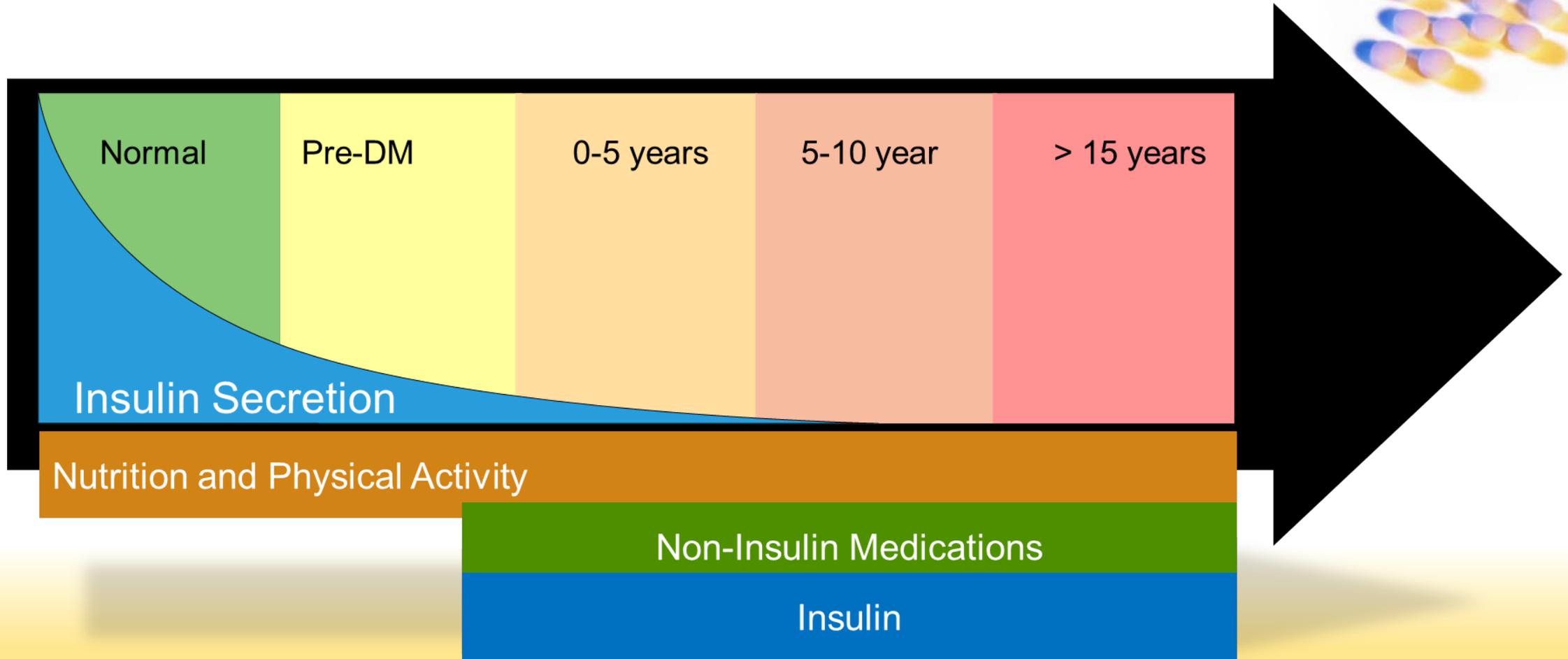




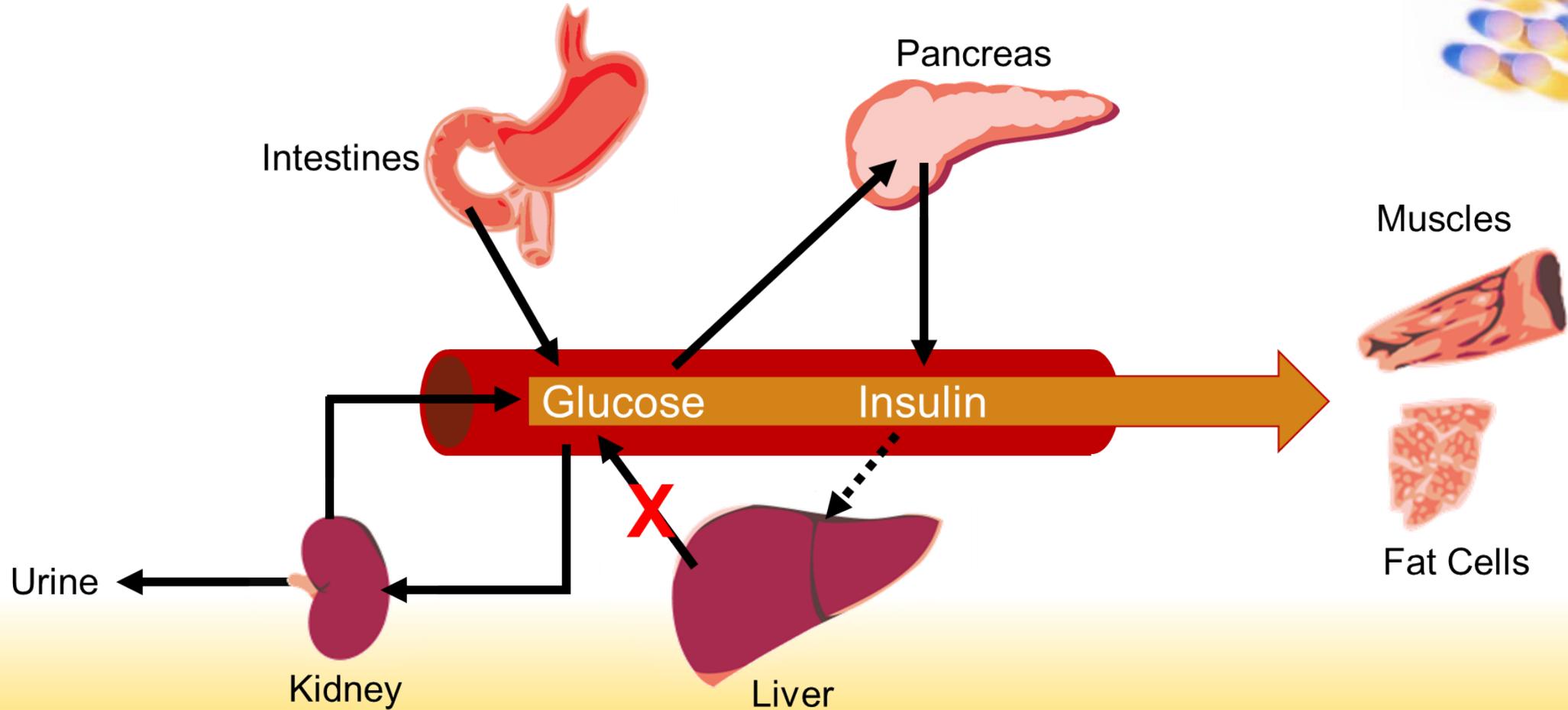
Diabetes Medications: 2016

Chris Lamer

Progression of Diabetes



Pathophysiology



Diabetes Medications



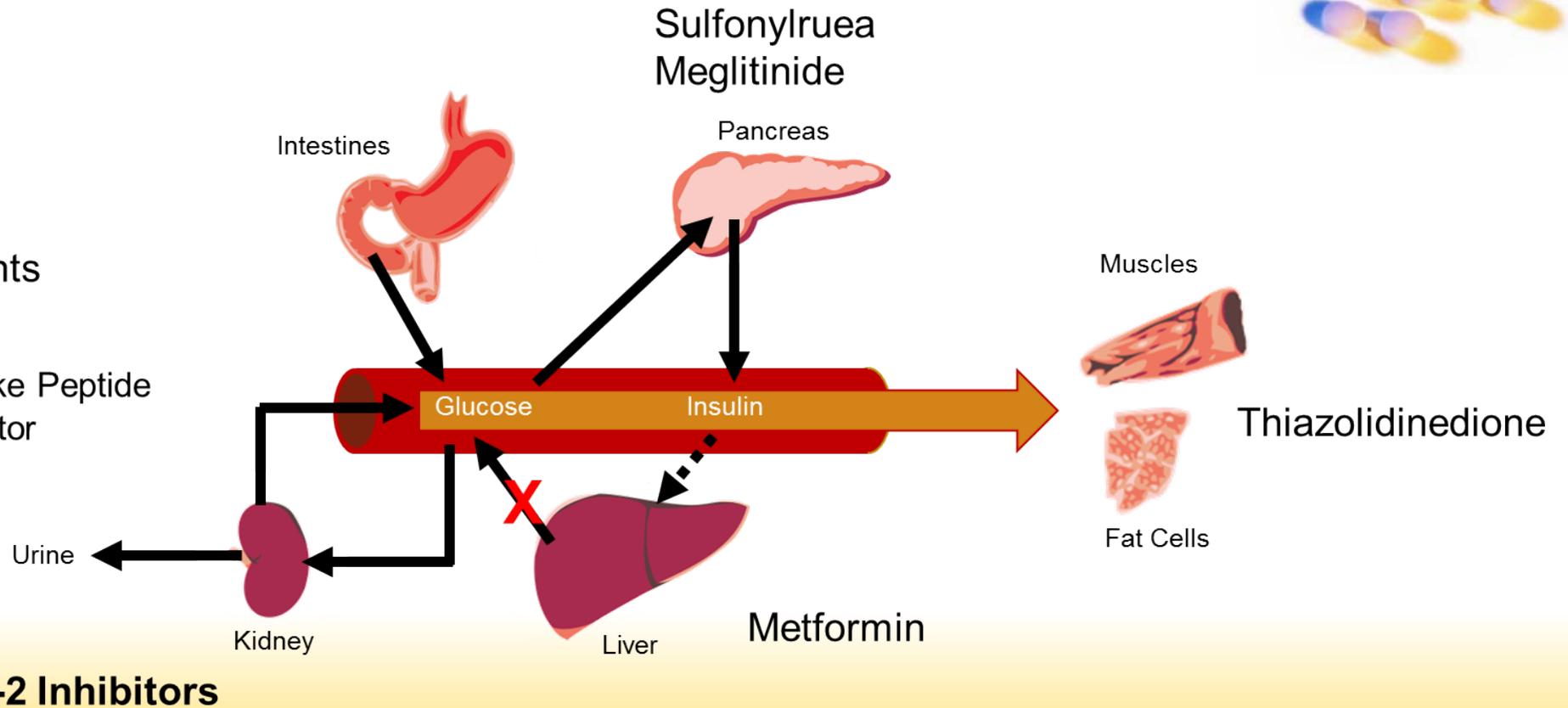
Alpha Glucosidase Inhibitors

Amylin Analog

Bile Acid Sequestrants

Incretin Mimetics

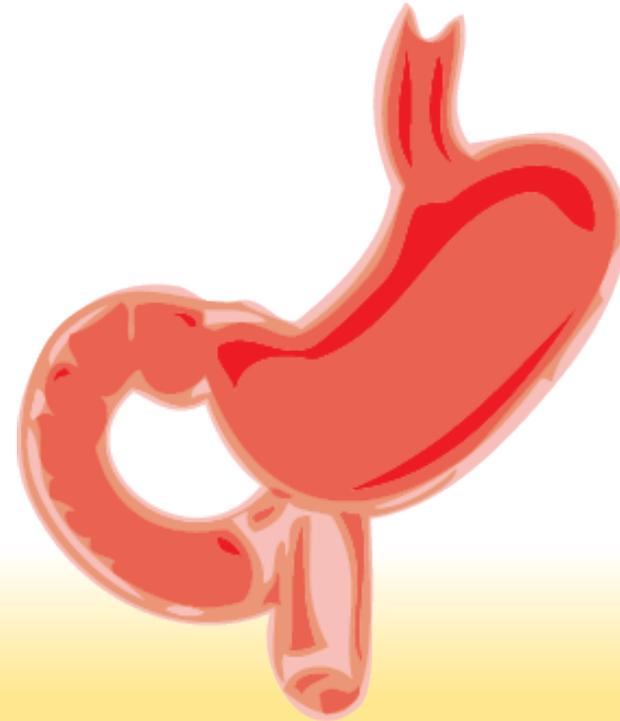
Glucagon Like Peptide
DPP-4 Inhibitor



Medications that affect Glucose Absorption



- Alpha Glucosidase Inhibitor
 - Acarbose (Precose®)
 - Miglitol (Glyset®)
- Amylin Analog
 - Pramlintide (Symlin®)
- Bile Acid Sequestrant
 - Colesevelam (Welchol®)

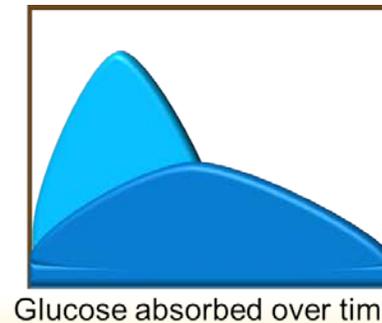
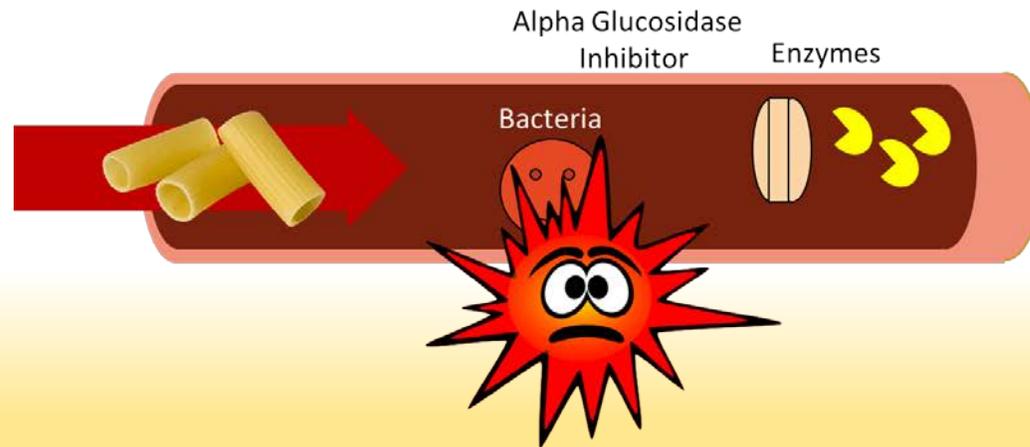


Alpha Glucosidase Inhibitors

Acarbose (Precose®)

Miglitol (Glyset®)

- Block the enzymes that break down carbohydrates into simple sugars (glucose)



Alpha Glucosidase Inhibitors (cont.)



- Major Side effects include cramping, constipation, and gas
 - Titrate slowly to minimize effects

Acarbose

- Starting dose: 25 mg TID
- Increase dose slowly at 4-8 week intervals
- Max dose: 50-100 mg TID

- Decrease A1C by about 0.5%

Miglitol

- Starting dose: 25 mg TID
- Max dose: 50-100 mg TID

Amylin Analogs

