

Kennebec Regional Health Alliance – Guidelines for Management of Type 2 DM

Final Draft 6.7.2017

Author: Alejandro Enriquez Zamalloa, PharmD, MS

Endorsed by: Dr. Elias Lemoine, Dr. Erin Lichtenstein, Dr. Rokshana Thanadar

Goal		Suggested Strategy or Resource			
Screening	Population		Frequency		
	Overweight or obese (BMI \geq 25 kg/m ² or \geq 23 kg/m ² in Asian Americans) adults with one or more risk factors* (See Page 5)		Every 3 years		
	After age 45		Every 3 years		
	Those with prediabetes		Every year		
Referrals for initial Care Management	Eye care professional for annual dilated eye exam				
	Family planning for women of reproductive age				
	Registered dietitian for MNT				
	DSME/DSMS-Diabetes and Nutrition center, Living Well with Diabetes				
	Dentist for comprehensive dental and periodontal examination				
	Mental health professional, if indicated				
A1C Target	< 7%	Many non-pregnant adults			
	< 8%	Long duration of diabetes, known history of hypoglycemia, advanced atherosclerosis, or advanced age/frailty			
	< 6.5%	Short duration of diabetes, type 2 diabetes treated with lifestyle or metformin only, long life expectancy, or no significant cardiovascular disease, low risk of hypoglycemia			
Choose the most appropriate agent(s) to achieve A1C target	A1C < 9%	Initial Therapy	Not at goal after 3 months	Not at goal after 6 months of initial therapy	
	A1C \geq 9%	Dual combination oral therapy	Triple combination therapy	Proceed to or intensify insulin therapy	

Kennebec Regional Health Alliance – Guidelines for Management of Type 2 DM

Final Draft 6.7.2017

Author: Alejandro Enriquez Zamalloa, PharmD, MS

Endorsed by: Dr. Elias Lemoine, Dr. Erin Lichtenstein, Dr. Rokshana Thanadar

		<ul style="list-style-type: none"> insulin metformin + GLP-1 agonist 	<ul style="list-style-type: none"> insulin metformin + GLP-1 agonist + basal insulin 	
Choose the most appropriate agent(s) to achieve A1C target	A1C Results	Initial Therapy	Not at goal after 3 months	
	Symptomatic and/or A1C $\geq 10\%$ and/or blood glucose levels ≥ 300 mg/dL	Basal insulin +/- metformin	Intensify insulin regimen	
Start basal insulin	<ul style="list-style-type: none"> 10 units per day or 0.1-0.2 units/kg/day (if severe insulin resistance suspected i.e. 0.2-0.3u/kg/day) 			
Dose Titration	Fixed regimen	Adjustable regimen		
	Increase TDD by 2 U every 3 to 4 days	Preceding 3 Days of FPG Values (mg/dL)		Change in Units/Day by
		<56		-4
		<80		-2
		109-126		+1
		127-144		+3
		145-162		+4
		163-180		+6
≥ 180		+10		
<i>Diabetes Care 2003;26(11): 3080-3086</i>				
Intensify insulin regimen	<ul style="list-style-type: none"> If glycemic control not at goal after 3 months consider adding GLP-1 agonist or SGLT-2 inhibitor or DPP4- inhibitor Add prandial insulin per algorithm below 			
Use Statin therapy when appropriate	See primary and secondary cardiovascular disease prevention guideline			
Blood Pressure Control	Goal BP <140/90 mmHg in most patients. Consider goal of <130/80 if high CV risk			
	No albuminuria	thiazide-like diuretic (HCTZ or Chlorthalidone) or dihydropyridine calcium channel blocker (amlodipine, nifedipine ER)		
	Microalbuminuria	ACE inhibitors and ARBs first line		

