### BP Goals

<table>
<thead>
<tr>
<th>Condition</th>
<th>Conventional Office</th>
<th>Automated Office BP (AOBP) Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Adults</td>
<td>≤ 139 / 89</td>
<td>≤ 134 / 84</td>
</tr>
</tbody>
</table>

If: ≥ 75 yrs, eGFR 20 – 59 mL/min, ASCVD or ≥10% 10-yr ASCVD risk

- Consider ≤ 129/84
- Consider ≤ 129 / 84

### A1c Goals

- ≤ 7.9%: ≥ 65 yrs or clinical factors
- ≤ 6.9%: < 65 yrs w/o clinical factors

**Type 2 DM**

- **A1c ≥ 2% above goal**
  - Add Metformin + NPH insulin

**Start Metformin**

- 500mg: ½ tablet bid → 1 tablet bid → 2 tablets bid
  - Contraindicated: eGFR < 30 or HF NY class 3–4 or LFTs > 3 x ULN
  - Start not recommended: If baseline eGFR < 45
  - Assess risk/benefits: If eGFR falls < 45

- If GFR 30–45, 1000mg = max.
- Titrate every 1-2 weeks aiming for AM SMBG target
  - ≤ 6.9: 70–130; ≤ 7.9: 100–160

**Risk of Severe Hypoglycemia**

- Yes
  - Add Alternate agent

**At goal**

- Yes
  - Monitor

**No**

- Add Glipizide

**Add Alternate agent**

- Add NPH Insulin

**Start / Add NPH Insulin**

- 10 units SQ at hs
  - 2 units every 2 days until at target

### Statin Goals

**Atorvastatin 40-80 mg**

- Clinical ASCVD Age < 75 + any LDL
- DM: Age < 75 + LDL ≥ 190

**Atorvastatin 10-20 mg**

- Clinical ASCVD Age ≥ 75 + any LDL
- DM: Age ≥ 40 + LDL 70-189*

**Start Statin**

- Atorvastatin 20 mg daily
  - See CAUTION/INFO
  - Verify contraception

**Optional:** LDL monitoring to ensure appropriate response

- For DM w/ LDL <70, see primary prevention guidelines.

**If recommended dose of statin not tolerated, switch to a different statin (such as rosuvastatin). If that doesn’t work, reduce to highest tolerated dose. [update SIG w/ dosing changes]**

### A1c Goals

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**No**

- Add Glipizide

**Add Alternate agent**

- Add NPH Insulin

**Start / Add NPH Insulin**

- 10 units SQ at hs
  - 2 units every 2 days until at target

### Thiazoladinedione

- Oral
- Wt: Avg 1-3 kg gain
- Risk: CHF, Fx
- Formulary
- Generic co-pay

### DPP-4 Inhibitor

- Oral
- Wt: Neutral
- Non-formulary; brand co-pay

### GLP-1 R Agonist

- SQ injection (Needs Endocrine approval)
- Wt: Avg 1-3 kg loss
- Risk: Nausea / vomiting
- Non-formulary; brand co-pay

### SGLT2 Inhibitor

- Oral
- Wt: Avg 1-3 kg loss
- Risk: Genital yeast infections, DKA
- Non-formulary; brand co-pay

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1. Beta Blockers, independent of their mild anti-hypertensive effect, are sometimes indicated for secondary cardio-protection
2. Adapted from KPNC CPG for:
   - CAD, DM, Cholesterol, HTN, HF and Stroke
   - Complete guidelines, including updated guidelines on the
   - Dx of HTN, can be found in the Clinical Library at http://cl.kp.org
3. ©2018 Kaiser Permanente
4. "Clinical Atherosclerotic Cardiovascular Disease (ASCVD), e.g. CAD, TIA/CVA, Symptomatic PAD.
5. Individualize A1c goal based on hypoglycemia risk, duration of DM, life expectancy, co-morbidities, vascular complications, member resources and support system.
6. If intolerant to immediate release metformin, strongly consider sustained release metformin.
7. If severe hypoglycemia = Hypoglycemia resulting in / likely to result in seizures, loss of consciousness, or needing help from others. Mild to moderate hypoglycemia = Symptoms of neuro-glycopenia such as hunger or sweating that the patient can effectively self treat.
8. A1C above goal 3 months despite non-insulin agents, strongly consider discontinuing ineffective medications and initiating insulin + metformin.
### Cardiovascular Risk Management Medications

