Note to Providers This pathway can be used as a treatment guide for patients with a new diagnosis of Type 2 Diabetes. For the patients who are currently being treated for Type 2 Diabetes, use this guide to determine next treatment steps, and if a referrals to ancillary services would benefit your patient.

For most patients: Fasting BG goal of 80-130 and 2-hour post-prandial BG of <180

Monotherapy

Initiate metformin 250 mg QD, follow below titration schedule as tolerated, and recheck A1c in 3 months.

If patient's A1c is >10, consider starting **Dual Therapy** metformin and glimepiride.

Lifestyle Management: Refer all newly diagnosed or uncontrolled patients to Diabetes & Nutrition Education.

	regular formulation	**Metformin Titration Schedule**	*XR formulation*
Week One:	500 mg 1/2 tab QD (250 mg)		500mg 1 tab QD
Week Two:	500 mg 1 tab QD (500 mg)		1000mg 1 tab QD
Week Three:	500 mg 1 tab in AM, 0.5 tab in PM (750 mg)		1500mg 1 1/2 tab QD
Week Four:	500 mg 1 tab BID (1000 mg)		1000 mg BID

Precautions:	1) **Reduce** metformin dose to max 500 mg BID in patients with eGFR 30-45 2) **Discontinue** metformin dose in patients with eGFR <30. 3) **Avoid** metformin use in patients with known binge or excessive alcohol use. 4) **Suspend** metformin use if patient is to undergo a surgical procedure or be given iodinated contrast media for a radiological procedure. **Restart** metformin when normal renal function is verified. Metformin should be withheld in patients with dehydration and/or prerenal azotemia. 5) **Reduce** dose in patients who experience GI side effects. Consider XL formulation forpatients who cannot tolerate regular release formulation. If metformin discontinued for >2 weeks, consider re-titration to avoid side effects. Any significant GI complaints warrants a trial off metformin to see if symptoms resolve.

If A1c is at goal (<7-8) continue current regimen and monitor A1c at regular intervals. If A1c not controlled, continue to **Dual Therapy** protocol.

Dual Therapy

If patient's A1c is >10 or A1c uncontrolled with Monotherapy protocol, add one of the following medications to the patient's current regimen. Recheck A1c in 3 months.

	SGLT-2 Inhibitors		
	first choice if patient has ASCVD		
	starting dose…	*if A1c uncontrolled titrate to…*	*considerations*
empagliflozin	10 mg QD	25 mg QD	
canagliflozin	100 mg QD	300 mg QD	
dapagliflozin	5 mg QD	10 mg QD	creatinine clearance requirement of >45

	Glimepiride
	first choice if patient does not *have ASCVD*
Week 1	1 mg QD before breakfast
Weeks 2-3:	2 mg QD before breakfast
Weeks 4+	Increase by 2mgs QD at 1- to 2- week intervals to maximum of 8 mg daily.
Precautions:	1) Consider prescribing the XL formulation for patients who cannot tolerate regular release formulation due to hypoglycemia or reduce by 1 mg.

	Glargine Insulin
	can be used in conjunction with glimepiride
	Check blood glucose fasting and at bedtime and get weekly average. The target is mean FBG of 80-130 mg/dL. Treat-to-target strategy:
Initial dose…	10 units of basal insulin at bedtime
Increase if…	FBG is higher than 130. Increast bedtime insulin dose by 2 units.
Continue increasing…	by 2 units at a time until FBG is in target range of 80-130 mg/dL.

If A1c is at goal (<7-8) continue current regimen and monitor A1c at regular intervals. If A1c not controlled, see **Referral Algorithm**.

Triple Therapy

If the above therapies have not achieved A1c control goal (<7-8), a third anti-diabetic agent would be warranted.

Referral Algorithm

Patients whose A1c remains uncontrolled with the above therapies should be referred to the following:

Diabetes Education	for education and dietician support
Pharmacist	for medication management
Care Manager	for high risk patients with high ED and/or Inpatient utilization
Behavioral Health Consultant	for patients who aren't engaged and/or have social determinates
Endocrinology	for medication management