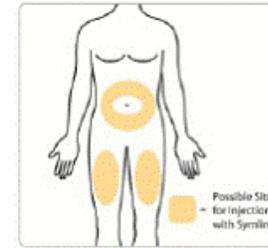
Pramlintide (Symlin®)



- Slows gastric emptying, increases satiety
- Decrease A1C by 0.5%
- Decrease weight by 1.5 kg

Amylin Analogs (cont.)

- SC Injection
- Must be given 2 inches from site of insulin injection.
 - Do not mix with any type of insulin.
- Pen needles are not included
 - Provide Rx for 29, 30, or 31 gauge needles
- Store unopened in fridge until expiration (do not freeze)
- Store opened at room temperature or fridge for up to 30 days



Amylin Analogs (more)



- Administer immediately before every major meal
 - Only take if eating ≥ 250 kcal or ≥ 30 g Carbohydrate
- Start Dose 60 mcg SC increase after 3 days of no nausea
 - Target (Max) Dose 120mcg SC
- Decrease pre-meal insulin dose 50% on day 1 of therapy
 - Monitor blood glucose and adjust insulin as needed

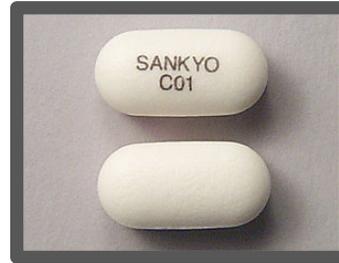
Bile Acid Sequestrants

- **Colesevelam (Welchol®)**
- Bile acid binding sequestrant for lowering LDL
 - Unknown mechanism of action for lowering blood glucose
- Decrease A1C by 0.5%
 - Additive to metformin therapy
 - May increase metformin ER concentrations
- Decrease LDL 15-20%; increase Triglycerides 10%



Bile Acid Sequestrants (cont.)

