Diabetes Management Guidelines – Over 18 Years of Age

DEPARTMENT: Utilization Management Physician Practice Guidelines

EFFECTIVE DATE: 02/06

DATE LAST REVIEWED: 02/21

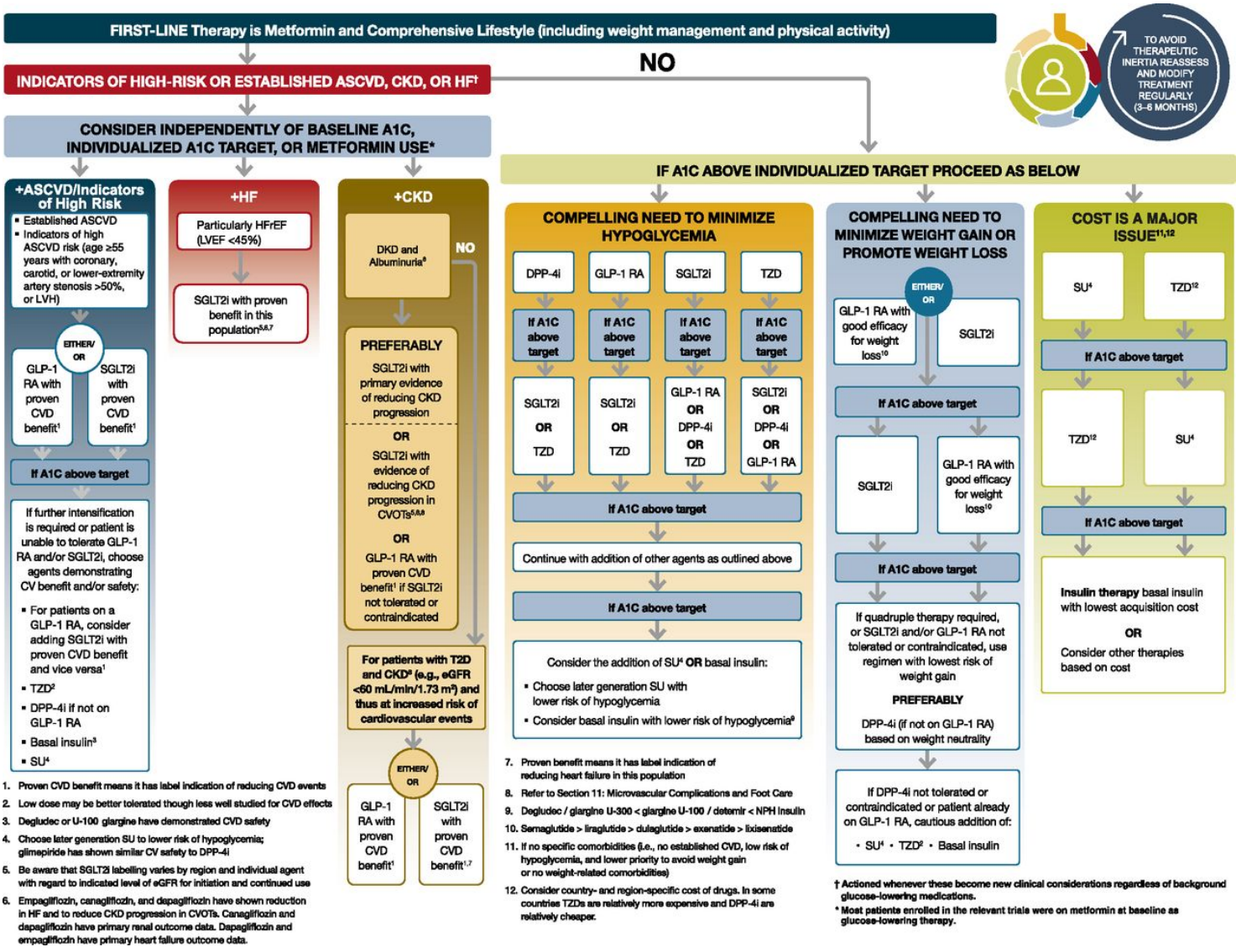
SOURCES: Standards of Medical Care in Diabetes, American Diabetes Association, January 2021 http://professional.diabetes.org/sites/professional.diabetes.org/files/media/dc_40_s1_final.pdf
Tomczyks, Bennett NM, Stoecky C, et al. Use of B-valent pneumococcal conjugate vaccine and 23-valent pneumococcal polysaccharide vaccine among adults ≥65 years: recommendation of the Advisory Committee on Immunization Practices (ACIP) MMWR Morb Mortal Wkly Rep 2014, 63:822