Kennebec Regional Health Alliance – Guidelines for Management of Type 2 DM

Final Draft 6.7.2017

Author: Alejandro Enriquez Zamalloa, PharmD, MS

Endorsed by: Dr. Elias Lemoine, Dr. Erin Lichtenstein, Dr. Rokshana Thanadar

<p>Primary prevention >50 years old who have at least one additional major risk factor and are not at increased risk of bleeding</p>												
<p>Low dose ASA</p>												
<p>Up to date on vaccines</p>	<table border="1"> <thead> <tr> <th>Vaccine</th> <th>Recommendation</th> </tr> </thead> <tbody> <tr> <td>Flu</td> <td>Adults with DM 6 months of age and older</td> </tr> <tr> <td rowspan="2">Pneumococcal</td> <td>≤64 yo</td> <td>PPSV23</td> </tr> <tr> <td>≥65 yo</td> <td>PCV13 at least a year after last PPSV23 then PPSV23 at least a year after PCV 13 and 5 years after first PPSV23</td> </tr> <tr> <td>Hepatitis B</td> <td>All unvaccinated adults with diabetes, who are 10-59yo</td> </tr> </tbody> </table>	Vaccine	Recommendation	Flu	Adults with DM 6 months of age and older	Pneumococcal	≤64 yo	PPSV23	≥65 yo	PCV13 at least a year after last PPSV23 then PPSV23 at least a year after PCV 13 and 5 years after first PPSV23	Hepatitis B	All unvaccinated adults with diabetes, who are 10-59yo
	Vaccine	Recommendation										
	Flu	Adults with DM 6 months of age and older										
	Pneumococcal	≤64 yo	PPSV23									
≥65 yo		PCV13 at least a year after last PPSV23 then PPSV23 at least a year after PCV 13 and 5 years after first PPSV23										
Hepatitis B	All unvaccinated adults with diabetes, who are 10-59yo											
<p>Prevent and manage complications</p>	<ul style="list-style-type: none"> • Yearly Eye exam 											
	<ul style="list-style-type: none"> • Yearly nephropathy screen 											
	<ul style="list-style-type: none"> • Yearly neuropathy screen and foot exam by podiatry 											
	<ul style="list-style-type: none"> • Abbreviated foot exam at every visit 											
<p>Abbreviated foot exam</p>	<p>What to ask?</p> <ul style="list-style-type: none"> • History of leg/foot ulcer or lower limb amputation/surgery • History of angioplasty, stent, or leg bypass surgery • Burning, tingling or pain in legs • Loss of lower extremity sensation 											
	<p>What to look for?</p> <ul style="list-style-type: none"> • Dermatologic exam <ul style="list-style-type: none"> ○ Discolored, ingrown, elongated nails, infection, skin lesions, calluses, corns or interdigital maceration? • Neurologic exam <ul style="list-style-type: none"> ○ Responsive to Ipswich touch test or 10-g monofilament? • Musculoskeletal exam <ul style="list-style-type: none"> ○ Full range of motion? ○ Deformities present, if yes how long? ○ Is midfoot hot, red or inflamed? • Vascular exam <ul style="list-style-type: none"> ○ Decreased hair growth on foot dorsum or lower limb? ○ Palpable dorsalis pedis and posterior tibial pulses? ○ Temp difference between calves and feet or between left and right foot? 											

Kennebec Regional Health Alliance – Guidelines for Management of Type 2 DM

Final Draft 6.7.2017

Author: Alejandro Enriquez Zamalloa, PharmD, MS

Endorsed by: Dr. Elias Lemoine, Dr. Erin Lichtenstein, Dr. Rokshana Thanadar

Referrals	<ul style="list-style-type: none">• Consider nephrology consult if<ul style="list-style-type: none">○ Persistent proteinuria○ Worsening microalbuminuria despite ACE or ARB○ Increasing Cr/BUN○ GFR<30
	<ul style="list-style-type: none">• Consider endocrine consult if<ul style="list-style-type: none">○ Goals not met after adequate titration○ Recurrent hypoglycemia○ Basal insulin dose >1 unit/kg/day
	<ul style="list-style-type: none">• Consider pharmacy consult if<ul style="list-style-type: none">○ Goals not met○ Adherence is a concern○ Patient needs additional tailored education on medication management○ During care transitions○ Polypharmacy
	<ul style="list-style-type: none">• Consider yearly Podiatry consult for all diabetic patients• Consider more frequent referrals to podiatry for patients with ADA risk category 1-3 and those with active pathology (see algorithm below)

Diabetes Care 2017;40
Endocrine Practice. 2016; 22
Pharmacist Letter. 2017;33(2):330202