- Tablets 625mg
 - Take 6 tablets once daily
 - Or take 3 tablets twice daily



- Powder 3.75 g dose mixed with 4-8 ounces of water, fruit juice, or diet soft drink
 - Suspension – will be cloudy
 - Can dissolve in juice, water, or diet soda
 - Do not take as dry powder



Bile Acid Sequestrants (more)



- Gastrointestinal
 - Constipation, Dyspepsia, Nausea
 - Contraindicated if bowel obstruction
- Increased risk for increased levels of triglycerides,
 - Contraindicated if triglyceride levels > 500 mg/dL.
- May decrease absorption of vitamins A, D, E, and K
 - Take vitamins 4 hours before cholesevelam

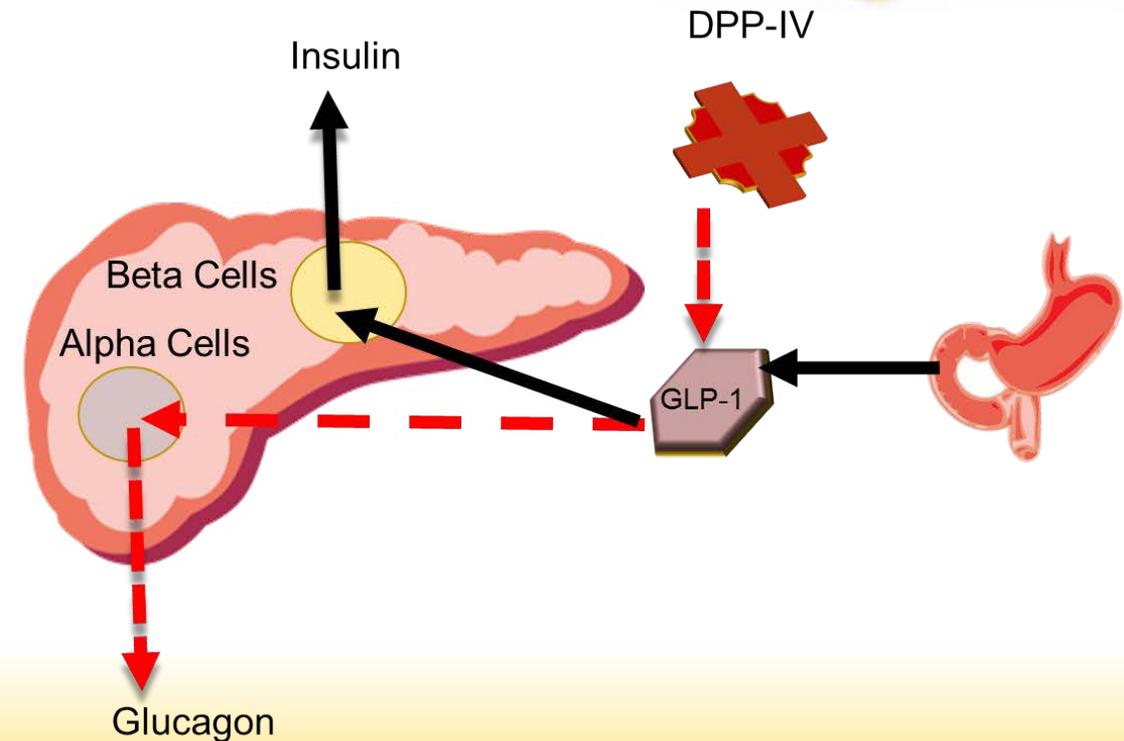
Incretin Mimetics

GLP-1 Agonists

- Exenatide (Byetta®, Bydureon®)
- Liraglutide (Victoza®)
- Albiglutide (Tanzeum®)
- Dulaglutide (Trulicity®)

DPP-4 Inhibitors

- Sitagliptin (Januvia®)
- Saxagliptin (Onglyza®)
- Alogliptin (Nesina®)
- Linagliptin (Tradjenta®)



GLP-1 Agonists

- Exenatide (Byetta®, Bydureon®)
- Liraglutide (Victoza®)
- Albiglutide (Tanzeum®)
- Dulaglutide (Trulicity®)
- *Liraglutide (Saxenda®)*



GLP-1 Agonists (1)



- Decrease A1C 0.5-1%
- Decrease weight 0.9-4 kg

Medication	Starting Dose	Maximum Dose
Exenatide	5 mcg Q12 hours 60 minutes before meals	Increase to 10 mcg after 1 month
Exenatide Weekly	2 mcg weekly	
Liraglutide	0.6 mg daily x 7 days	1.2 mg daily
Albiglutide	30 mg weekly	Increase to 50 mg weekly
Dulaglutide	0.75 mg weekly	Increase to 1.5 mg weekly

GLP-1 Agonists (2)



- HS is a middle aged man with Type 2 Diabetes diagnosed just over 6 years ago. He has been taking Albiglutide 50mg every Monday morning for about 9 months. He calls you on Thursday stating that he forgot to take his medication on Monday and wonders if it is OK to take it now or should he just wait until next Monday?

GLP-1 Agonists (3)



- Missed weekly doses: take when remembered if ≤ 3 days of the next dose



- Switching days: after at least 4 days of last dose



- Liraglutide: If dose missed for ≥ 3 days, reduce dose to 0.6mg to reduce side effects

GLP-1 Agonists (4)



- Exenatide: switching from immediate to weekly– begin extended release next day.
 - Blood sugars may be increased for first two weeks



GLP-1 Agonists (5)



- Mild to moderate nausea, Diarrhea, and Vomiting
- May reduce the extent and rate of absorption of oral drugs
- Thyroid cancer (black box warning)
 - Contraindicated with personal or family history of MTC or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)
- Pancreatitis
- Pancreatic exhaustion in humanized mice with long term use
- Renal impairment with exenatide and dulaglutide

DPP-4 Inhibitors

Sitagliptin (Januvia®)

Saxagliptin (Onglyza®)

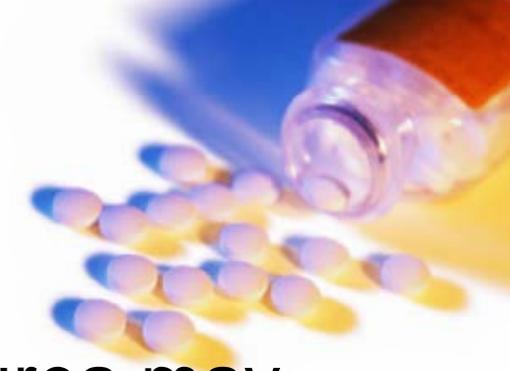
Alogliptin (Nesina®)

Linagliptin (Tradjenta®)



- Competitive inhibitor of DPP-4
- Decrease A1C 0.5-1%
- No effect on weight

DPP-4 Inhibitors (cont.)

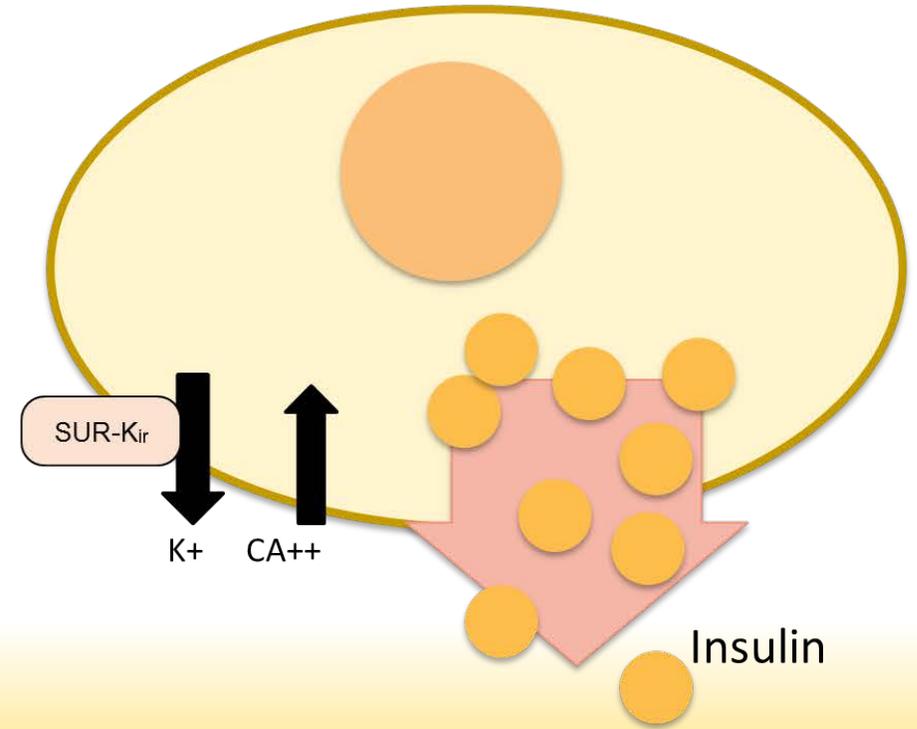
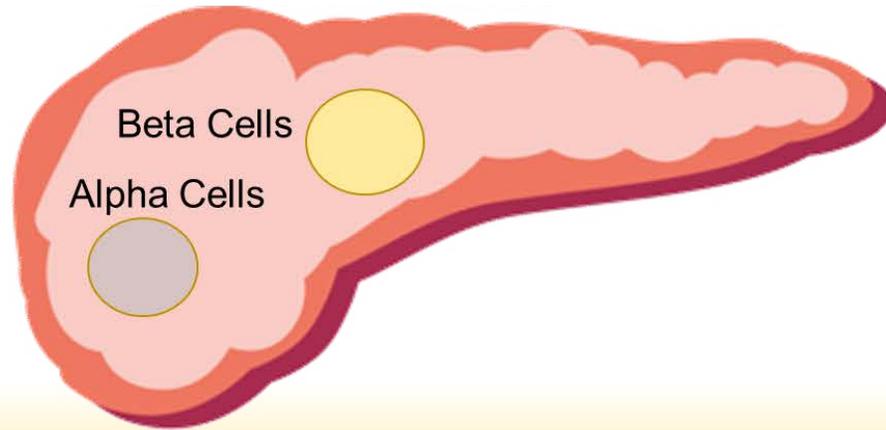


