**LIPID LOWERING THERAPY RECOMMENDATIONS FOR PERSONS 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 Pooled Cohort Equations 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 of age 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, S4.3-11, S4.3-13).

In adults 20 to 39 years of age with diabetes mellitus that is either of long duration (<10 years of type 2 diabetes mellitus, >20 years of type 1 diabetes mellitus), albuminuria (>200 mg albumin/1 g creatinine), estimated glomerular filtration rate (eGFR) less than 60 mL/min/1.73 m², nephropathy, neuropathy, or ABI (<0.9), it may be reasonable to initiate statin therapy (S4.3-5, S4.3-6, S4.3-8, S4.3-16–S4.3-25).

In adults with ASCVD, where LDL-C remains >70 mg/dL while on maximally tolerated statin therapy ezetimibe can be added and for those at very high risk a PCSK9i.

**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 ASCVD risk at the point of care, for providers to consider in their risk stratification and treatment decision-making process. 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.

- **Measure height, weight, waist circumference:**
  - Age, sex, race

- **Measure blood pressure:**
  - Systolic blood pressure
  - Measure blood pressure (systolic blood pressure)
  - Measure lipid levels

- **Medication use**
  - (antihypertensives, statin, aspirin)

- **Assess tobacco use**
  - (smoking status)

**LIFE’S ESSENTIAL 8**

- **Life’s Essential 8: Updating and Enhancing the American Heart Association’s Construct**
  - The American Heart Association’s (AHA) has identified eight simple measures (“Life’s Essential 8”) to prevent cardiovascular disease.

1. **Measure height, weight, waist circumference**
2. **Measure blood pressure**
3. **Measure A1C**
4. **Measure lipid levels**
5. **Assess physical activity level**
6. **Assess dietary pattern**
7. **Assess sleep pattern**
8. **Measure body mass index (BMI)**

- **Adults who are 40 to 75 years of age and are being evaluated for cardiovascular disease prevention should undergo a 10-year atherosclerotic cardiovascular disease (ASCVD) risk estimation and have a clinician–patient risk discussion before starting on pharmacological therapy, such as antihypertensive therapy, a statin, or aspirin.**

**ASCVD Risk Calculator:**

KnowDiabetesbyHeart.org/RiskCalc

**ASCVD Risk Calculator**

- **Measure height, weight, waist circumference**
  - Age, sex, race

- **Measure blood pressure**
  - Systolic blood pressure

- **Measure lipid levels**

- **Medication use**
  - (antihypertensives, statin, aspirin)

- **Assess tobacco use**
  - (smoking status)

**ASCVD Risk Calculator**

- **Measure height, weight, waist circumference**
  - Age, sex, race

- **Measure blood pressure**
  - Systolic blood pressure

- **Measure lipid levels**

- **Medication use**
  - (antihypertensives, statin, aspirin)

- **Assess tobacco use**
  - (smoking status)
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.

PHARMACOLOGIC TREATMENT OF HYPERGLYCEMIA IN ADULTS WITH TYPE 2 DIABETES

CHRONIC KIDNEY DISEASE SCREENING

At least annually, urinary albumin (e.g., spot urinary albumin-to-creatinine ratio) and estimated glomerular filtration rate should be assessed in patients with type 1 diabetes with duration of ≥5 years and in all patients with type 2 diabetes regardless of treatment.

Patients with diabetes and urinary albumin ≥300 mg/g creatinine and/or an estimated glomerular filtration rate 30–60 mL/min/1.73 m² should be monitored twice annually to guide therapy.

Please visit KnowDiabetesByHeart.org/Professional/Guidelines/ for more information.

5. Standards of Medical Care in Diabetes—2022. Diabetes Care 1 January 2022; 45 (Supplement_1): S50–S59. https://doi.org/10.2337/dc22-S009
7. Standards of Medical Care in Diabetes—2022. Diabetes Care 1 January 2022; 45 (Supplement_1): S87–S95. https://doi.org/10.2337/dc22-S010