Healthy lifestyle behaviors, self-management education/support, and social determinants of health should be considered in all patients

**First-line pharmacotherapy (metformin** or other agents) should be selected based upon <u>patient-specific factors</u> (e.g., glycemic goals, weight goals, comorbidities, tolerability, cost)

Consider **combination pharmacotherapy** at initiation if A1C ≥1.5% above target goal



Consider **early insulin initiation** if A1C >10%, BG ≥300 mg/dL, or symptoms of hyperglycemia (e.g., polydipsia, polyuria,

(e.g., polydipsia, polyuria, unexpected weight loss) Page 2

**Chronic Kidney Disease** 

No

Reassess treatment plan every  ${f 3-6}$  months and modify, if appropriate

Established ASCVD/High Risk, Heart Failure, or Chronic Kidney Disease?

Recommended irrespective of A1C or use of metformin

# ASCVD (established or high risk†) GLP-1 RA or SGLT2i

### If A1C above target

with proven CVD benefit

- On GLP-1 RA?
   Consider adding SGLT2i with CVD benefit (or vice versa)
- Consider low-dose pioglitazone

## Heart Failure (preserved or reduced EF)

**SGLT2i** (or SGLT1/2i) with proven HF benefit

<u> Or</u>

GLP-1 RA with proven HF benefit in those with symptomatic **HFpEF** and **obesity** 

<u>Or</u>

GLP-1 RA with proven CKD benefit

Maximally tolerated ACEi/ARB

SGLT2i with primary evidence for

reducing CKD progression

May be initiated with eGFR ≥20 mL/min/1.73 m2

If A1C above target

On **SGLT2i**?
Consider adding **GLP-1 RA** (or vice versa)

#### Additional therapy needed to achieve treatment goals?

† High risk for ASCVD: Typically age ≥55 years plus ≥2 risk factors (e.g., hypertension, obesity, smoking, dyslipidemia, albuminuria) ‡ Avoid use in patients with heart failure

CLASS	<b>♥</b> ASCVD	<b>W</b> HEART FAILURE	୍ଧା RENAL
SGLT2is**	FDA approved CVD benefit:      canagliflozin     empagliflozin  Neutral:     bexagliflozin     dapagliflozin     ertugliflozin	FDA approved HF benefit:  • dapagliflozin  • empagliflozin  Evidence for HF benefit:  • canagliflozin  • ertugliflozin	FDA approved renal benefit:
GLP-1 RAs^^	FDA approved CVD benefit:  • dulaglutide  • liraglutide  • semaglutide (SUBQ)  Neutral:  • exenatide ER  • semaglutide (oral)	Evidence for benefit in symptomatic HFpEF and obesity: • semaglutide (SUBQ)	Evidence for renal benefit:  • dulaglutide  • liraglutide  • semaglutide (SUBQ)
		FDA labeled indications and evidence for individual agents are subject to frequent change and geographic variability. Last updated 1/2025.	

\*\* The ADA recommends sotagliflozin (SGLT1/2 inhibitor) as an option for heart failure benefit. It is not FDA-approved for glycemic management

^^ Tirzepatide (GIP/GLP-1 RA) is under investigation for cardiorenal benefit.

### **Type 2 Diabetes Pharmacotherapy**

Adapted from the 2025 ADA Standards of Care in Diabetes

Glycemic Treatment Goals

Must be individualized and periodically reassessed after considering patient-specific characteristics

POPULATION

A1C PREPRANDIAL 2-HR PPG

80-130 mg/dL <180 mg/dL

- -

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- \* Stricter goals may be reasonable for certain patients, if achievable without significant hypoglycemia risk
- ^ e.g., risk of severe hypoglycemia, limited life expectancy, significant comorbidities

Tirzepatide

Insulin

Combination oral

or injectable therapy

High:

**GLP-1 RA** 

(not listed above)

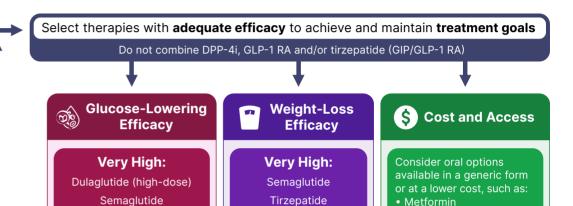
Metformin

SGLT2i

Sulfonylurea

Pioglitazone

Intermediate:



**High:** Dulaglutide Liraglutide

Intermediate:

GLP-1 RA (not listed above) SGLT2i

Neutral:

DPP-4i

available at lower cost:

NPH or regular
Insulin analogs have lower
hypoglycemia risk than human
insulin (NPH or premixed)

Consider insulins that are

Sulfonvlurea

• Pioglitazone

Patient assistance programs may be available for certain brand name medications

Additional therapy needed to achieve treatment goals?

#### Metabolic Dysfunction-Associated Steatotic Liver Disease (MASLD):

Consider use of a GLP-1 RA or GIP/GLP-1 RA in adults with T2DM, MASLD, and overweight/obesity for weight loss and potential benefit in metabolic dysfunction-associated steatohepatitis (MASH).

In adults with T2DM and biopsy-proven **MASH** (or those at high risk for clinically significant liver fibrosis), the use of pioglitazone, GLP-1 RA, or GIP/GLP-1 RA is preferred for glucose management due to potential benefits in MASH. Combination therapy (pioglitazone plus GLP-1 RA) may also be considered in these patients.

In patients with T2DM and decompensated cirrhosis, insulin therapy is preferred for management of hyperglycemia.



### **Type 2 Diabetes Pharmacotherapy**

#### Adapted from the 2025 ADA Standards of Care in Diabetes