- Side effects: headache, nasopharyngitis, URI
- When used with a sulfonylurea, a lower dose of sulfonylurea may be required to reduce the risk of hypoglycemia
- Post marketing findings:
 - Pancreatitis
 - Arthralgia (occurs days to years after starting therapy)
 - Hepatic failure with Alogliptan
 - Heart failure (alogliptin, saxagliptin)
 - Encourage patients to contact provider if: unusual shortness of breath, trouble breathing when laying down, fatigue, weight gain and swelling in the ankles, feet, legs, or stomach
- *Report all side effects to the FDA through MedWatch*

Sulfonylureas/Meglitinides

Sulfonylureas

Meglitinides



Sulfonylureas/Meglitinides (1)

- Stimulates insulin release
 - Requires functional pancreas and ability to create insulin
- Decrease A1C 1-2% (sulfonylureas)
- Decrease A1C up to 1.6 – 1.8% (meglitinides)
- Weight gain



Sulfonylureas/Meglitinides (2)



Drug	Starting Dose	Max Dose	Duration	Comments
Tolbutamide	0.25-3 g divided doses	2-3 g	6-12 hours	Metabolized by liver, excreted by kidney. Least potent sulfonylurea.
Tolazamide (Tolinase®)	0.1-1 g single or divided doses	0.75-1 g (500mg BID)	10-14 hours	Slow absorption. Active metabolite. Excreted via kidney.
Chlorpropamide	0.1-0.5 g single dose	0.5 g	72 hours	Metabolized; significant proportion excreted unchanged by the kidney. Disulfiram type reaction. May cause hyponatremia (antidiuretic effect)

Sulfonylureas/Meglitinides (3)



Drug	Starting Dose	Max Dose	Duration	Comments
Glyburide (Diabeta®, Micronase®)	1.25-10mg daily (single or divided dose)	20mg daily	24 hours	Metabolized by the liver. Excreted in urine and bile.
Glyburide (Glynase®)	0.75-12mg daily	12mg daily		
Glipizide (Glucotrol® Glucotrol XL®)	2.5-20mg daily (single or divided dose)	40mg (20mg if XL)	12-16 hours	Metabolized by the liver. Excreted in the urine. Take on empty stomach.
Glimepiride (Amaryl®)	1-4mg daily	8mg daily	24 hours	2 major metabolites. Hepatic & renal elimination. Take with first main meal

Sulfonylureas/Meglitinides (4)



Drug	Starting Dose	Max Dose	Duration	Comments
Repaglinide (Prandin®)	0.5-4 mg before meals	16 mg per day	2-3 hours	Metabolized by liver
Nateglinide (Starlix®)	120 mg before meals	120 mg before meals	2-3 hours	Metabolized by liver, small amount excreted via kidney. Shortest duration.

Example



HS is taking Albiglutide 50mg weekly, metformin 2g BID and glyburide 5mg BID. After walking back from the local bar, his wife noted that he was acting funny, sweating, and had the shakes. She said that he lay down and felt better, but she is concerned about what happened.

Medication Induced Hypoglycemia



Metformin

Thiazolidinedione

GLP-1

DPP-4 Inhibitor

SGLT-2

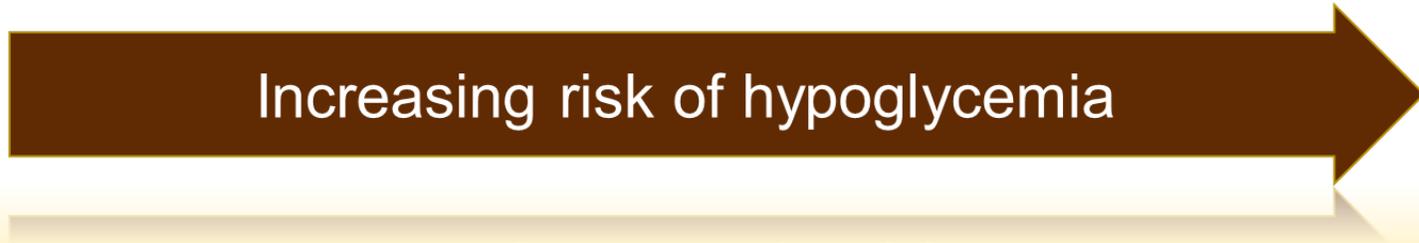
Sulfonylurea
Meglitinide

Rapid Insulin

Long Acting
Insulin

Regular Insulin

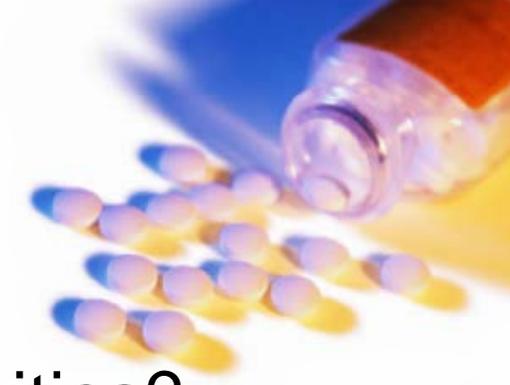
NPH Insulin



Hypoglycemia

Type	Comments	Treatment
Severe BG < 70	The patient requires assistance life threatening	Administer Glucagon injection or Glucose gel/tablets
Symptomatic BG < 70	Patient feels shaky, nervous, hungry, sweating Prodrome – lip numbness, itchy scalp	15-20 grams of glucose 15/15 rule (15 grams check BG in 15 min) ½ cup juice or soda, 1 tbsp sugar or honey, 2-3 glucose tablets, 6-7 hard candies
Asymptomatic BG < 70	No symptoms Hypoglycemic unaware Increased risk of developing severe hypoglycemia	15-20 grams of glucose 15/15 rule (15 grams check BG in 15 min) ½ cup juice or soda, 1 tbsp sugar or honey, 2-3 glucose tablets, 6-7 hard candies
Nocturnal BG < 70	Occurs at night (>70% of cases) Confusion, irritation, sweating or tiredness upon waking; nightmares during sleep	
Pseudo-hypoglycemia BG > 70	Patients have symptoms of hypoglycemia even though blood glucose readings normal	Decrease blood glucose more slowly if patient does not tolerate the change

Managing Hypoglycemia



- Individualize
- Identify the cause(s) – exercise, missed meal, other activities?
- Determine if an isolated case or a trend
- Modify medications
 - Decrease doses
 - Change medications
 - Move administration times (insulin)
- Consider raising A1C target

Biguanides

Metformin

- Decreases hepatic glucose production
 - Decreases intestinal glucose absorption
 - Increases insulin sensitivity
-
- Decrease A1C 1-2%
 - Decrease weight
 - Decrease triglycerides



Biguanides (cont.)

- Start with 500mg once a day with largest meal of the day.
- Regular Release
 - Increase to 1 tablet 2 times a day for at least 1 week.
 - Increase by 1 tablet weekly if able.
 - Maximum dose 2500mg per day (5 tablets)
- XR (Extended Release)
 - Increase to 2 tablets with largest meal for at least 1 week.
 - Increase by 1 tablet weekly if able.
 - Maximum dose 2000mg per day (4 tablets)



Biguanides (more)

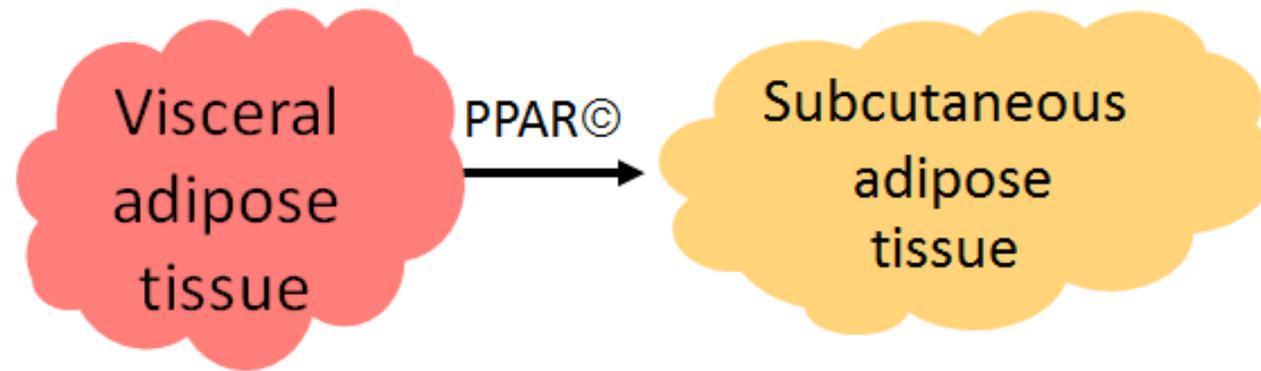


- GI Upset
- Unpleasant metallic taste
- Decrease Vitamin B12 levels in some
- Lactic acidosis:
 - **Contraindications**
 - Severe renal impairment: eGFR < 30 mL/min
 - Acute or chronic metabolic acidosis
 - **Temporarily discontinue**
 - Radiologic studies using iodinated contrast media
 - Hold for non-minor surgery – restart when eating and renal function normal
 - **Cautions**
 - Hypoxia (shock, CHF, AMI)
 - Hepatic dysfunction
 - Excessive alcohol intake
 - Severe renal impairment : eGFR 30-45 mL/min

Thiazolidinediones (1)

