**ASCVD RISK CALCULATOR**

The assessment of ASCVD risk remains the foundation of primary prevention. The purpose of the ASCVD Risk Calculator is to estimate a patient’s 10-year risk at an initial visit to establish a reference point. ACC/AHA guidelines recommend the use of the PCE as an important starting point, not as the final arbiter, for decision-making in primary prevention of ASCVD.

**STATIN RECOMMENDATIONS FOR ADULTS WITH TYPE 2 DIABETES**

In adults 40 to 75 years of age with diabetes mellitus, regardless of estimated 10-year ASCVD risk, moderate-intensity statin therapy is indicated (S4.3-1—S4.3-9).

In adults 40 to 75 years of age with diabetes mellitus and an LDL-C level of 70 to 189 mg/dL (1.7 to 4.8 mmol/L), it is reasonable to assess the 10-year risk of a first ASCVD event by using the race and sex-specific PCE to help stratify ASCVD risk (S4.3-10, S4.3-11).

In adults with diabetes mellitus who have multiple ASCVD risk factors, it is reasonable to prescribe high-intensity statin therapy with the aim to reduce LDL-C levels by 50% or more (S4.3-12, S4.3-13).

In adults older than 75 years with diabetes mellitus and who are already on statin therapy, it is reasonable to continue statin therapy (S4.3-5, S4.3-8, S4.3-13).

In adults with diabetes mellitus and 10-year ASCVD risk of 20% or higher, it may be reasonable to add ezetimibe to maximally tolerated statin therapy to reduce LDL-C levels by 50% or more (S4.3-14, S4.3-15).

In adults older than 75 years with diabetes mellitus, it may be reasonable to initiate statin therapy after a clinician-patient discussion of potential benefits and risks (S4.3-5, S4.3-8, S4.3-16—S4.3-25).
DECISION CYCLE FOR PATIENT-CENTERED GLYCEMIC MANAGEMENT IN TYPE 2 DIABETES

Approaches to management of glycemia in adults with type 2 diabetes, with the goal of reducing complications and maintaining quality of life in the context of comprehensive cardiovascular risk management and patient-centered care. The principles of how this can be achieved are summarized and underpin the approach to management and care. These recommendations are not generally applicable to patients with monogenic diabetes, secondary diabetes, or type 1 diabetes, or to children.

GOALS OF CARE
- Prevent complications
- Optimize quality of life

IMPLEMENT MANAGEMENT PLAN
- Patients not meeting goals generally should be seen at least every 3 months as long as progress is being made; more frequent consultation is often desirable for SGLT2s.

ASSESS KEY PATIENT CHARACTERISTICS
- Current lifestyle
- Comorbidities, i.e., ASCVD, CKD, HF
- Clinical characteristics, i.e., age, HbA1c, weight
- Issues such as motivation and depression
- Cultural and socioeconomic context

CONSIDER SPECIFIC FACTORS THAT IMPACT CHOICE OF TREATMENT
- Individualized HbA1c target
- Impact on weight and hypoglycemia
- Side effect profile of medication
- Complexity of regimen, i.e., frequency, mode of administration
- Choice regimen to optimize compliance and persistence
- Access, cost, and availability of medication

SHARE DECISION MAKING TO CREATE A MANAGEMENT PLAN
- Involves an educated and informed patient (and their family/caregiver)
- Seeks patient preferences
- Effective consultation includes motivational interviewing, goal setting, and shared decision making
- Empowers the patient
- Ensures access to SGLT2s

GLUCOSE-LOWERING MEDICATION IN TYPE 2 DIABETES: OVERALL APPROACH

IF A1C ABOVE INDIVIDUALIZED TARGET PROCEED AS BELOW

1. Phone CHF benefit means it has been linked to reduced CHF events.  
2. Once-daily single-agent therapy is recommended for indication-specific and individual agents regardless of titrated dosing of GLP-1 RA and SGLT2i, doses and safety.  
3. Glucagon-like peptide-1 (GLP-1) receptor agonists and glucagon-like peptide-2 (GLP-2) receptor agonists in the setting of HbA1c >7% are not GLP-1 RA and SGLT2i.  
4. Basal insulin.  
5. DPP-4.  
6. Avoid DPP-4 in the setting of HbA1c >7% and use GLP-1 receptor agonists.  
7. For patients on a SGLT2i, consider adding a GLP-1 RA with proven CHF benefit.  
9. Consider basal insulin with lower risk of hypoglycemia.  
10. Consider basal insulin with lower risk of hypoglycemia.  
11. If specific therapy is required, consider SGLT2i, GLP-1 RA, and insulin with concurrent or alternate dose of insulin.  
13. Consider HbA1c and age-specific goals of disease, in some situations HbA1c optimizing strategies and in other situations insulin resistance and C-peptide deficiency.  
15. DPP-4 in the setting of HbA1c >7% and use GLP-1 receptor agonists.  
17. Dapagliflozin (≤60 kg), dapagliflozin ≥60 kg.  
18. SGLT2i, GLP-1 RA, or both.  
19. Consider basal insulin with lower risk of hypoglycemia.  
20. GLP-1 RA or insulin with concurrent or alternate dose of insulin.  
22. Consider HbA1c and age-specific goals of disease, in some situations HbA1c optimizing strategies and in other situations insulin resistance and C-peptide deficiency.  
23. Basal insulins.