T2DM — Treatment Pathway

Lifestyle, metformin, then cardiorenal-guided escalation

CLINICAL PATHWAY

Escalate whenever HbA1c is above the individualised target after ~3 months. In established CVD, heart failure or CKD, an SGLT2 inhibitor or GLP-1 receptor agonist is commonly preferred for its organ-protective benefit — independent of HbA1c.

THE STEPPED-CARE PYRAMID

Escalate at each step if the individualised HbA1c target isn't met.

1	**Foundation — lifestyle:** nutrition review, ≥150min/week activity, 5–10% weight loss where overweight, smoking cessation — started at diagnosis, continued throughout
2	**Metformin:** start 500mg, titrate to 1g twice daily as tolerated — first-line unless contraindicated. If contraindicated or not tolerated, pioglitazone is a PBS-listed first-line alternative
3	**Dual therapy — add one agent:** SGLT2 inhibitor, GLP-1 receptor agonist, DPP-4 inhibitor, or sulfonylurea — choice guided by the patient's profile, see right
4	**Triple therapy:** add another class from the list above. A GLP-1RA + SGLT2i combination is clinically reasonable but has a PBS funding restriction — see the note opposite
5	**Insulin ± GLP-1RA:** usually basal insulin first, ± a GLP-1RA, then stepping to premixed or basal-bolus regimens if targets remain unmet

CHOOSING THE NEXT AGENT

- **Established ASCVD or multiple CV risk factors:** an SGLT2 inhibitor or GLP-1RA is commonly preferred for cardiovascular benefit
- **Heart failure:** an SGLT2 inhibitor is commonly the preferred first add-on — see CV-02A
- **CKD with albuminuria:** an SGLT2 inhibitor is commonly preferred for kidney-protective benefit — see REN-01A
- **Obesity (BMI>30):** a GLP-1RA is often favoured for its weight-loss benefit
- **Hypoglycaemia a concern:** an SGLT2 inhibitor or DPP-4 inhibitor carries low intrinsic hypoglycaemia risk
- **Older or weight-neutral preference:** a DPP-4 inhibitor is often well tolerated

GLP-1RA + SGLT2i — PBS FUNDING RULE

Combining a GLP-1RA and an SGLT2 inhibitor is clinically reasonable, but the PBS generally doesn't subsidise both together for a glycaemic indication. Exception: if the SGLT2i is funded for a non-glycaemic indication (heart failure or CKD) and glycaemic response to it was inadequate, a GLP-1RA can then be added with PBS support. Confirm current wording at pbs.gov.au.

■ SAFETY

- SGLT2 inhibitors: stop temporarily during acute illness, dehydration, or before major surgery — risk of euglycaemic ketoacidosis
- Sulfonylureas and insulin carry genuine hypoglycaemia risk — educate on recognition and treatment, especially in older patients
- Apply sick-day rules (SADMANS) during illness — see EN-01B / REN-01B

■ RED FLAGS / REFER

- HbA1c persistently above target despite optimised triple therapy → consider endocrinology or diabetes educator referral
- Recurrent severe hypoglycaemia, or hypoglycaemia unawareness → refer
- Suspected type 1 diabetes/LADA, or pregnancy planning/pregnancy → refer

For health-professional use. Framework: RACGP T2DM Handbook (Nov 2024, upd. Aug 2025); ADS Glycaemic Algorithm (May 2026).
Companion sheet: EN-01B T2DM — Targets & Annual Cycle of Care.