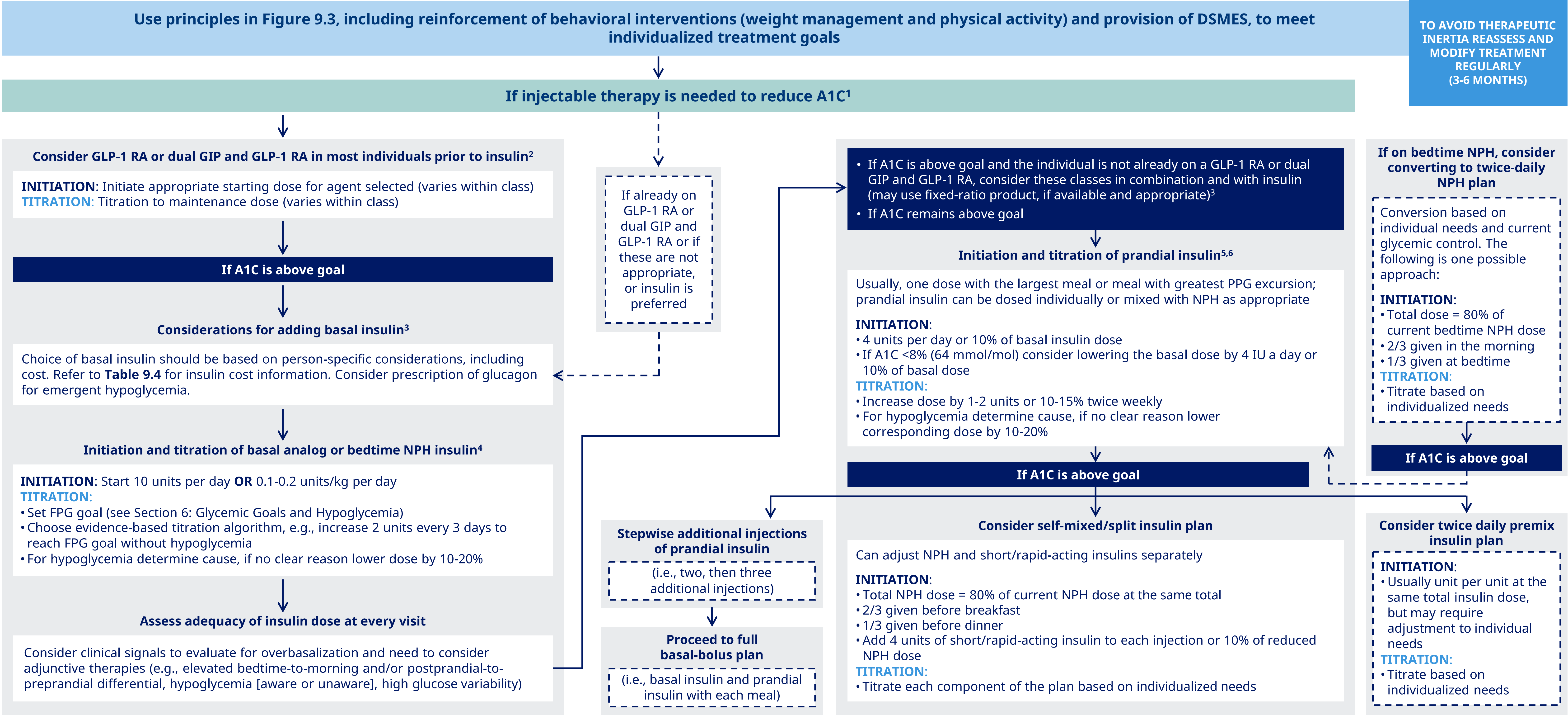


American Diabetes Association (ADA) Standards of Medical Care – 2025

2025 ADA: Algorithm for intensifying to injectable therapies (Figure 9.4; S192)



1. Consider insulin as the first injectable if symptoms of hyperglycemia are present, when A1C or blood glucose levels are very high (i.e. A1C >10% [86 mmol/mol] and blood glucose ≥300 mg/dL [≥16.7 mmol/L]), or a diagnosis of type 1 diabetes is a possibility.

2. When selecting GLP-1 RAs, consider individual preference, A1C lowering, weight-lowering effect, and frequency of injection. If CVD, is present, consider GLP-1 RA with proven CVD benefit; oral or injectable GLP-1 RAs are appropriate.

3. For people 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 a morning dose of a long-acting basal insulin. Consider dosing NPH in the morning for steroid-induced hyperglycemia.

5. Prandial insulin options include injectable rapid- and ultra-rapid-acting analog insulins, injectable short-acting human insulin, or inhaled human insulin.

6. If adding prandial insulin to NPH, consider initiation of a self-mixed or premixed insulin plan 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* 2025;48(Suppl. 1):S181-S206.