Kennebec Regional Health Alliance – Guidelines for Management of Type 2 DM

Final Draft 6.7.2017

Author: Alejandro Enriquez Zamalloa, PharmD, MS

Endorsed by: Dr. Elias Lemoine, Dr. Erin Lichtenstein, Dr. Rokshana Thanadar

*Risk factors for screening

- A1C \geq 5.7%, IGT, or IFG on previous testing
- First-degree relative with diabetes
- High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
- Women who were diagnosed with GDM
- History of CVD
- Hypertension (>140/90 mmHg or on therapy for hypertension)
- HDL cholesterol level \leq 35 mg/dL and/or a triglyceride level >250 mg/dL
- Women with polycystic ovary syndrome
- Physical inactivity
- Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)

Diabetes Care 2011; 34, Supp 1 562-569

Referral to Podiatry

Priority	Indications	Timeline	Suggested follow-up by specialist
Urgent (active pathology)	Open wound or ulcerative area, with or without signs of infection New neuropathic pain at rest Signs of active Charcot neuropathy Vascular compromise	Immediate referral/consult	As determined by specialist
High (ADA risk category 3)	Previous history of ulcer, Charcot neuropathy or lower extremity amputation	Immediate or "next"	Every 1-2 months

Kennebec Regional Health Alliance – Guidelines for Management of Type 2 DM

Final Draft 6.7.2017

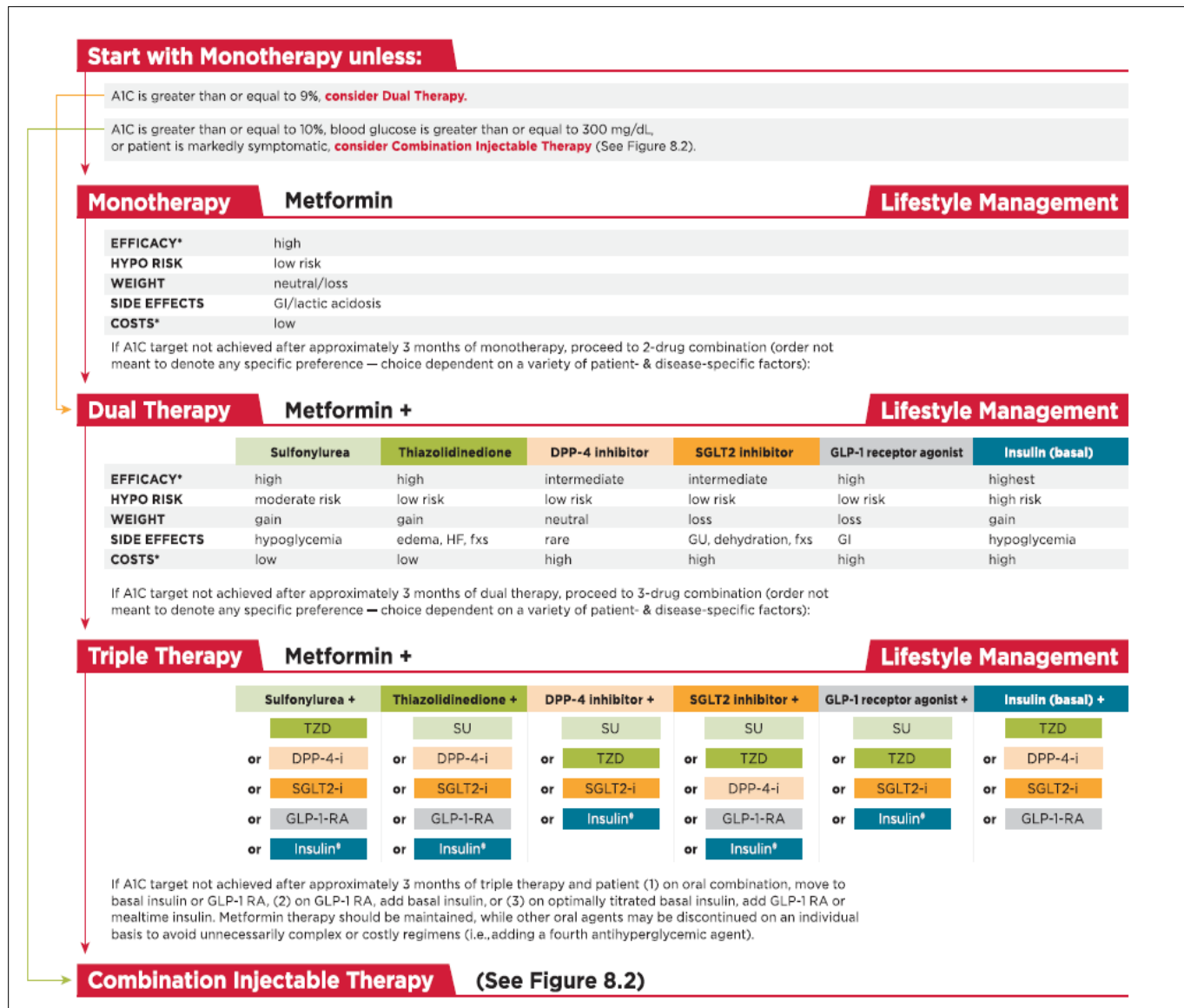
Author: Alejandro Enriquez Zamalloa, PharmD, MS