RECOMMENDED GUIDELINES:

Please click here to read the entire American Diabetes Association's Standards of Medical Care in Diabetes (Jan. 2019).

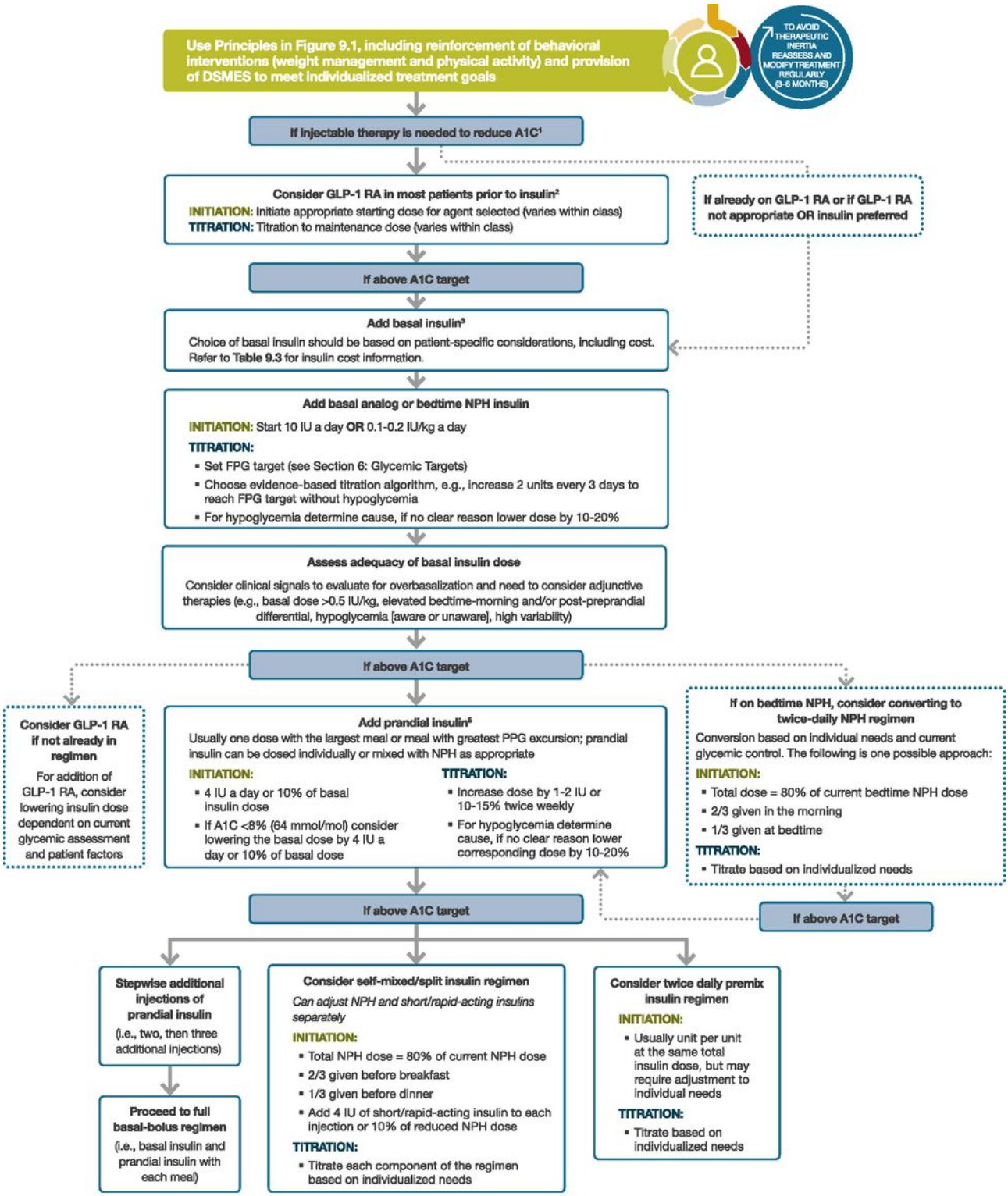
1) Each visit: Wt., Ht., BMI, and status of home monitoring are recorded.
2) Physician visit every 3 months. May extend to every 6 months, if excellent glycemic control. Fasting glucose goal: 80-130.
3) HgbA1C: every 3 months, unless < 7; then every 6 months is acceptable.
4) Lipid status addressed every year. If concomitant cardiovascular disease, use medium to high intensity statin therapy.
   a) Lipid status addressed every 2 years if LDL <100, HDL >50, TG <150.
   b) Statin therapy recommended regardless of lipid status. (Exception: <40yo, no risk factors)
5) Liver function tests annually.
6) TSH in type 1 diabetics.
7) Current medication recorded on chart.
8) Accurate record of type, dose and time of Insulin administration, if applicable.
9) Hypertension addressed at each visit: goal < 140/90 with an ideal goal of 130/80.
10) Documentation of yearly dilated eye exam. If no retinopathy x 2 years, then exam every 2 years is acceptable.
11) Documented foot exam annually: color, temp, pulse and skin integrity. Monofilament exam (Tensile Touch Test), yearly. Quarterly examination for diabetics with established neuropathy, foot deformities or history of prior ulcer.
12) Quantitative microalbumin at least yearly, unless macro already present.
13) Serum creatinine yearly.
14) Vaccinations:
   a) Fluvax yearly;
   b) Hepatitis B vaccination considered for those 19-59 yo (C).
   c) Pneumovax PPSV23 recommended for all diabetics.
   d) Smoking cessation education and/or referral for all smoking diabetics. E-cigarettes are not supported as an alternative to smoking.

