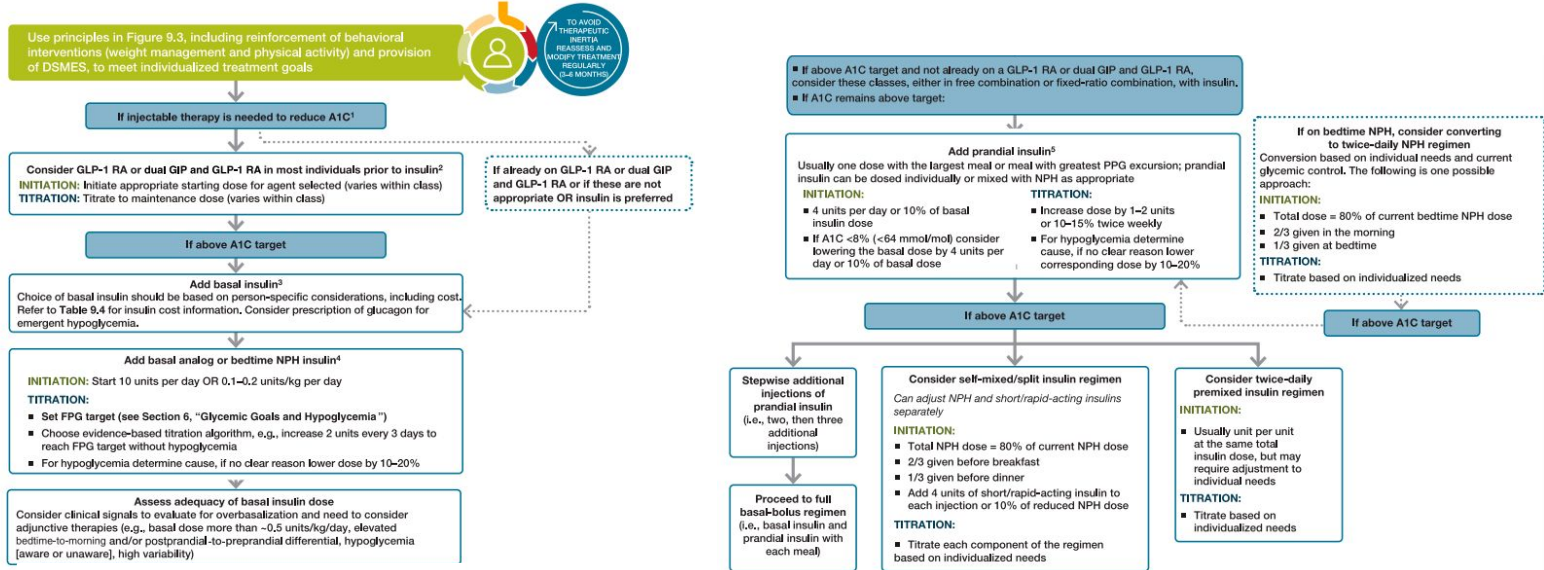
Goal: Achievement and Maintenance of Glycemic and Weight Management Goals



* In people with HF, CKD, established CVD, or multiple risk factors for CVD, the decision to use a GLP-1 RA or SGLT2i with proven benefit should be independent of background use of metformin; A strong recommendation is warranted for people with CVD and a weaker recommendation for those with indicators of high CV risk. Moreover, a higher absolute risk reduction and thus lower numbers needed to treat are seen at higher levels of baseline risk and should be factored into the shared decision-making process. See text for details. ^a Low-dose TZD may be better tolerated and similarly effective; ^b For SGLT2i, CV renal outcomes trials demonstrate their efficacy in reducing the risk of composite MACE, CV death, all-cause mortality, MI, HF, and renal outcomes in individuals with T2D with established/high risk of CVD; ^c For GLP-1 RA, CVDs demonstrate their efficacy in reducing composite MACE, CV death, all-cause mortality, MI, stroke, and renal endpoints in individuals with T2D with established/high risk of CVD.

- Identify barriers to goals:
- Consider DSMES referral to support self-efficacy in achievement of goals
 - Consider technology (e.g., diagnostic CGM) to identify therapeutic gaps and tailor therapy
 - Identify and address SDOH that impact achievement of goals

Intensifying to Injectable Therapies



1. Consider insulin as the first injectable if evidence of ongoing catabolism is present, symptoms of hyperglycemia are present, when A1C or blood glucose levels are very high (i.e., A1C >10% >86 mmol/mol) or blood glucose >300 mg/dL [16.7 mmol/L], or when a diagnosis of type 1 diabetes is a possibility.
2. When selecting GLP-1 RAs, consider individual preference, A1C lowering, weight-lowering effect, or frequency of injection. If CVO is present, consider GLP-1 RA with proven CVO benefit. Oral or injectable GLP-1 RAs are appropriate.
3. For people on GLP-1 RA and basal insulin combination, consider use of a fixed-ratio combination product (IDegLira or IGLarLix).
4. Consider switching from evening NPH to a basal analog if the individual develops hypoglycemia and/or frequently forgets to administer NPH in the evening and would be better managed with an A.M. dose of a long-acting basal insulin.
5. If adding prandial insulin to NPH, consider initiation of a self-mixed or premixed insulin plan to decrease the number of injections required.