Endorsed by: Dr. Elias Lemoine, Dr. Erin Lichtenstein, Dr. Rokshana Thanadar

		available outpatient referral	
Moderate (ADA risk category 2)	PAD +/-LOPS Diminished pulses Presence of swelling or edema	Referral within 1-3 weeks	Every 2-3 months
Low (ADA risk category 1)	LOPS +/- longstanding, nonchanging deformity Prescriptive or accommodative footwear required	Referral within 1 month	Every 4-6 months
Very low (ADA risk category 0)	No LOPS or PAD Patient seeks education regarding foot care	Referral within 1-3 months	Annually at minimum

Family practice 2014; 63, 11, 646-656

2017 ADA Pharmacologic Approaches to Glycemic Treatment Algorithm



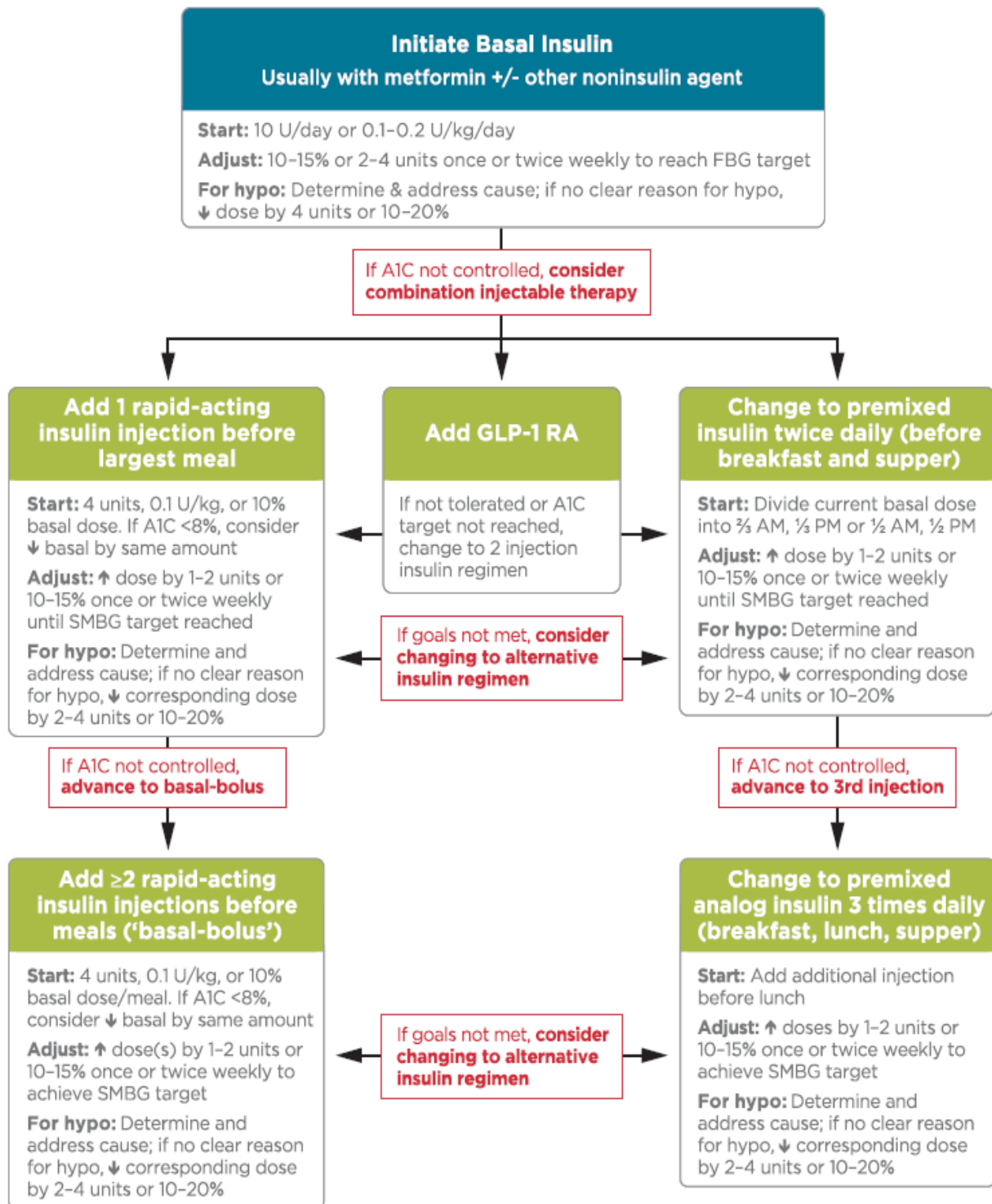


Figure 8.2—Combination injectable therapy for type 2 diabetes. FBG, fasting blood glucose; GLP-1 RA, GLP-1 receptor agonist; hypo, hypoglycemia. Adapted with permission from Inzucchi et al. (21).

Kennebec Regional Health Alliance – Guidelines for Management of Type 2 DM

Final Draft 6.7.2017

Author: Alejandro Enriquez Zamalloa, PharmD, MS

Endorsed by: Dr. Elias Lemoine, Dr. Erin Lichtenstein, Dr. Rokshana Thanadar

Diabetes Care 2017;40 Sup 1

Medications for Type 2 DM

Class/Estimated A1C reduction (monotherapy)	Specific Agent	Initial dose (approx cost for 30 day supply)	Advantages	Disadvantages
<p>Biguanide</p> <p>1% to 1.5%</p> <p>MOA: Inhibits hepatic glycogenolysis and gluconeogenesis. Enhances insulin sensitivity in muscle and fat</p>	<p>Metformin (<i>Glucophage, Glucophage XR</i>)</p> <p>Available in combination with alogliptin, glimepiride, glipizide, glyburide, linagliptin, pioglitazone, rosiglitazone, saxagliptin, sitagliptin, repaglinide, and canagliflozin. See specific agents.