Pioglitazone (Actos®)

Rosiglitazone (Avandia®)

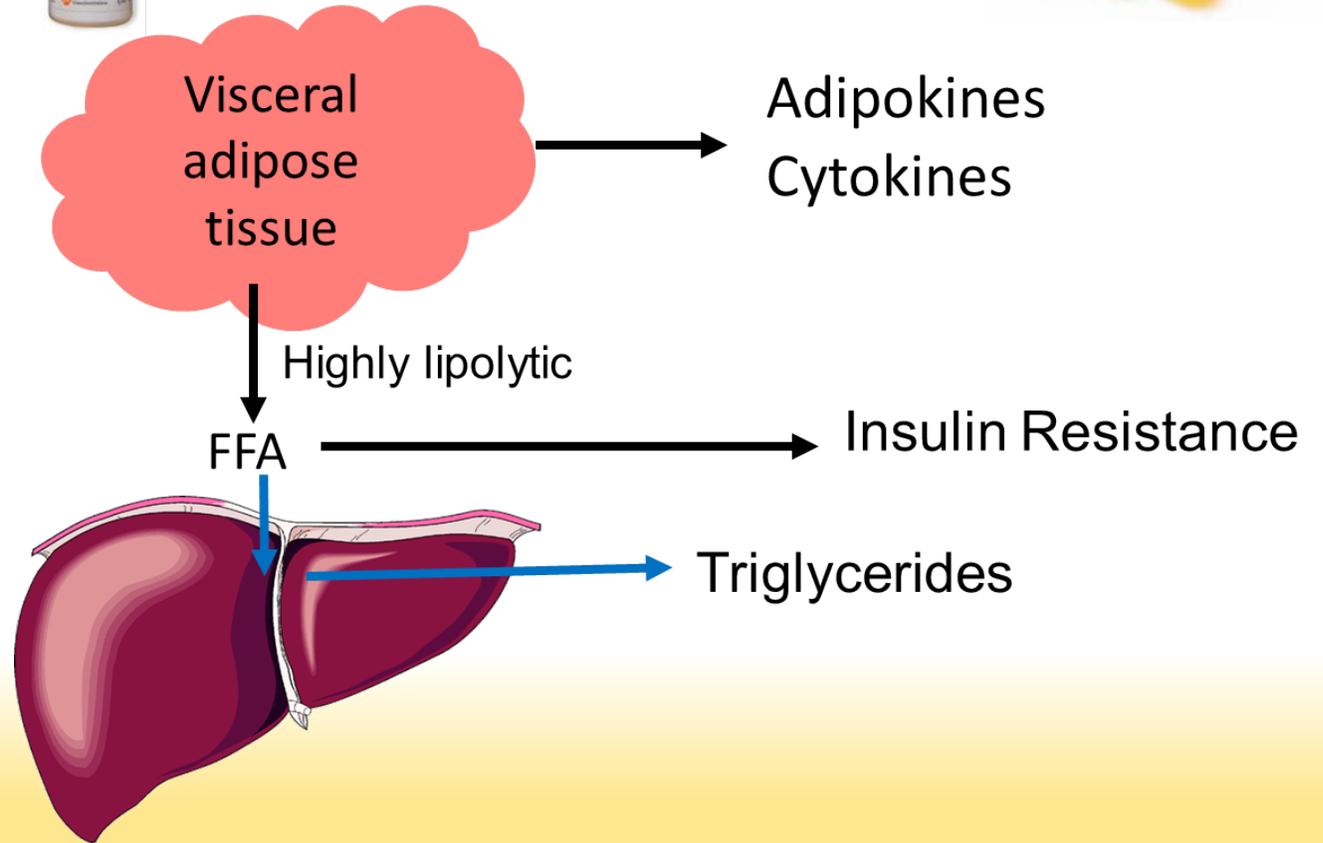


Thiazolidinediones (2)

Pioglitazone (Actos®)

Rosiglitazone (Avandia®)

- Decrease A1C 1-2%
- Decrease triglycerides
- Increase LDL
- Weight gain



Thiazolidinediones (3)



Drug	Starting Dose	Max Dose	Comments
Pioglitazone (Actos®)	15-45 mg daily	45 mg daily	Metabolized by the liver. LFTs every 2 months x first year then periodically.
Rosiglitazone (Avandia®)	2-8 mg daily	8 mg daily	Metabolized by the liver. LFTs every 2 months x first year then periodically.

4mg rosiglitazone daily = 15mg pioglitazone

8mg rosiglitazone daily = 30mg pioglitazone

4mg rosiglitazone BID = 45mg pioglitazone daily

Thiazolidinediones

- May stimulate ovulation in premenopausal anovulatory women with insulin resistance.
- May cause fluid retention which can exacerbate or lead to heart failure in predisposed patients.
 - Caution use in patients with class II-IV HF
- Concerns of bone fractures observed during post marketing



SGLT-2 Inhibitors

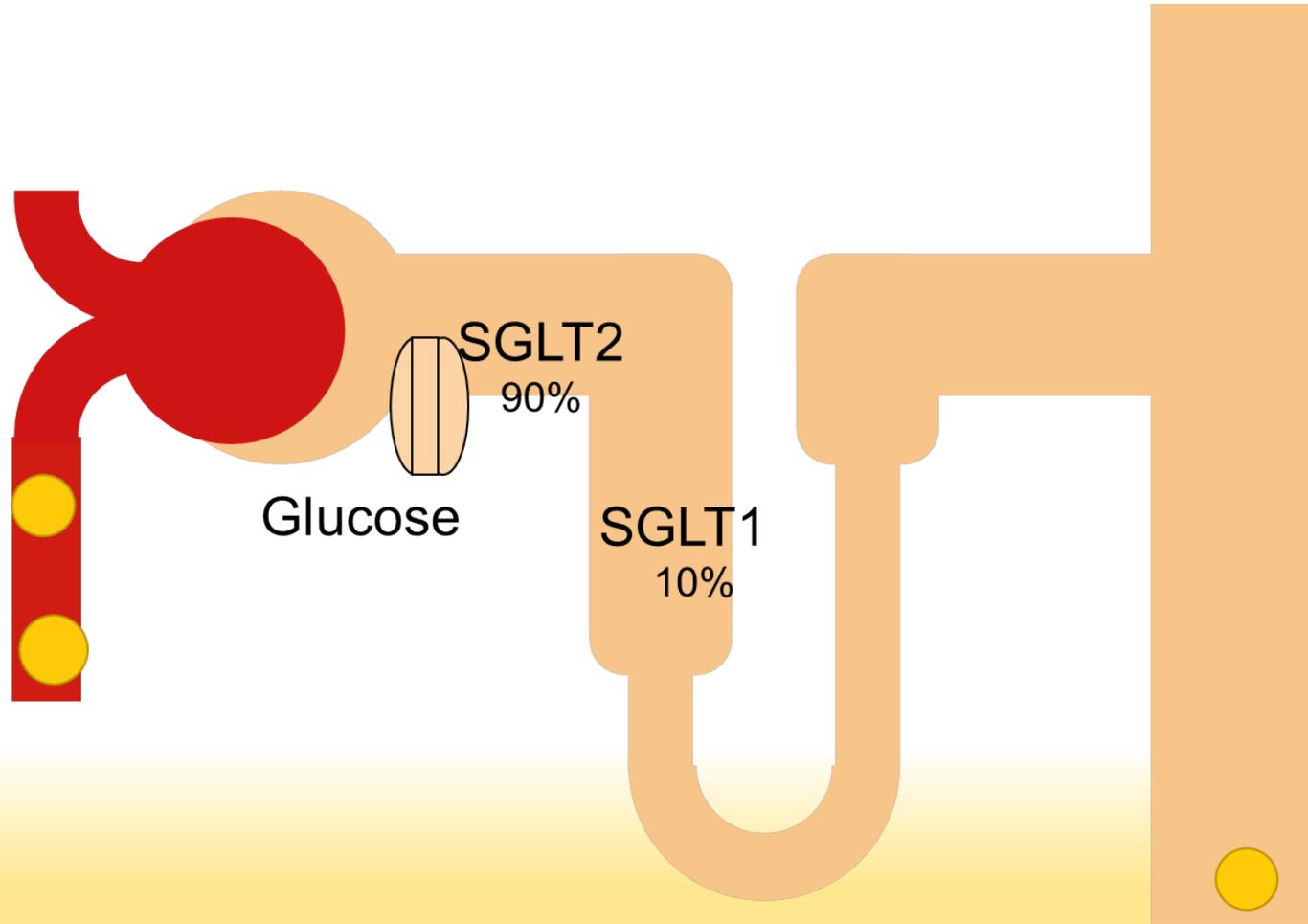
- Canagliflozin (Invokana)
- Dapagliflozin (Farxiga)
- Empagliflozin (Jardiance)



Medication	Starting Dose	Maximum Dose
Canagliflozin	100mg daily before the first meal	300mg daily
Dapagliflozin	5mg daily with or without food	10mg daily
Empagliflozin	10mg daily with or without food	25mg daily

SGLT-2 Inhibitor2 (1)

Glucose



SGLT-2 Inhibitors (2)