e) ACE inhibitor/ARB recommended for renal protection, if hypertensive or microalbumin>30.
f) Aspirin therapy if at increased CVD risk.
g) CAD screening is not recommended for asymptomatic patients.
h) Diabetic and nutritional education recommended.
i) Encourage regular activity to break up any sedentary period >90 minutes.
j) Medication recommendations



1. Proven CVD benefit means it has label indication of reducing CVD events
2. Low dose may be better tolerated though less well studied for CVD effects
3. Degludec or U-100 glargine have demonstrated CVD safety
4. Choose later generation SU to lower risk of hypoglycemia; glimepiride has shown similar CV safety to DPP-4i
5. Be aware that SGLT2i labelling varies by region and individual agent with regard to indicated level of eGFR for initiation and continued use
6. Empagliflozin, canagliflozin, and dapagliflozin have shown reduction in HF and to reduce CKD progression in CVOTs. Canagliflozin and dapagliflozin have primary renal outcome data. Dapagliflozin and empagliflozin have primary heart failure outcome data.
7. Proven benefit means it has label indication of reducing heart failure in this population
8. Refer to Section 11: Microvascular Complications and Foot Care
9. Degludec / glargine U-300 < glargine U-100 / detemir < NPH insulin
10. Semaglutide > liraglutide > dulaglutide > exenatide > lixisenatide
11. If no specific comorbidities (i.e., no established CVD, low risk of hypoglycemia, and lower priority to avoid weight gain or no weight-related comorbidities)
12. Consider country- and region-specific cost of drugs. In some countries TZDs are relatively more expensive and DPP-4i are relatively cheaper.

† Actioned whenever these become new clinical considerations regardless of background glucose-lowering medications.
* Most patients enrolled in the relevant trials were on metformin at baseline as glucose-lowering therapy.



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