</p>	<p>Metformin INITIAL 500 mg PO BID or 850 mg PO once daily (less than \$20/month)</p>	<p>Lack of hypoglycemia</p> <p>Weight neutral</p> <p>Likely reduces CVD events</p> <p>Beneficial in the treatment of prediabetes</p> <p>Metformin can be initiated if eGFR is > 45 mL/min/1.73. (Discontinue if eGFR later falls below 30 mL/min/1.73 m².)</p>	<p>Diarrhea</p> <p>Abdominal cramping</p> <p>B12 deficiency</p> <p>Lactic acidosis (rare) in patients with cardiovascular, renal, or hepatic dysfunction</p>
<p>Dipeptidyl peptidase-4 (DPP-4) inhibitor ("gliptins")</p> <p>0.5% to 1%</p> <p>MOA: Inhibits degradation of endogenous incretins resulting in increased insulin secretion in response to elevated blood glucose, decreased</p>	<p>Alogliptin (<i>Nesina</i>) With metformin (<i>Kazano</i>) With pioglitazone (<i>Oseni</i>)</p> <p>Linagliptin (<i>Tradjenta</i>) With metformin (<i>Jentadueto</i>) With empagliflozin (<i>Glyxambi</i>)</p> <p>Saxagliptin (<i>Onglyza</i>) With metformin</p>	<p>Alogliptin INITIAL 25 mg PO once daily (\$310)</p> <p>Linagliptin INITIAL: 5 mg PO once daily (\$330)</p> <p>Saxagliptin INITIAL: 2.5 or 5 mg PO once daily (\$325)</p> <p>Sitagliptin</p>	<p>No hypoglycemia when used as monotherapy</p> <p>Weight neutral</p> <p>Generally well tolerated</p>	<p>Dosage modification with renal impairment needed (sitagliptin, saxagliptin, alogliptin)</p> <p>CYP3A4 interactions (saxagliptin, linagliptin)</p> <p>May be associated with pancreatitis</p> <p>New or worsening heart failure (saxagliptin alogliptin)</p> <p>May cause severe joint</p>