- Lower A1C 1%
- Weight loss 2-3 kg
- Renal impairment
- Genital mycotic infections
- Vulvovaginal pruritis
- Increased urination
- Increased thirst
- GI effects
- Volume depletion
- Increased LDL levels

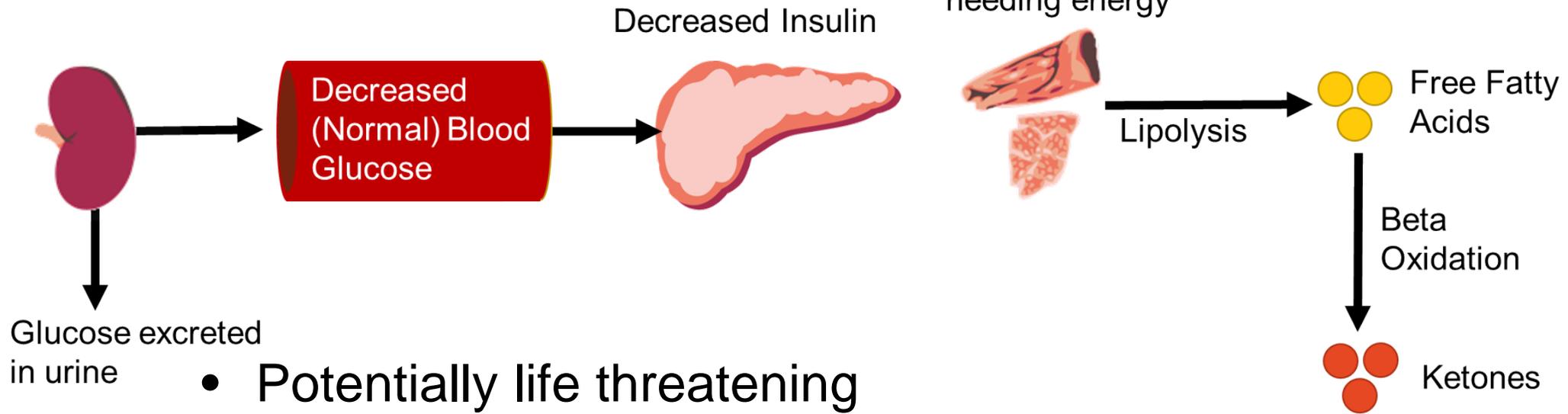
SGLT-2 Inhibitors (3)



- Post-Marketing findings:
 - Bone fractures in as early as 12 weeks with canagliflozin
 - Falls (related to hypotension) in the first few weeks with canagliflozin
 - Increased risk of bladder cancer with dapagliflozin
 - Arthralgia with empagliflozin

SGLT-2 Inhibitors (4)

- Ketoacidosis



- Potentially life threatening
- Requires immediate treatment
- Caution patients to watch for signs of DKA

SGLT-2 Inhibitors (5)



- The EMPA-REG study demonstrated a reduction in CV mortality
- Combination of SGLT-2 inhibitors and DPP-4 inhibitors may further decrease urine albumin excretion which is a risk factor for kidney disease



- Metformin, if not contraindicated and if tolerated, is the preferred initial pharmacological agent for type 2 diabetes **A**
- If noninsulin monotherapy at maximal tolerated dose does not achieve or maintain the A1C target over 3 months, add a second oral agent, a **GLP-1** receptor agonist, or insulin **A**
- Due to the progressive nature of type 2 diabetes, insulin therapy is eventually indicated for many patients with type 2 diabetes **B**

Type 2 Diabetes - Glucose Management		Type 2 Diabetes - Glucose Management
<p>DM Diagnosis (confirm with second test)</p> <ol style="list-style-type: none"> A1C \geq 6.5% FPG \geq 126 2 hour (OGTT) \geq 200 Non-fasting lab glucose \geq 200 with symptoms <p>Prediabetes is A1C 5.7 - 6.4%, FPG 100 - 125, or 2 hour OGTT 140 - 199</p>	<p>Targets for Healthier Patients</p> <p>Prenatal: < 60 - 130 1-2 hour Post Prandial: < 180 A1C: < 7%</p> <p><i>Individualize based on age, duration of diabetes, individual patient concerns, & comorbidities</i></p>	<p>Biguanides: Metformin & Metformin XR (Glucophage®)</p> <p>Start 500mg daily with meals and increase no faster than 500mg each week. If GI sx occur may increase more slowly.</p> <p>Max dose: 2000mg daily or divided with XR tablets. Do not split XR tablets.</p> <p>2500mg divided BID-TID with regular release tablets.</p> <p>Can decrease weight. Do not use if creatinine \geq 1.5 in males or \geq 1.4 in females. Do not use if liver disease (check ALT) or significant ETOH use. Discontinue before surgery or IV contrast dye administration.</p>
<p>Step 1: Lifestyle Interventions</p>	<p>Step 2: Add Metformin</p>	<p>Sulfonylureas: Gliburide (Micronase®) and Glipizide (Glucotrol®)</p> <p>Start 2.5-5mg daily - Max 10mg BID. Can increase weight and cause hypoglycemia.</p>
<p>Step 3: Add a second agent based on clinical indications and formulary options</p>	<p>Step 4: Intensify therapy: Increase dose/add additional agents</p>	<p>Thiazolidinediones (TZD): Max A1C changes may take up to 12 weeks to occur. Check ALT baseline & periodically. No underlying liver dz or significant ETOH use. Warning: heart failure and fracture risk. May use in renal insufficiency. Can cause weight gain.</p> <p>Pioglitazone (Actos®): Start 15mg daily, may increase to 30-45mg daily.</p> <p>Rosiglitazone (Avandia®): Start 4mg daily, may increase to 8mg daily.</p>
<p>Insulin</p> <p>Consider insulin as an additional agent at any time</p> <p>Basal insulin: Bedtime NPH 10 Units or Long Acting Insulin 10 Units</p> <p>Initiate Insulin as primary therapy if ANY of the following:</p> <p>FPG > 250, Glucose > 300, A1C > 10%, Active liver disease or ETOH abuse, Ketonuria, or Weight Loss. (hospitalize if acedotic)</p> <p><i>(see insulin algorithm card)</i></p>	<p>Monitoring DM</p> <p>A1C every 3-6 months</p> <p>Creatinine and eGFR yearly</p> <p>UACR yearly</p> <p>Lipid panel yearly as needed</p> <p>LFIs as needed</p> <p>Complete foot exam yearly</p> <p>Foot inspection each visit</p> <p>Retinopathy exam yearly</p> <p>Pap, Mammogram, and contraception as needed</p> <p>Evaluate sexual function</p> <p>Depression, tobacco, ETOH, and DV screening yearly</p>	<p>DPP-4 Inhibitors: Mild to mod A1C lowering.</p> <p>Sitagliptin (Januvia®): Dose: 100mg PO daily. Reduce dose if \geq Stage 3 CKD.</p> <p>Saxagliptin (Onglyza®): Dose: 2.5-5mg PO daily.</p> <p>Dose 2.5mg if strong P450 3A4 inhibitors or mod-sev renal impairment.</p> <p>Linagliptin (Trelispa®): Dose: 5mg daily.</p> <p>Alogliptin (Seroso®): Dose: 25mg daily, 12.5mg if CrCl 30-59; 6.25mg if CrCl < 30.</p>
<p>Immunizations:</p> <p>Pneumococcal: if age < 65 - PPSC23; if age \geq 65 - PCV13 then PPSC23 in 1 yr</p> <p>Flu shot yearly</p> <p>Td/Tdap (routine)</p> <p>Zoster at age 60</p> <p>Hepatitis B series</p> <p>PPD once after dx of DM (Pos is \geq 10mm)</p> <p>Providing education on diabetes, nutrition, physical activity, and medication can help patients manage their diabetes. Evaluate medication adherence. Ask about hypoglycemia and other side effects.</p>	<p>GLP-1 Mimetics: May reduce weight, mild to mod A1C lowering. May be associated with pancreatitis - seek medical care if persistent severe abdominal pain with or without vomiting.</p> <p>Exenatide (Byetta®): Start 5 mcg/dose BID SC inj in thigh, abdomen, or upper arm. May increase to 10 mcg/dose BID after 1 month of treatment. Administer within 60 minutes before meals. Do not use if \geq Stage 4 CKD.</p> <p>Exenatide Extended (Bydureon®): Start 2mg SC weekly. Caution if CrCl 30-50mL/min. Do not use if CrCl < 30mL/min.</p> <p>Liraglutide (Victoza®): Start 0.6mg SC daily in thigh, abdomen, or upper arm. Increase to 1.2mg daily in 1 week. May increase to 1.8mg daily.</p> <p>Albiglutide (Tanzeum®): Start 30mg SC weekly, may increase to 50mg weekly.</p> <p>Dulaglutide (Trulicity®): Start 0.75mg SC weekly, may increase to 1.5mg weekly.</p>	<p>SGLT-2 Inhibitors: May reduce weight, mild to mod A1C lowering. May cause volume depletion/orthostatic hypotension.</p> <p>Empagliflozin (Jardiance®): Start 5 mg every morning. May increase to 10mg daily. Discontinue if eGFR < 60mL/min. May cause volume depletion/hypotension.</p> <p>Canagliflozin (Invokana®): Start 100mg daily before first meal. May increase to 300mg daily. Discontinue if eGFR < 45mL/min. Do not exceed 100mg daily if eGFR 45-59mL/min.</p> <p>Empagliflozin (Jardiance®): Start 10mg daily. May increase to 25mg daily. Do not use if eGFR < 45mL/min.</p>
<p>FPG = Fasting plasma glucose PP = Post prandial glucose OGTT = Oral glucose tolerance test</p>	<p>Drug names in <i>italics</i> are not on the IHS National Core Formulary. Commonly used medications are included; this is not an exhaustive list. No endorsement of specific products is implied. Note: This is not a medical reference. This algorithm is not intended for treatment selection in children or in women who are or could become pregnant.</p>	<p>A1C%: 6 7 8 9 10 11 12</p> <p>Mean plasma glucose: 126 154 183 212 240 269 298 mg/dL</p> <p>Ref: ADA Clinical Practice Recommendations 2015. DIABETES CARE, VOLUME 38, SUPPLEMENT 1, JANUARY 2015</p>

