

Intensifying to Injectable Therapy – Figure 9.2 ADA 2020 Standards

Use Principles in Figure 9.1 including reinforcement of behavioral interventions (weight management and physical activity) and provision of DSMES to meet individualized treatment

To Avoid Therapeutic Inertia - Reassess and modify treatment

If injectable therapy is needed to reduce A1C¹

Consider GLP RA in most individuals prior to insulin²

INITIATION: Initiate appropriate starting dose for agent selected (varies within class)

TITRATION: Gradual titration to maintenance dose (varies within class)

If already on GLP-1 RA or if GLP-1 RA not appropriate OR insulin preferred

If above A1C target

Add basal insulin³

Choice of basal insulin should be based on person-specific considerations, including cost.

Add basal analog or bedtime NPH insulin

INITIATION: Start 10 IU a day OR 0.1-0.2 IU/kg a day

TITRATION:

- Set fasting glucose target (see Section 6: Glycemic Targets)
- Choose evidenced-based titration algorithm, e.g., increase 2 units every 3 days to reach fasting glucose target without hypoglycemia
- For hypoglycemia determine cause, if no clear reason lower dose by 10-20%

If on bedtime NPH, consider converting to twice-daily NPH

Conversion based on individual needs, glycemic control. The following is one approach:

INITIATION:

- Total dose= 80% of current hs NPH dose
- 2/3 given in morning
- 1/3 given at bedtime

TITRATION: based on individualized needs

If above A1C target – Add prandial insulin

Despite adequately titrated basal analog or bedtime NPH⁴
OR once basal dose >0.5 IU/kg OR FPG at target

Add prandial insulin⁵

Usually one dose with the largest meal or meal with the greatest post prandial glucose excursion; prandial insulin can be dosed individually or mixed with NPH (clear to cloudy)

INITIATION:

- 4 IU a day or 10% of basal insulin dose
- If A1C <8% (64 mmol/mol) consider lowering the basal dose by 4 IU a day
- Increase dose by 1-2 IU or 10-15% twice weekly
- For hypoglycemia determine cause, if no clear reason lower corresponding dose by 10-20%

TITRATION:

If above A1C target

ADA Standards of Care 2020 Pg 1 of Insulin Algorithm – Std 9.2

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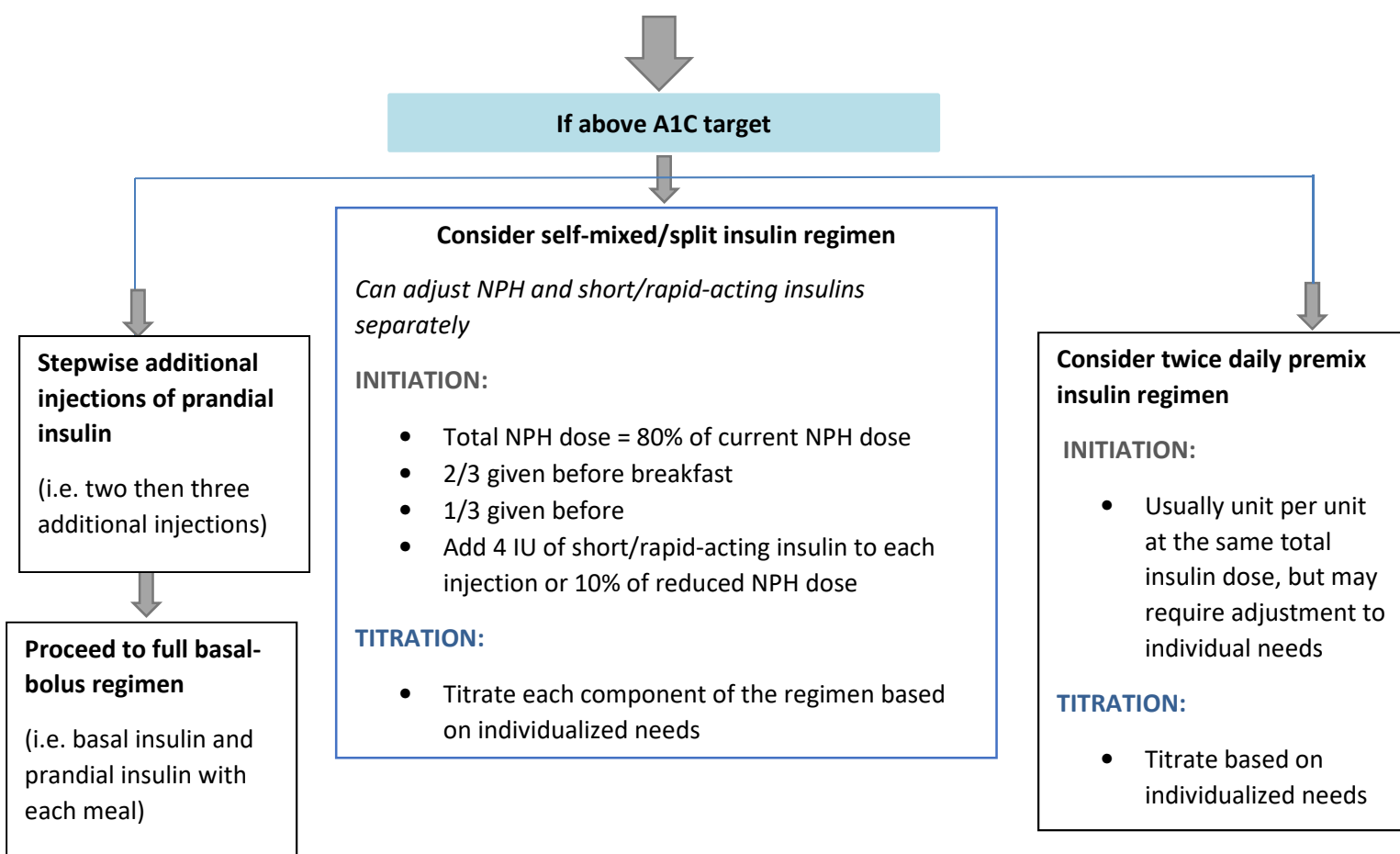


Figure 9.2 Footnotes:

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

ADA Standards of Care 2020 Figure 9.2 – Intensifying to injectable therapies. DSMES, diabetes self-management education and support; FPG, fasting plasma glucose; FRC, fixed-ratio combination; GLP-1RA, glucagon-like peptide 1 receptor agonist; max, maximum; PPG, postprandial glucose. Adapted from Davies et al. (33).

Reformatted and edited to include person centered language. Font enlarged for easier viewing by Diabetes Education Services. January 2020