Prediabetes Management

A1c 5.7-6.4%
Fasting glucose 100-125 mg/dl

Lifestyle action plan*:
Target 7% weight loss and moderate physical activity (150 min/week)

May ↓ risk of developing diabetes by > 50%

Start metformin
Especially consider if:
BMI > 35, age < 60, prior gestational DM

* Consider eConsult to Diabetes Prevention Program in motivated patients
Criteria: Prediabetes and overweight (BMI >25 or >23 if Asian)
Online/in-person, English/Spanish/Cantonese

Type 2 Diabetes – 1st Line

Step 1: What is patient's A1c goal? → For most, A1c < 7%
- Correlates to fingerstick glucoses:
  - Fasting/preprandial glucose 80–130 mg/dL
  - 1-2 hr postprandial glucose < 180 mg/dL
- For some, higher or lower A1c treatment targets may be appropriate
- Risk factors for hypoglycemia: CKD, older age, food insecurity, frailty

Step 2: How far is the patient from their A1c goal?
- This will help determine if adding a certain agent will help you achieve the A1c goal.
- For example, if A1c is 9% and goal is 7%, adding an agent that only decreases A1c by 0.5% will not get you to goal.

Step 3: Make a lifestyle action plan
- Refer to diabetes education and/or nutritionist
- Dietary changes can make meaningful improvements → Identify actionable changes to diet
- Exercise – ideal 150 min/week

A1c > 10% or symptomatic → Lifestyle action plan + Start **metformin and basal insulin***

*No clinically meaningful advantage of one basal insulin over another (ex. NPH vs glargine). Consider formulary.

A1c ≥ 9% → Lifestyle action plan + Start **metformin and glipizide**‡ in parallel

A1c ≥ 7% → Lifestyle action plan + Start **metformin**
See supplement for eGFR and dosing recommendations
→ **FBG > 130 after 6 wks? Or A1C > 7 after 12 wks?**
→ Titrate **glipizide**‡
See supplement for eGFR and dosing recommendations

‡ If food insecurity and at significant risk of hypoglycemia, consider repaglinide

→ **FBG > 130 after 6 wks? Or A1C > 7 after 12 wks?**

- Add **basal insulin***
- Consider adding **other agent** *(see "Next Steps" section)*

*No clinically meaningful advantage of one basal insulin over another (ex. NPH vs glargine). Consider formulary.

ZSFG Diabetes Team July 2019
*See **SharePoint** for most current version*

T2DM – Next steps

Before moving on to other agents, carefully consider reasons why the patient is not at goal with metformin/glipizide/± basal insulin, in particular with medication adherence.

With established ASCVD*? Yes → *Consider adding:* GLP1-agonist with CV benefit (liraglutide, semaglutide) OR SGLT2 inhibitor with CV benefit, especially with CKD or heart failure (empagliflozin, canagliflozin)
See supplement for precautions

*ASVCD = hx of MI, CVA, or revascularization procedure

With CKD - eGFR 30-90* with UACR > 300? Yes → *Consider adding:* SGLT2 with CKD benefit (canagliflozin, empagliflozin, dapagliflozin)
See supplement for precautions

*For eGFR 30-45: monitor closely and see supplement for details

Obesity? Yes → *Consider adding:* GLP-1 agonists
See supplement for precautions

With NASH? Yes → *Consider adding:* Pioglitazone
See supplement for precautions

Other considerations → If postprandial hyperglycemia → Meal time insulin, acarbose (if < 0.5% from A1c goal)
If within 0.5% of A1c goal → could consider DPP4 inhibitor

FBG > 130 after 6 wks? Or A1C > 7 after 12 wks?

Consider stopping additional agent if no benefit noted
+
Add **basal insulin***

*No clinically meaningful advantage of one basal insulin over another (ex. NPH vs glargine). Consider formulary.