# U-500 Insulin Conversion Guidelines to U-100 Subcutaneous Insulin

| Conversion | Example |
|---|---|
| 1. Calculate outpatient U-500 total daily dose (TDD) | • 400 units/day |
| 2. Reduce TDD by 50% for inpatient safety | • Adjusted TDD = 200 units/day |
| 3. Basal insulin (~50% of adjusted TDD) | • Example: 100 units/day<br>• Uses clinical judgement for once-daily vs twice-daily dosing<br>• Consider BID dosing for glargine U-100 at ≥100 units/day |
| 4. Prandial insulin (~50% of adjusted TDD) | • Example: ~33 units before meals (TID)<br>• Further reduce for NPO status or poor oral intake |
| 5. Correctional insulin | • High-dose or high-intensity correction scales are often required<br>• Especially for patients with historical TDD≥200 units/day |
| 6. Timing basal insulin | • Administer first U-100 basal dose ~12 hours after the last U-500 dose |
| 7. Ongoing management | • Frequent reassessment and titration expected<br>• Rapid up-titration may be required for hyperglycemia<br>• Hypoglycemia remains possible despite dose reduction |