

Patient-centered management guidance that highlight evidence-based, ADA-aligned strategies to support individualized, whole-person care for adults with type 2 diabetes.

Individualized, Patient-Centered Care

- Set individualized A1c goals based on age, comorbidities, hypoglycemia risk, and patient preferences.
- Address social drivers of health, health literacy, access to medications, and cost barriers.
- Engage in shared decision-making when selecting therapies.

Lifestyle and Nutrition Support

- Nutrition: Emphasize whole foods, portion control, reduced refined carbohydrates, and culturally appropriate meal planning.
 - [UC-VEG Nutrition Course](#)
- Physical activity: At least 150 minutes/week of moderate-intensity aerobic activity plus resistance training.
 - Exercise support: [YMCA of Douglas County](#)
- Weight management: Even 5–10% weight loss can significantly improve glycemic control.
- Diabetes self-management education and support (DSMES): Refer at diagnosis and as needed.
 - [UHA Diabetes Prevention Program](#)

Pharmacologic Management (ADA-Aligned)

- First-line: Metformin (unless contraindicated), alongside lifestyle modification.
- Therapy escalation: Base on comorbidities, not A1c alone.
 - ASCVD or high risk: GLP-1 receptor agonist and/or SGLT2 inhibitor with proven cardiovascular benefit.
 - Heart failure: SGLT2 inhibitor preferred.
 - Chronic kidney disease: SGLT2 inhibitor (if eGFR allows) or GLP-1 RA.
- Initiating Insulin: Recommended when blood glucose is ≥ 300 mg/dL (≥ 16.7 mmol/L) or A1C $> 10\%$ or when non-insulin therapies fail to meet targets.
 - Basal insulin is the preferred starting point (Initiation at 10 units per day OR 0.1-0.2 units/kg/day), with individualized titration over days to weeks as needed to achieve and maintain glycemic goals.
 - Education on self-administration, glucose monitoring, and managing hypoglycemia is essential.
- Avoid hypoglycemia where possible, especially in older adults.

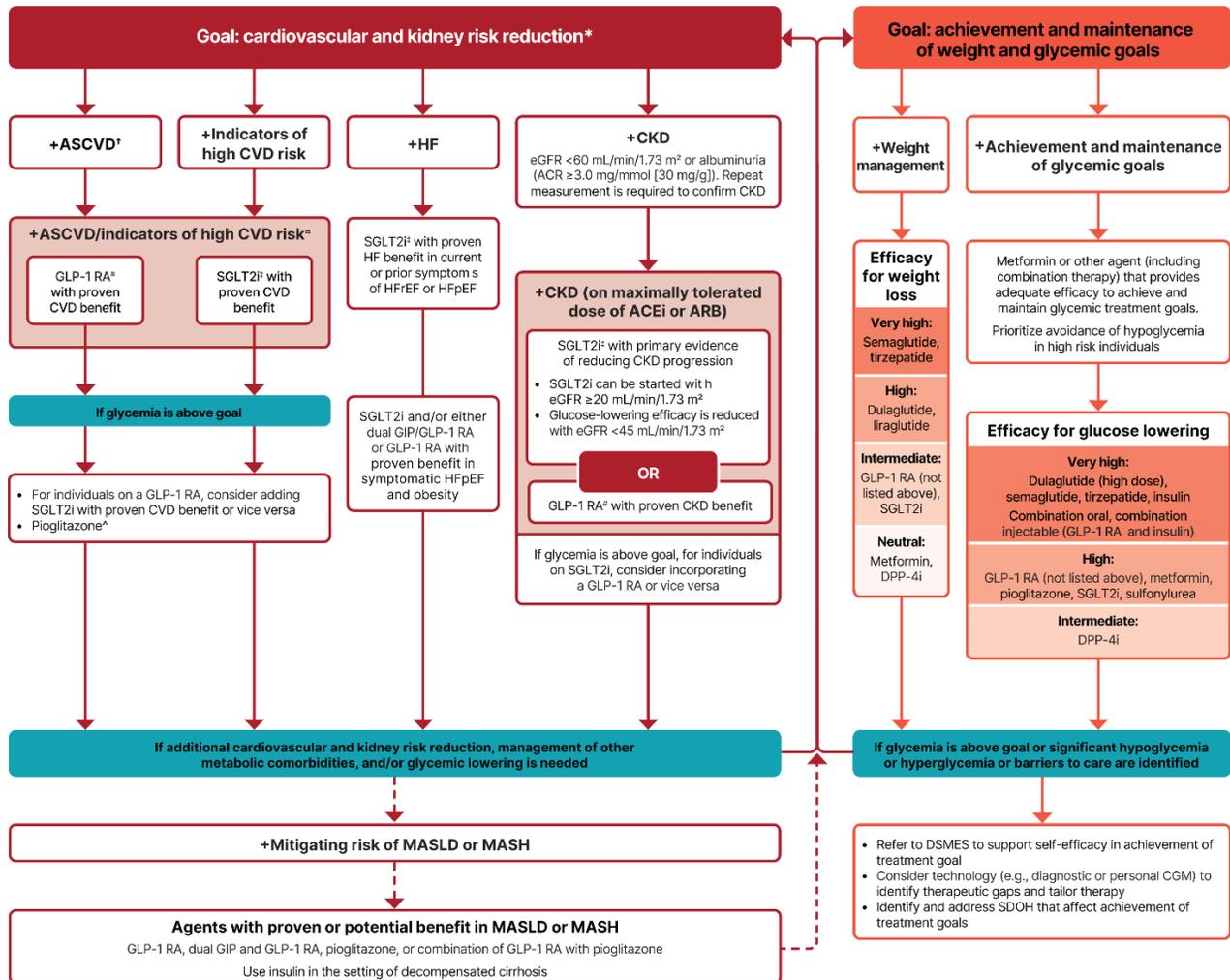
Preventing and Managing Complications

- Annual eye exams (or per ophthalmology guidance).
- Foot exams: At every visit (visual) and annually (comprehensive).
- Neuropathy screening: Starting at diagnosis.
- Vaccinations: Influenza, pneumococcal, hepatitis B, COVID-19 as recommended.