Kennebec Regional Health Alliance – Guidelines for Management of Type 2 DM

Final Draft 6.7.2017

Author: Alejandro Enriquez Zamalloa, PharmD, MS

Endorsed by: Dr. Elias Lemoine, Dr. Erin Lichtenstein, Dr. Rokshana Thanadar

glucagon secretion, slowed gastric emptying, and increased satiety	(<i>Kombiglyze XR</i>) Sitagliptin (<i>Januvia</i>) With metformin (<i>Janumet, Janumet XR</i>)	INITIAL: 100 mg PO once daily (\$330)		pain
Class/Estimated A1C reduction (monotherapy)	Specific Agent	Initial dose (approx cost for 30 day supply)	Advantages	Disadvantages
<p>Glucagon-like, peptide-1 (GLP-1) agonist or incretin mimetic</p> <p>1% to 1.5%</p> <p>MOA: Stimulation of GLP-1 receptors results in increased insulin secretion in response to elevated blood glucose, decreased glucagon secretion, slowed gastric emptying, and increased satiety. (GLP-1 is an incretin hormone.)</p>	<p>Albiglutide (<i>Tanzeum</i>)</p> <p>Dulaglutide (<i>Trulicity</i>)</p> <p>Exenatide (<i>Byetta</i>)</p> <p>Exenatide extended-release (<i>Bydureon</i>)</p> <p>Liraglutide (<i>Victoza</i>)</p>	<p>Albiglutide INITIAL 30 mg SC once weekly (\$325)</p> <p>Dulaglutide INITIAL 0.75 mg SC once weekly (\$490)</p> <p>Exenatide INITIAL: 5 mcg SC BID (\$480)</p> <p>Exenatide extended-release INITIAL: 2 mg SC once weekly (\$475)</p> <p>Liraglutide INITIAL: 0.6 mg SC once daily x 1 week, then increase to 1.2 mg SC once daily (\$430)</p>	<p>Lack of hypoglycemia when used as monotherapy</p> <p>Weight loss</p> <p>Reduces postprandial glucose values</p> <p>In patients who need more than one or two antidiabetes agents, combination injectable therapies of basal insulin and a GLP-1 agonist is an efficient, emerging strategy.</p> <p>Liraglutide may reduce cardiovascular (CV) death (NNT=77 for four years) and overall mortality (NNT=71 for four years) in</p>	<p>Nausea (often transient)</p> <p>Diarrhea</p> <p>Dosage modification with renal dysfunction needed (albiglutide, dulaglutide)</p> <p>Avoid in severe renal impairment (exenatide)</p> <p>May be associated with pancreatitis</p> <p>Associated with thyroid cell cancer in rodents</p> <p>May be associated with renal insufficiency</p> <p>May be associated with gallbladder disease (liraglutide, exenatide)</p> <p>Injectable</p>

Kennebec Regional Health Alliance – Guidelines for Management of Type 2 DM

Final Draft 6.7.2017

Author: Alejandro Enriquez Zamalloa, PharmD, MS

Endorsed by: Dr. Elias Lemoine, Dr. Erin Lichtenstein, Dr. Rokshana Thanadar

Class/Estimated A1C reduction (monotherapy)	Specific Agent	Initial dose (approx cost for 30 day supply)	Advantages	Disadvantages
<p>Sodium-glucose co-transporter 2 (SGLT2) inhibitor or “flozins”</p> <p>0.5% to 1%</p> <p>MOA: Blocks glucose reabsorption in kidney, increases glucosuria.</p>	<p>Canagliflozin (<i>Invokana</i>) With metformin (<i>Invokamet</i>)</p> <p>Dapagliflozin (<i>Farxiga</i>)</p> <p>Empagliflozin (<i>Jardiance</i>) With linagliptin (<i>Glyxambi</i>) With metformin (<i>Synjardy</i>)</p>	<p>Canagliflozin INITIAL: 100 mg PO once daily (\$340)</p> <p>Dapagliflozin INITIAL: 5 mg PO once daily (\$340)</p> <p>Empagliflozin INITIAL 10 mg PO once daily (\$340)</p>	<p>patients with high CV risk or CV disease</p> <p>Lack of hypoglycemia</p> <p>Weight loss</p> <p>May reduce blood pressure</p> <p>Empagliflozin reduces cardiovascular (CV) mortality (NNT=45 for three years), overall mortality (NNT=39 for three years), and hospitalization due to heart failure (NNT=71 for three years) in type 2 diabetes patients with CV disease²⁰</p>	<p>Genital fungal infections (male and female)</p> <p>Urinary tract infection (may be severe)</p> <p>Increased urination</p> <p>Hypotension</p> <p>Increase LDL</p> <p>Do not use if eGFR <45 mL/min/1.73m (canagliflozin, empagliflozin) or <60 mL/min/1.73m (dapagliflozin)</p> <p>Fractures (rare, in susceptible patients)</p> <p>Decrease in BMD (canagliflozin).</p> <p>May be associated with increased risk of</p>

