Clinician Decision Aid

Guideline Directed Medical Therapy for T2D

SGLT2 inhibitors and GLP-1-based medications are first-line treatments for T2D in patients with cardiorenal disease. ***This aid is meant to support the use of GLP-1-based meds and SGLT2 inhibitors, alongside your own clinical judgement, to guide patient-centered diabetes treatment.***[1]

FDA Labeled (preferred) *Off Label*

ALL PATIENTS WITH T2D — Recommend lifestyle change with reduced carb intake and weight loss if indicated. Promote diabetes self management education and support (DSMES) upon diagnosis.

CLINICAL GOAL — To reduce cardiorenal risk independent of A1C in high risk patients

Established ASCVD[a]

Shared Decision Making (SGLT2i or GLP-1-based meds):

Invokana, Jardiance

or

Ozempic (SQ/PO), Trulicity, Victoza

Mounjaro

Heart Failure[b]

Farxiga[c]
Jardiance[c]

Invokana[d]
Steglatro[d]

If HFpEF with symptoms + obesity: Pick any above SGLT2i and/or Ozempic or Mounjaro.

CKD[e]

On maximum tolerated dose of ACEi/ARB

Farxiga[c]
Invokana
Jardiance[c]
or
Ozempic

If glucose is above target, consider the following:
- Consider adding SGLT2i to GLP-1-based med or vice versa

CLINICAL GOAL — To achieve and sustain glycemic control and promote weight loss

Glycemic Lowering / Weight Lowering

Metformin
(About 1% A1C lowering, weight neutral)

For additional glycemic lowering and low hypoglycemia risk

Glycemic lowering categories:
(% A1C lowering)

Very High *(>1.5%)*	Ozempic SQ, Mounjaro, Trulicity (3, 4.5 mg)
High *(~1%)*	Ozempic PO, Trulicity (1.5 mg), Victoza, SGLT2i
Modest *(~0.6%)*	DPP-4i

Set weight loss goals and engage in shared decision making for therapeutic interventions

Weight lowering categories:

Very High	Ozempic SQ, Mounjaro
High	Trulicity, Victoza
Modest	Ozempic PO, SGLT2i
Neutral	DPP-4i

If glucose is above target, consider the following:
- Additional agents based on glycemic, weight lowering, and metabolic dysfunction-associated steatohepatitis (MASH).[f]
- Initiation of a CGM.
- Referral or re-referral to DSMES.

a. **Consider use in HIGH risk patients:** ADA Standards gives a weaker recommendation for use given cardiovascular outcomes trial (CVOT) data were not powered for primary analysis in this subgroup. This subgroup includes: age ≥ 55 with 2 or more risk factors (e.g, obesity, hypertension, smoking, hyperlipidemia, albuminuria).

b. **Heart failure includes:** HFpEF (preserved EF) and HFrEF (reduced EF, ≤40% with or without symptoms).

c. **When using for HF and/or CKD protection:** See Figure 1 dosing considerations on next page.

d. **Invokana in HF:** Data for use from secondary outcomes of CVOT T2D trials. **Steglatro in HF:** Data for use from a non-inferiority trial, no proven benefit.

e. **Diagnosis of CKD (eGFR<60) and/or presence of albuminuria:** Determine after repeating measures of GFR and albuminuria **twice** (3 months apart).

f. **Additional Agents:** Insulin is a very highly effective glucose-lowering therapy, while sulfonylureas and pioglitazone are also highly effective; however, these agents can cause weight gain, and insulin and sulfonylureas increase the risk of hypoglycemia. Semaglutide SQ has FDA labeled indication for MASH (with moderate to advance fibrosis [stage F2 to F3]). Consider pioglitazone in combination with a GLP-1–based medication for patients with biopsy-proven MASH or those at high risk; pioglitazone may also reduce ASCVD events.

Prescribing Reminders and Recommendations

	GLP-1-based Medications	SGLT2 Inhibitors
Contraindications	**Personal or family history of medullary thyroid cancer or MEN-2-syndrome**, pregnancy, lactation, or allergy to medication.	**T1D, very low carbohydrate diet (less than 50g/day),** pregnancy, lactation, or allergy to medication.
Precautions	**History of:** • Pancreatitis • Severe GI disease (gastroparesis) • Gallbladder disease	**On dialysis:** • Contraindicated due to lack of safety studies in dialysis populations. **High risk for amputation** (e.g. active foot ulcers, prior amputations, or severe peripheral artery disease). • *See MCT2D Precautions Guide.* **If A1c greater than 10%:** • Consider alternative medication to lower glucose to avoid excess glucosuria.
Considerations for impaired renal function	**Monitor for volume depletion:** Use caution in patients with GI side effects or acute illness (e.g. vomiting, diarrhea, dehydration) when initiating or escalating doses.	**For glycemic lowering benefit:** **Avoid initiation if eGFR < 45 (all SGLT2i's),** given glycemic lowering is reduced with renal impairment
Considerations for medication adjustments	**If A1C is less than 9% and on:** • ***Basal insulin:*** lower by 10%[2] • ***Prandial insulin:*** lower by 30-40%[2]	**If A1C less than 8.5% and patient is on:** • ***Insulin:*** lower total daily dose by 10-20% - ***Avoid insulin discontinuation to minimize risk of euglycemic DKA*** • ***Sulfonylurea:*** Discontinue or lower dose by 50%
Key counseling points	• GI mitigating strategies and expected time for improvement • Sensitizing doses have negligible impact on glucose	• Hydration • Sick day management • Perineal hygiene • Blood pressure monitoring
Drug interactions	**DPP-4 Inhibitors (all GLP-1-based meds):** • No benefit from combination **Oral contraceptives (Tirzepatide only):** • Add backup method for 4 weeks after initiation and for 4 weeks after each dose escalation.	**Diuretic therapy - Monitor for:** • Volume depletion • Hypotension with other antihypertensive therapy *Adjustment upon initiation of SGLT2i is not required.*
Prior to surgery	Use shared decision-making with surgery and anesthesia teams on whether to hold based on patient risk of aspiration. *See Figure 2.*	**Hold for 4 days prior.** Resume after full oral intake is established. *Bridge with other glucose lowering medications if necessary.*

Figure 1: SGLT2i Renal Cutoffs:
For Patients with CKD/HF

	eGFR 25 - 45	eGFR 20 - 30
	Farxiga	Jardiance
CKD Heart Failure	10 mg daily (can continue if eGFR < 25)	10 mg daily (can continue if eGFR < 20)
On Dialysis: **Contraindicated**		

Figure 2: GLP-1-based Medication Surgical Considerations[3]

Action (prior to surgery)	**Hold** (if aspiration risk is **high**)	**Continue** (if aspiration risk is **low**)
Factors increasing aspiration risk	1. Currently in Escalation Phase of agent 2. On higher dose 3. On weekly formulation (GI side effects more common vs. daily) 4. Presence of GI symptoms 5. Medical conditions which delay gastric emptying	
Timing, if held: *(Bridge with other glucose lowering medications if necessary)*	Daily agents: **Day of** surgery	
	Weekly agents: At least **7 days prior** to surgery	

Medication Dosing Guide

michmed.org/Zxn7B

Patient Medication Handouts

michmed.org/bmx5B

References

1. ADA 2026 doi:10.2337/dc26-S009
2. Van Dril 2022 doi: 10.1016/j.ahjo.2022.100163
3. Kindel 2025 doi:10.1016/j.cgh.2024.10.003

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