Diabetes Treatment Algorithms



U.S. Department of Health and Human Services | www.hhs.gov

Indian Health Service
The Federal Health Program for American Indians and Alaska Natives

A - Z Index: A B C D E F G H I J K L M N O P Q R S T U V W X Y Z #

IHS Home • Medical Programs | Give Us Feedback

Division of Diabetes Treatment and Prevention
Leading the effort to treat and prevent diabetes in American Indians and Alaska Natives

Saturday, April 09, 2016 | MOBILE

HOME

SDPI

- Community-Directed Grant Resources
- SDPI Outcomes System (SOS)
- DP/HH Initiatives Grant Resources
- FY 2016 Best Practices
- Fact Sheets
- Report to Congress

TRAINING

- CME/CE Online Education
- SDPI Grant Training
- Other Trainings

IHS DIABETES AUDIT

AUDIT/SOS LOGIN

CLINICAL TOOLS

- Treatment Algorithms
- Standards of Care
- Quick Guide Cards

MATERIALS

- Printable
- Online Catalog
- Videos and Stories
- Podcasts

PEOPLE

ABOUT US

SITE MAP

clinician tools : diabetes treatment algorithms

Diabetes Treatment Algorithms

The Diabetes Treatment Algorithms were developed to provide clinicians with a quick reference to treatment algorithms based on national guidelines and the [Standards of Care and Clinical Practice Recommendations: Type 2 Diabetes](#). The algorithms are a collaborative effort between Indian health system professionals and have been reviewed by the [IHS Division of Diabetes](#). [Show details](#)

[Type 2 Diabetes – Lipid and Aspirin Therapy](#)
(Mobile version)

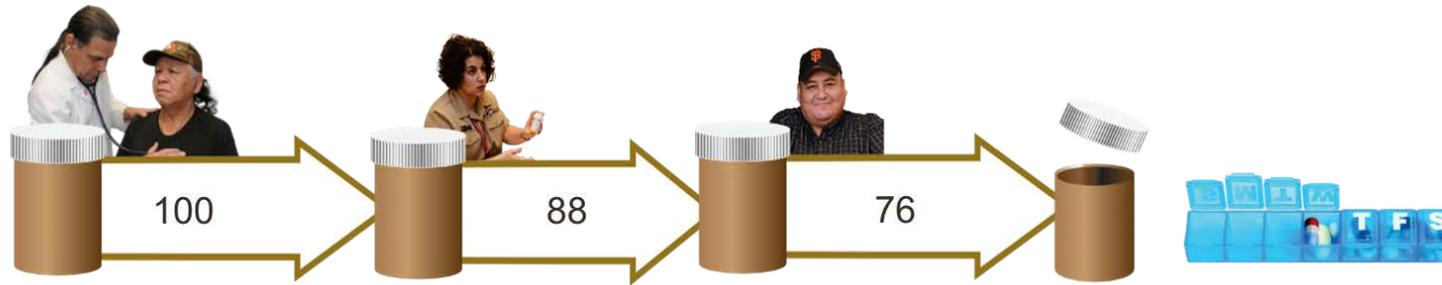
Title	Algorithm
Hypertension Management	Algorithm Version [PDF - 417KB] Text Version [PDF - 170KB]
Type 2 Diabetes and Insulin	Algorithm Version [PDF - 76KB] Text Version [PDF - 30KB]
Type 2 Diabetes and Neuropathy	Algorithm Version [PDF - 142KB] Text Version [PDF - 34KB]
Type 2 Diabetes and Chronic Kidney Disease	Algorithm Version [PDF - 229KB] Text Version [PDF - 41KB]

Drugs don't work if....

....people don't take them!



Medication Adherence



100 Prescriptions written

88 are filled at the pharmacy

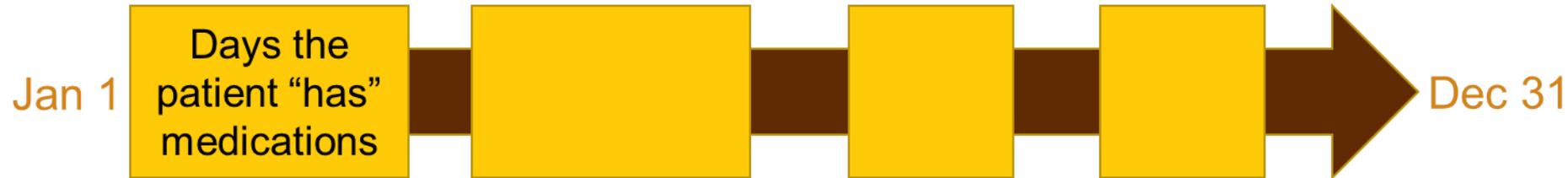
76 are taken by the patient

49 are refilled after the prescription runs out

Medication Adherence

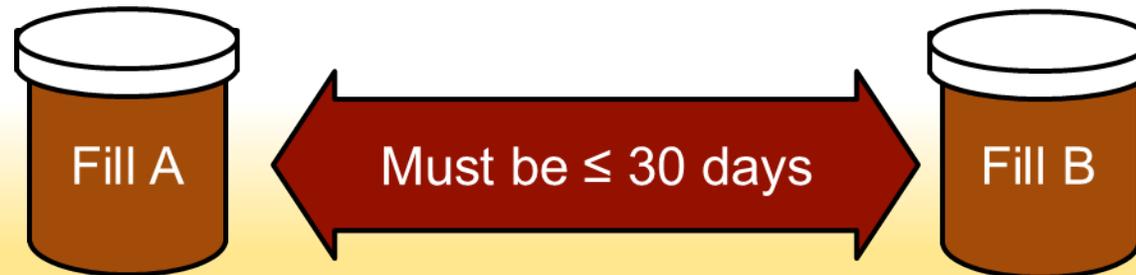


- Proportion of Days covered

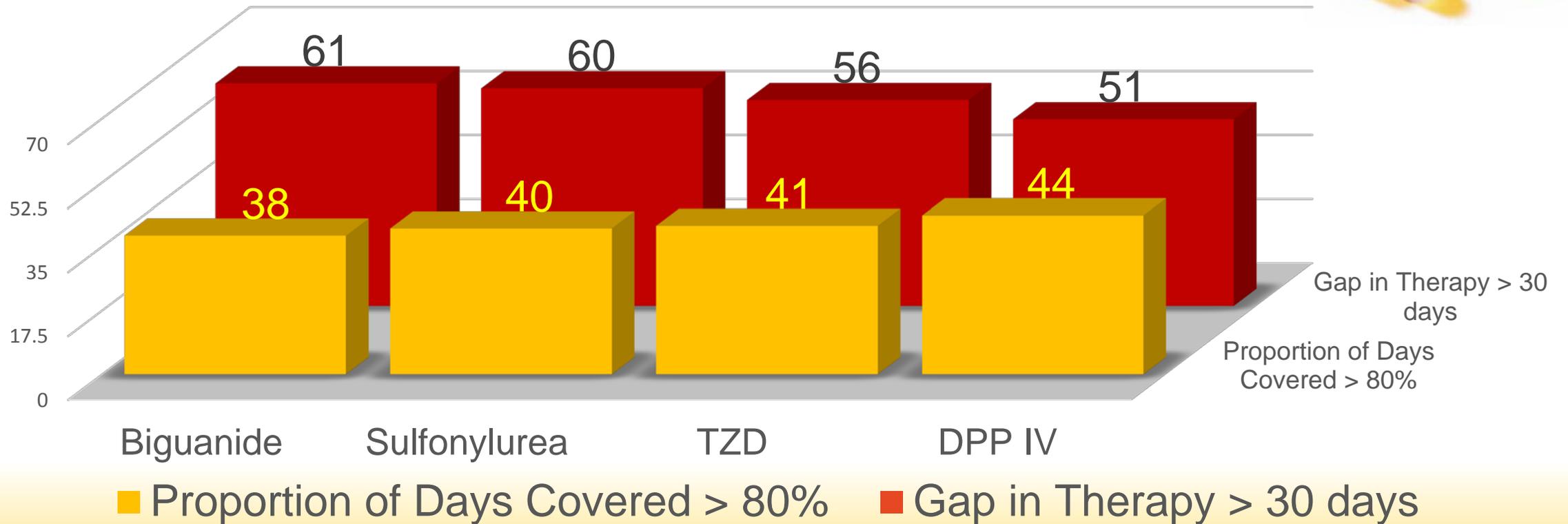


Total days must be $\geq 80\%$ (> 292 days supply)