ADA: Use of glucose-lowering medications in the management of type 2 diabetes

Healthy lifestyle behaviors; diabetes self-management education and support; social determinants of health

To avoid therapeutic inertia, reassess and modify treatment regularly (3–6 months)



* In people with HF, CKD, established CVD, or multiple risk factors for CVD, the decision to use a GLP-1 RA or SGLT2i with proven benefit should be made irrespective of attainment of glycemic goal.

† ASCVD: Defined differently across CVOTs but all included individuals with established CVD (e.g., MI, stroke, and arterial revascularization procedure) and variably included conditions such as transient ischemic attack, unstable angina, amputation, and symptomatic or asymptomatic coronary artery disease. Indicators of high risk: While definitions vary, most comprise ≥55 years of age with two or more additional risk factors (including obesity, hypertension, smoking, dyslipidemia, or albuminuria).

‡ A strong recommendation is warranted for people with CVD and a weaker recommendation for those with indicators of high risk CVD. Moreover, a higher absolute risk reduction and thus lower numbers needed to treat are seen at higher levels of baseline risk and should be factored into the shared decision-making process. See text for details.

For GLP-1 RAs, CVOTs demonstrate their efficacy in reducing composite MACE, CV death, all-cause mortality, MI, stroke, and kidney end points in individuals with T2D with established or high risk of CVD. One kidney outcome trial demonstrated benefit in reducing persistent eGFR reduction and CV death for a GLP-1 RA in individuals with CKD and T2D.

‡ For SGLT2is, CV and kidney outcomes trials demonstrate their efficacy in reducing the risks of composite MACE, CV death, all-cause mortality, MI, HFrEF, and kidney outcomes in individuals with T2D and established or high risk of CVD.

* Low-dose pioglitazone may be better tolerated and similarly effective as higher doses.

Medication Class	Formulary Status	Medications
Biguanides	Preferred- No PA Required	Metformin IR and ER
TZDs	Preferred- No PA Required	Pioglitazone
Sulfonylureas	Preferred- No PA Required	Glimepiride, Glipizide IR and ER, Glyburide
DPP-4 Inhibitor	Preferred- No PA Required	Alogliptin
Insulin	Preferred- No PA Required	<ul style="list-style-type: none"> ▪ Insulin aspart pen/cartridge ▪ Insulin aspart protamine mix 70/30 pen/vial ▪ Insulin lispro Kwikpen/vials ▪ Insulin lispro Junior Kwikpen ▪ Insulin lispro protamine Mix75-25 ▪ Insulin glargine-yfgn pen ▪ Lantus Solostar pen ▪ Humulin N vial ▪ Novolin N vial ▪ Humulin N Mix 70-30 vial ▪ Novolin 70-30 vial
	Non-Preferred- PA Required	<ul style="list-style-type: none"> ▪ Novolog (insulin aspart) cartridge ▪ Novolog Flexpen (insulin aspart) pen ▪ Novolog Mix 70-30 Flexpen (insulin aspart protamine/insulin aspart) pen ▪ Basaglar (insulin glargine) ▪ Toujeo Solostar U-300 (insulin glargine) pen ▪ Admelog Solostar (insulin lispro) pen ▪ Humalog (insulin lispro) cartridge ▪ Humalog Mix 50-50 Kwikpen (insulin lispro protamine/lispro) pen ▪ Humalog Mix 75-25 Kwikpen (insulin lispro protamine/lispro) pen ▪ Humulin 70-30 Kwikpen (insulin NPH/insulin regular) pen ▪ Novolin 70-30 Flexpen (insulin NPH/insulin regular) pen ▪ Humulin N Kwikpen (insulin NPH) pen ▪ Humulin R U-500 (insulin regular) pen ▪ Humulin R U-500 Kwikpen (insulin regular) pen ▪ Tresiba U-100 and U-200 ▪ Insulin degludec U-100 and U-200
SGLT-2 Inhibitors	Preferred	Brenzavvy (bexagliflozin) and Steglatro (No PA required) Dapagliflozin propanediol (PA required)
	Non-preferred- PA required	Jardiance (empagliflozin), Invokana (canagliflozin), Inpefa (sotogliflozin)
GLP-1 Receptor Agonists and combo GLP-1/GIP Receptor Agonists	Preferred- PA required	Rybelsus (oral semaglutide), Ozempic Pen Injector (semaglutide), Exenatide Pen Injector, Trulicity (dulaglutide), Victoza (liraglutide) Pen Injector
	Non-preferred- PA required	Mounjaro (tirzepatide)

UHA Formulary and Clinical Criteria Summary

The most current [formulary](#) and [PA guidelines](#) are available online.

Non-preferred agents require prior authorization (PA) with documentation of trial and failure or contraindication to preferred agents.

Preferred products are formulary products and do not require PA unless indicated.