#### PHASE POPULATIONS

**CAD**  
Symptomatic PAD

**DM**  
If 10 y CV risk > 10% ages 50-59 ASA recommended; if 10 y CV risk > 10% ages 60-69 consider ASA

#### PHASE MEDICATIONS & CAUTIONS

**ASA**  
81mg daily

**ACEI**  
Lisinopril 10mg daily

**ARB**  
Losartan (Cozaar®) F

**Calcium Channel Blocker**  
Amlodipine (Norvasc®) F

**Potassium Sparring Diuretic**  
Spironolactone (Aldactone®) F

**Beta 1 blocker**  
Bisoprolol (Zebeta®) F

**DM 2 (non-insulin agents)**

**Biguanide**  
Metformin (Glucophage®) F

**Sulfonylurea**  
Gliclazide (GlucoMax®) F

**Thiazolidinedione**  
Piglitazone (Actos®) F

**DPP-4 inhibitor**  
Linagliptin (Tradjenta®) NF

**SGLT2 inhibitor**  
Empagliflozin (Jardiance®) NF

**GLP-1 receptor agonist**  
Exenatide ER inj (Bydureon® NF)

**Statins**

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<tr>
<th>Medication</th>
<th>Preferred Dosage Forms</th>
<th>Max. Rec. Dose</th>
<th>Optimal Titration Interval</th>
<th>Baseline Labs</th>
<th>Cautions / Contraindications</th>
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<td>Atorvastatin (Lipitor®) F</td>
<td>Tab 40, 80mg</td>
<td>80mg daily hs</td>
<td>N/A</td>
<td>ALT, Scr</td>
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<td>Tab 10, 20mg</td>
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Lisinopril - HCTZ (Prinzide®) F | Tab 20 / 25mg | 40 / 50mg daily | 2 weeks | K+ and Scr. < 6 months (Na+ optional) | K+ and Scr. 1 week after initiation or dosage change (Na+ optional) |
| **Thiazide Diuretics**  
HCTZ (Hydrodiuril®, Esioid®) F | Tab 25mg | HCTZ 50mg daily | 2 weeks | K+ and Scr. < 6 months (Na+ optional) | K+ and Scr. 1 week after initiation or dosage change (Na+ optional) |
| **ACE Inhibitor**  
Lisinopril (Prinivil®) F | Tab 5, 10, 20mg | 40mg daily | 1 week | K+ and Scr. < 6 months (Na+ optional) | K+ and Scr. 1 week after initiation. K+ 2 weeks after dosage change |
| **ARB**  
Losartan (Cozaar®) F | Tab 25, 50mg | 100mg daily or 50mg BID | 1 week | K+ and Scr. < 6 months (Na+ optional) | K+ and Scr. 1 week after initiation. K+ 2 weeks after dosage change |
| **Calcium Channel Blocker**  
Amlodipine (Norvasc®) F | Tab 2.5, 5, 10mg | 10mg daily | 1 week | None | None |
| **Potassium Sparring Diuretic**  
Spironolactone (Aldactone®) F | Tab 25mg | 25mg daily | 1 week | K+ and Scr. < 1 month | Maintain pulse > 55 |
| **Beta 1 blocker**  
Bisoprolol (Zebeta®) F | Tab 5, 10mg | 10mg daily | 1 week | None | None |

**DM**  
2 (non-insulin agents)

**Biguanide**  
Metformin (Glucophage®) F

**Sulfonylurea**  
Glipizide (GlucoMax®) F

**Thiazolidinedione**  
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*Do not routinely measure CK. Consider baseline CK if increased risk for adverse muscle events (such as personal or family history of statin intolerance or muscle disease, clinical presentation, or concomitant drug therapy that might increase the risk for myopathy).