Clinician Decision Aid

Guideline Directed Medical Therapy for T2D

MCT2D MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

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

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]	Heart Failure[b]	CKD[c]
Shared Decision Making (GLP-1 RA or SGLT2i): Ozempic/Rybelsus, Trulicity, Victoza or Invokana, Jardiance	Farxiga Jardiance; Invokana[d] Steglatro[d]; Brenzavvy	On maximum tolerated dose of ACEi/ARB → Farxiga[e] Invokana Jardiance[e] or Ozempic

If A1C is above target, consider the following:
- Additional agents[g] (based on glycemic, weight lowering, and comorbidity needs)
- Initiation of a CGM
- Referral or re-referral to DSMES

FDA Labeled (preferred) — *No Evidence - low cost (see footnote f)*
Off Label

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[2]:
(% A1C lowering)

Very High[f] *(>1.5%)*	Ozempic, Mounjaro, Trulicity (3, 4.5 mg)
High[f] *(~1%)*	Rybelsus, 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[g]:

Very High	Ozempic, Mounjaro
High	Trulicity, Victoza
Modest	Rybelsus, SGLT2i
DPP-4i and metformin are weight neutral	

If A1C is above target, consider the following:
- Additional agents[g] (based on glycemic, weight lowering, and comorbidity needs)
- 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%).

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

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. **When using for HF and/or CKD protection:** Irrespective of T2D diagnosis, dose is 10mg daily, and can be used at renal functions below renal cutoffs for glycemic lowering (See chart on next page).

f. **Brenzavvy:** Low cost option ($50-60/month) if guideline directed SGLT2i is not affordable. No evidence to support added ASCVD/CKD benefits.

g. **Additional Glycemic Agents:** Insulin (very high), sulfonylureas and pioglitazone (high) are effective glycemic lowering agents, but are not included because they are associated with weight gain. These agents also cause hypoglycemia.

Updated Oct 2025. Based on 2025 ADA Standards of Care.

Prescribing Reminders and Recommendations

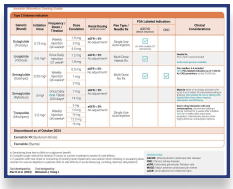
	Incretin Mimetics	SGLT2 Inhibitors
Contraindications	**Personal or family history of medullary thyroid cancer or MEN-2-syndrome**, pregnancy, lactation, or allergy to medication.	**T1D, very low carbohydrate diet (less than 50g/day),** pregnancy, lactation, or allergy to medication.
Precautions	**History of:** • Pancreatitis • Severe GI disease (gastroparesis) • Gallbladder disease	**On dialysis:** Contraindicated.[h] **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 if:** • ***eGFR < 45:*** Farxiga and Steglatro • ***eGFR < 30:*** Jardiance, Invokana, and Brenzavvy
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 incretin mimetics):** 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	**Daily agents:** Hold on the **day of** surgery[3] **Weekly agents:** Hold at least **7 days** prior[3] *Bridge with other glucose lowering medications if necessary. Use shared decision-making with surgery and anesthesia to hold incretin mimetic based on patient risk.*	**Hold for 4 days prior.** Resume after full oral intake is established.

h. Per KDIGO guidelines, contraindicated given lack of safety studies in those receiving dialysis. Studies are ongoing in the ESRD population.

SGLT2i Renal Cutoffs:
For Patients with CKD/HF and T2D

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

Medication Dosing Guide



michmed.org/Zxn7B

Patient Medication Handouts

michmed.org/bmx5B

References

1. ADA 2025 doi: 10.2337/dc25-S009
2. Van Dril 2022 doi: 10.1016/j.ahjo.2022.100163
3. Kindel 2024 doi: 10.1016/j.soard.2024.08.033

MCT2D
www.MCT2D.org

Tool developed by: ***Diez H et al. (2025)***

Tool designed by: ***Weisensel J, Young L***