Multidisciplinary Proactive E-consult for Chronic Kidney Disease and Type 2 Diabetes

Nephrology Note Template

Dear *PCP Name*,

A multidisciplinary team from primary care, endocrinology, nephrology and pharmacy is working to reduce the progression of diabetic kidney disease for patients at Montefiore.

This is the first in of a series of two e-consults with recommendations on how to implement maximally tolerated dose of ACE/ARB along with SGLT2 inhibitors to improve outcomes for patients with diabetic kidney disease with proteinuria.

Patient's Name blood pressure, potassium, GFR, and urine albumin have been reviewed.

Based on these clinical factors, we recommend a blood pressure goal of ≤130/80.
*****insert text about maximizing RAASi as a priority, other hypertension medication recommendations to achieve goal, and any additional testing recommended*****

*****IF acute kidney injury present include: Acute kidney injury is noted on laboratory review. Would not recommend starting ACE/ARB at this time. However, you can consider referral to Nephrology.*****

Monitoring:
- ACE/ARB are generally well tolerated, potential adverse events include: cough, hyperkalemia, or angioedema
- Serum creatinine and potassium 2-4 weeks after starting or changing dose. Goal to increase to maximally tolerated dose.
- If hyperkalemia: consider diuretics, sodium bicarbonate or GI cation exchanges
- If >30% increase in creatinine: correct volume depletion, assess concomitant medications (e.g. diuretics, NSAIDS)
- Reduce dose or stop ACEi or ARB as last resort

If you would like to discuss these recommendations, please reply to this message in the existing telephone encounter.

Sincerely,
Nephrologist Name

Multidisciplinary Proactive E-consult for Chronic Kidney Disease and Type 2 Diabetes

Endocrinology Note Template

Dear *PCP Name,*

A multidisciplinary team from primary care, endocrinology, nephrology and pharmacy is working to reduce the progression of diabetic kidney disease for patients at Montefiore.

This is the second in of a series of two e-consults with recommendations on how to implement maximally tolerated dose of ACE/ARB along with SGLT2 inhibitors to improve outcomes for patients with diabetic kidney disease with proteinuria.

Patient's Name HbA1C, GFR, and urine albumin and medications have been reviewed.

Based on these clinical factors, we recommend:
- **Addition of an SGLT2 inhibitor to slow the progression of proteinuria**
- **Changes to other diabetes medications: ***insert text about diabetes medication recommendations*****

See table for SGLT2 coverage based on health insurance formularies. Here is your patient's primary insurance coverage: *Payor information*

- You may access a pre-populated prior authorization form specific to your patients insurer by copy/pasting this link into Internet browser: **https://montefiore.box.com/s/clnp8375ko4wlm3kusabt5yzt6m7hsmi**
- If your patient's insurance is not listed and you require assistance, please place an **Ambulatory Referral to Medication Management (PharmD)**

If you would like to discuss these recommendations, please reply to this message in the existing telephone encounter.

Sincerely,
Endocrinologist Name

More tips for initiating SGLT2 inhibitors:
- It is important to counsel on potential adverse events including: increased risk of genitourinary infections, dehydration (particularly for elderly), and risk for euglycemic ketoacidosis (avoid very low carbohydrate diets, excess alcohol intake, dehydration)
- Metabolic monitoring includes: 1) Renal function, a modest and non-progressive increase in the plasma creatinine may occur and is generally not an indication to discontinue therapy, 2) Glucose for hypoglycemia if used in conjunction with insulin and/or sulfonylureas
- Hold SGLT2 inhibitors 3 days prior (4 days prior for ertugliflozin) to any surgery which requires patient to be NPO. Resume when oral intake is at baseline