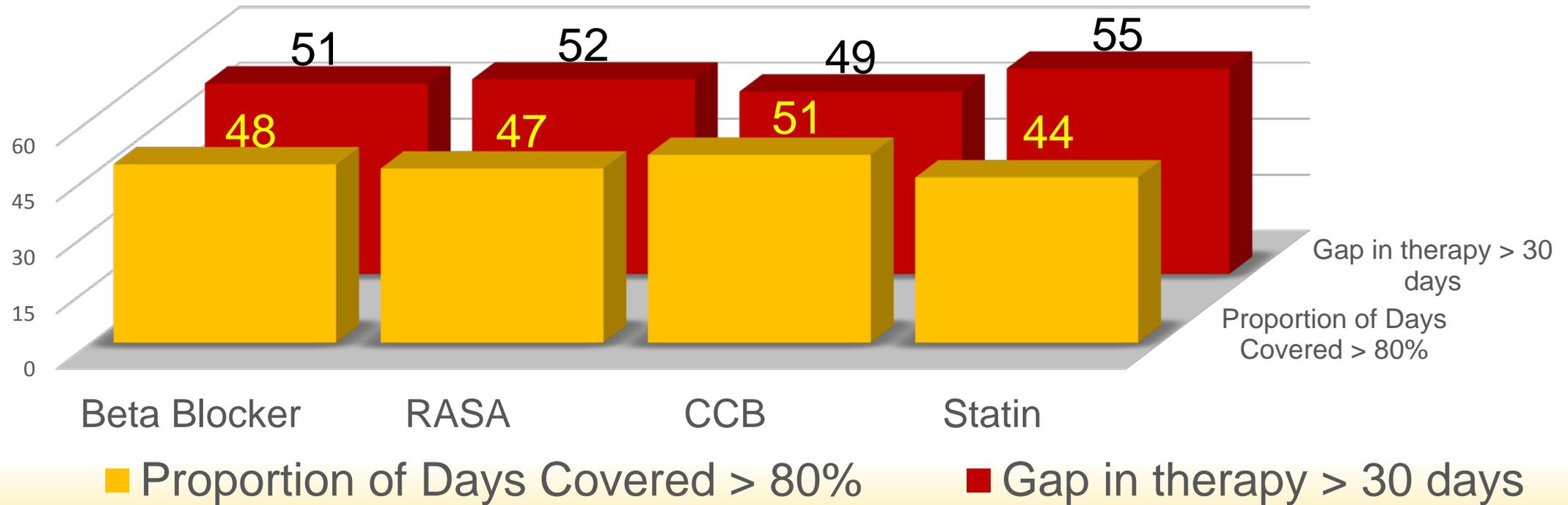
- Gaps in Therapy



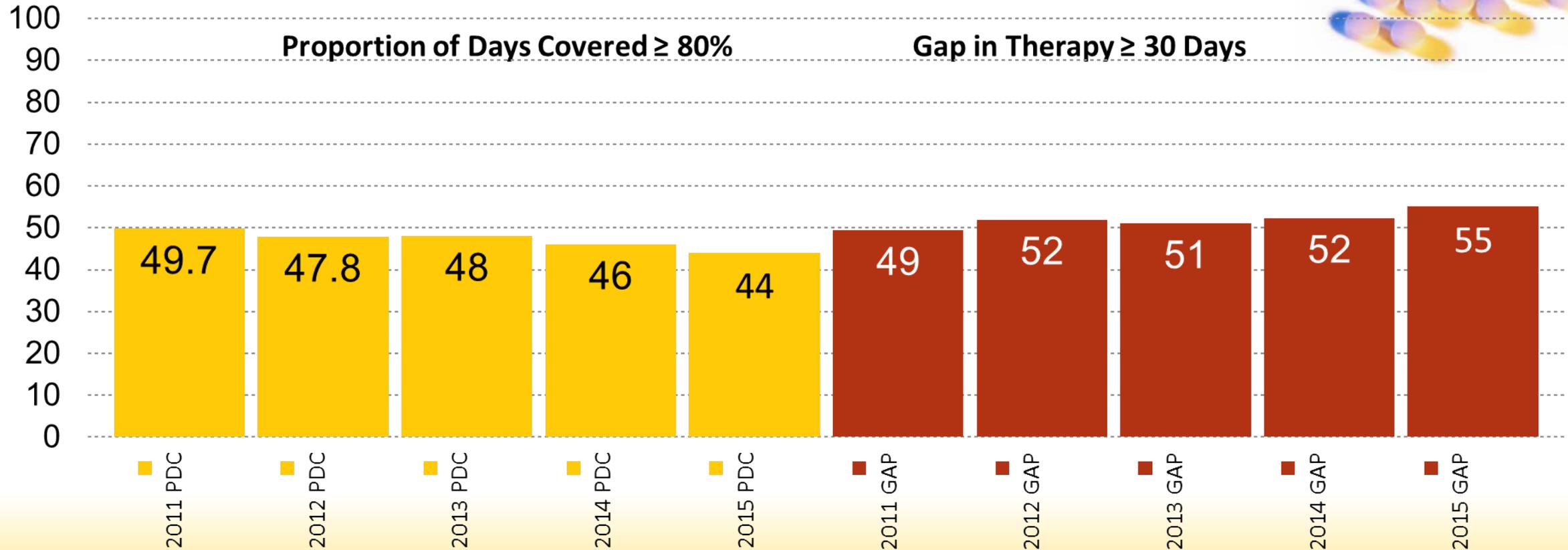
Diabetes Medications



Cardiovascular Medications



Adherence to Statin Medications 2011-2015

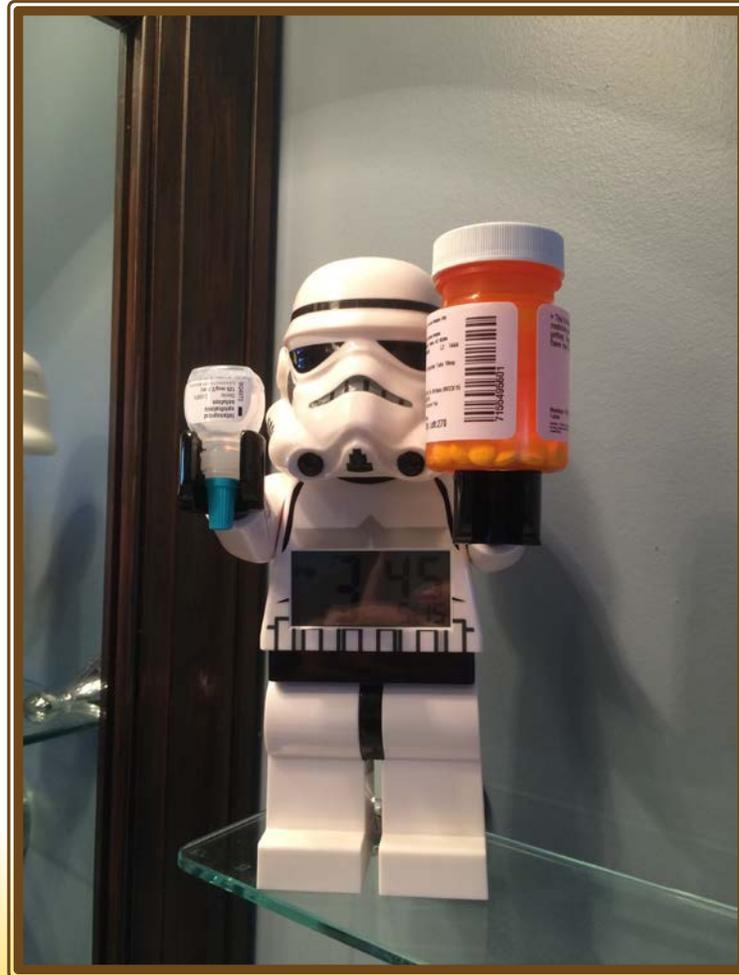


Addressing Adherence

- Simplify the regimen
- Impart knowledge
- Modify patient beliefs and human behavior
- Provide communication and trust
- Leave the bias
- Evaluate adherence



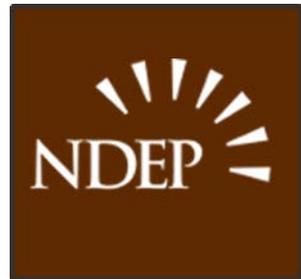
Addressing Adherence (cont.)



Medication Adherence Resources



<http://www.scriptyourfuture.org/medication-adherence/>



<http://www.niddk.nih.gov/health-information/health-communication-programs/ndep/health-care-professionals/medication-adherence/Pages/default.aspx>

Conclusion

