Table 23. (continued)

	scheduled follow-up visits for the duration of the condition favors continuity of care and person metrics.[527,530,531]	maintenance of lifestyle changes, based on a person's characteristics and needs.

of Leading Causes of Morbidity and Mortality).

- **Aggregate evidence quality**: Grade B, regarding the need for deprescribing, dangers of hypoglycemia, and lack of previous guidance on deprescribing based on 8 systematic reviews. Grade C, regarding the likelihood of lifestyle interventions to necessitate deprescribing and potential hypoglycemia based on several non-randomized, observational, or alternative method designed studies
- **Level of confidence in evidence**: Medium
- **Benefits**: Avoid adverse effects from hypoglycemia or overmedication; avoid hypotension; minimize weight gain; enable prescribed lifestyle changes; and promote sustainability of changes
- **Risk, harm, cost**: Person anxiety regarding changes in therapy; some medications may be costly, or not covered by insurance; short-term, permissive hyperglycemia
- **Benefit-harm assessment**: Preponderance of benefit over harm
- **Value judgments**: There is a perception among the GDG that people may experience anxiety about lifestyle interventions because of the potential impact on their current medications; perception of lack of awareness (for both medical teams and people) about anticipating the need to adjust pharmacologic therapy once lifestyle interventions are implemented
- **Intentional vagueness**: None
- **Role of patient (individual) preferences**: Moderate for shared decision-making regarding adjustments to medications
- **Exceptions**: None
- **Differences of opinion**: None
- **Implementation considerations**: Need for frequent follow-up to monitor impact of medication changes; glucose monitor access; anxiety about deprescribing medications; and access and availability of CGM

Supporting Text

The purpose of this statement is to provide guidance to clinicians for adjusting the type and dosing of pharmacological therapy for people with T2D who are engaging in intensive or moderate therapeutic lifestyle change interventions, particularly when the goal is to achieve remission. *Any adjustment should also take into account how the medication change may impact comorbid conditions, if present, such as chronic kidney disease, heart failure (with reduced or preserved ejection fraction), or a history of myocardial infarction.*

Deprescribing medications in people with T2D has historically been done to reduce polypharmacy[534-536] and inappropriate medications,[537-540] most commonly in older adults. Pharmacologic down-titration can occur during scheduled follow-up visits in person or on telehealth to prevent adverse events and to promote better outcomes.[504,511,514,541-544] Chapter 13 of the ADA guidelines, which focused on older adults, specifically recommends efforts be made to reduce hypoglycemia risk and to simplify treatment plans (level B).[545]

Hypoglycemia has been identified as a risk in multiple contexts, including in cases of weight loss,[546] following bariatric surgery among people with T2D,[547] over prescription among the elderly,[548] low-carbohydrate eating plans,[549,550] energy-restricted eating plans,[312,326] and low-fat, whole-food, plant-based eating plans[306,309] (**see KAS 8**). Weight loss may also occur when using GLP-1 receptor agonists, but only a minority of T2D adults lose more than 5% of their weight with these medications, which is less than observed in clinical trial participants.[551] Collaborating closely with pharmacists, as part of the interdisciplinary team that includes nurses, dietitians, health coaches, and certified diabetes care and education specialists (CDCES),[504] is recommended to monitor changes in needs for glucose-lowering and anti-hypertensive medications. We recommend clinicians be proactive in reducing diabetes medications associated with hypoglycemia risk, for people who will incorporate strong, consistent, lifestyle improvements (especially nutrition and exercise) (Figures 30 and 31). Should hypoglycemia occur, clinicians should follow the established standards of care for