Kennebec Regional Health Alliance – Guidelines for Management of Type 2 DM

Final Draft 6.7.2017

Author: Alejandro Enriquez Zamalloa, PharmD, MS

Endorsed by: Dr. Elias Lemoine, Dr. Erin Lichtenstein, Dr. Rokshana Thanadar

				<p>bladder cancer (dapagliflozin)</p> <p>Association with ketoacidosis (rare)</p> <p>Acute kidney injury reported with canagliflozin or dapagliflozin (may require dialysis)</p>
Class/Estimated A1C reduction (monotherapy)	Specific Agent	Initial dose (approx cost for 30 day supply)	Advantages	Disadvantages
<p>Sulfonylurea</p> <p>1% to 1.5%</p> <p>MOA: Stimulates pancreatic insulin secretion.</p>	<p>Glyburide (<i>Diabeta, Glynase, Micronase, others</i>) With metformin (<i>Glucovance</i>)</p> <p>Glipizide (<i>Glucotrol, Glucotrol XL, others</i>) With metformin (<i>Metaglip</i>)</p> <p>Glimepiride (<i>Amaryl, others</i>) With metformin (<i>Amaryl M</i>) With pioglitazone (<i>Duetact</i>) With rosiglitazone (<i>Avandaryl</i>)</p>	<p>Glyburide INITIAL: 2.5 mg PO once daily (less than \$10/month)</p> <p>Glipizide INITIAL: 5 mg PO once daily (less than \$10/month)</p> <p>Glimepiride INITIAL: 1 mg PO once daily (less than \$10/month)</p>	<p>Initially, good efficacy</p> <p>Inexpensive</p>	<p>Hypoglycemia, especially with renal dysfunction (less with glimepiride versus glyburide)⁵</p> <p>Weight gain (glyburide more than glipizide, glimepiride)</p> <p>Reduced efficacy over time</p> <p>For the elderly and those with hepatic or renal dysfunction, start with low doses and titrate up</p> <p>Discontinue when more complex insulin regimens (e.g., basal plus prandial insulins)</p>

Kennebec Regional Health Alliance – Guidelines for Management of Type 2 DM

Final Draft 6.7.2017

Author: Alejandro Enriquez Zamalloa, PharmD, MS

Endorsed by: Dr. Elias Lemoine, Dr. Erin Lichtenstein, Dr. Rokshana Thanadar

				are started
<p>Thiazolidinedione (TZD)</p> <p>1% to 1.5%</p> <p>MOA: Increases insulin sensitivity in muscle and fat.</p>	<p>Pioglitazone (Actos) With metformin (<i>Actoplus Met</i> or <i>Actoplus Met XR</i>) With glimepiride (<i>Duetact</i>) With alogliptin (<i>Oseni</i>)</p> <p>Rosiglitazone (Avandia) With metformin (<i>Avandamet</i>) With glimepiride (<i>Avandaryl</i>)</p>	<p>Pioglitazone INITIAL: 15 mg PO once daily (less than \$20)</p> <p>Rosiglitazone INITIAL: 4 mg PO once daily (\$115)</p>	<p>Lack of hypoglycemia when used as monotherapy</p> <p>Improves HDL cholesterol</p> <p>Reduced triglycerides (pioglitazone)</p> <p>May reduce CVD (pioglitazone)</p>	<p>Weight gain</p> <p>Volume retention, congestive heart failure</p> <p>Increased fracture risk</p> <p>Increases LDL (rosiglitazone)</p> <p>May possibly increase the risk of bladder cancer (pioglitazone)</p>
Class/Estimated A1C reduction (monotherapy)	Specific Agent	Initial dose (approx cost for 30 day supply)	Advantages	Disadvantages
Insulins	Rapid-acting	Lispro	Nearly universal	Hypoglycemia

