

# American Diabetes Association (ADA) Standards of Medical Care – 2024

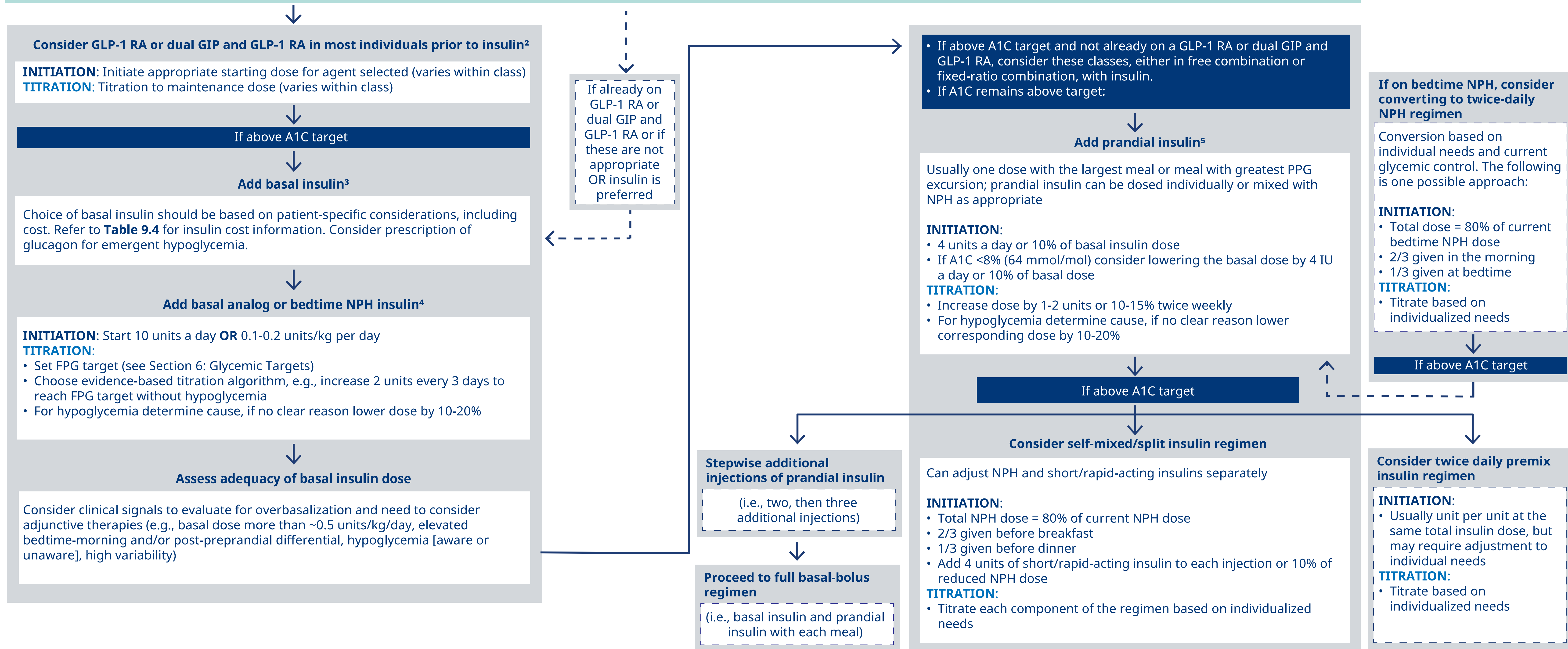
## 2024 ADA: Algorithm for intensifying to injectable therapies (Figure 9.4; S171)



Use principles in **Figure 9.3**, including reinforcement of behavioral interventions (weight management and physical activity) and provision of DSMES, to meet individualized treatment goals

TO AVOID THERAPEUTIC INERTIA REASSESS AND MODIFY TREATMENT REGULARLY (3-6 MONTHS)

### If injectable therapy is needed to reduce A1C<sup>1</sup>



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

A1C, glycated hemoglobin; CVD, cardiovascular disease; DSMES, diabetes self-management education and support; FPG, fasting plasma glucose; GLP-1 RA, glucagon-like peptide 1 receptor agonist; GIP, glucose-dependent insulinotropic peptide; NPH, Neutral Protamine Hagedorn; PPG, postprandial glucose. American Diabetes Association (ADA). *Diabetes Care* 2024;47(Supplement\_1):S158-S178.