Kennebec Regional Health Alliance – Guidelines for Management of Type 2 DM

Final Draft 6.7.2017

Author: Alejandro Enriquez Zamalloa, PharmD, MS

Endorsed by: Dr. Elias Lemoine, Dr. Erin Lichtenstein, Dr. Rokshana Thanadar

	<p>analogs</p> <ul style="list-style-type: none"> - Lispro (Humalog) - Aspart (Novolog) - Glulisine (Apidra) - Inhaled insulin <p>Short-acting</p> <ul style="list-style-type: none"> - Human Regular <p>Intermediate-acting</p> <ul style="list-style-type: none"> - Human NPH <p>Basal insulin analogs</p> <ul style="list-style-type: none"> - Glargine - Detemir - Degludec <p>Premixed insulin products</p> <ul style="list-style-type: none"> - NPH/Regular 70/30 270/30 aspart mix 275/25 lispro mix 250/50 lispro mix 	<p>\$202.60/10 mL vial, \$60.78/3 mL vial \$376.65/5 of 3 mL cartridge, \$391.50/5 of 3 mL <i>KwikPen</i></p> <p>Aspart \$203.24/10 mL vial \$377.56/5 of 3 mL <i>PenFill</i> cartridge \$392.63/5 of 3 mL <i>FlexPen</i></p> <p>Glulisine \$203.15/10 mL vial \$392.45/5 of 3 mL <i>SoloStar</i> pen</p> <p>Human Regular \$109.70/10 mL vial (U-100); \$32.91/3 mL vial (U-100)</p> <p>Human NPH \$109.70/10 mL vial, \$32.91/3 mL vial</p> <p>Glargine \$248.51/10 mL vial \$372.76/5 of 3 mL <i>SoloStar</i> pen</p> <p>Detemir \$248.51/10 mL vial \$372.76/5 of 3 mL <i>FlexTouch</i></p> <p>Degludec \$443.85/5 of 3 mL <i>FlexTouch</i> (100 unit/mL) \$532.62/3 of 3 mL <i>FlexTouch</i> (200 unit/mL)</p>	<p>response Theoretically unlimited efficacy</p> <p>↓ Microvascular risk</p>	<p>Weight gain</p> <p>Training requirements</p> <p>Patient and provider reluctance</p> <p>Injectable (except inhaled insulin)</p> <p>Pulmonary toxicity (inhaled insulin)</p>
--	---	--	--	---

Diabetes Care 2017;40 Sup 1
Pharmacist Letter. 2015; 31(6):310601

Kennebec Regional Health Alliance – Guidelines for Management of Type 2 DM

Final Draft 6.7.2017

Author: Alejandro Enriquez Zamalloa, PharmD, MS

Endorsed by: Dr. Elias Lemoine, Dr. Erin Lichtenstein, Dr. Rokshana Thanadar

Additional Resources

- American Diabetes Association. Standards of Medical Care in Diabetes 2017. *Diabetes Care* 2017;40.
- Alan J. Garber, et al. AACE/ACE consensus Statement-2016 Executive Summary. *Endocrine Practice*. 2016; 22.
- Improving Diabetes Outcomes. *Pharmacist Letter*. 2017;33(2):330202
- Drugs for Type 2 Diabetes. *Pharmacist Letter*. 2015; 31(6):310601
- Matthew C. Riddle, et al. The Treat-to-Target Trial. *Diabetes Care* 2003;26(11): 3080-3086
- American Diabetes Association. Diagnosis and Classification of Diabetes Mellitus. *Diabetes Care* 2011; 34, Supp 1 562-569

Practice Guidelines and Standard Processes Disclaimer

To promote the provision of efficient and effective healthcare services, Kennebec Region Health Alliance helps develop and disseminates practice guidelines for use by its member practices. Such guidelines are based upon various sources that KRHA believes to be reliable, which may include but is not limited to, guidelines from widely recognized professional societies, boards and colleges such as the American Medical Association (AMA). Practice guidelines are reviewed at least every two years and updated as necessary to reflect changes in medical practice.

These practice guidelines are not meant to express standards of care and should not be regarded as evidence of such standards. These Guidelines describe criteria for general operating practice and procedure and are for voluntary use. Guidelines are not a substitute for a physician's or healthcare professional's independent judgment.

Information on this website should not be relied on as an alternative to medical advice from a physician or other healthcare professional. If there are specific questions on any medical matter, a physician or healthcare professional should be consulted