domized clinical trial (Nauck et al. 2011, 52 weeks) comparing DAPA+MET vs SU+MET. This study determined the proportion of patients achieving 7 clinically relevant composite endpoints (CEP) including: changes in HbA1c, weight, glycemic events and systolic blood pressure (SBP). Additionally, it was calculated the cost per patient that achieved CEP. RESULTS: Patients treated with DAPA+MET had a lower probability to achieve the primary CEP and secondary CEPs. In the case of CEP combining HbA1c<7%, no glycemic events and <5% weight loss: 96% DAPA+MET and 4% SU+MET achieved it and were approximately 22 times more likely to achieve this CEP vs. SU+MET. In the case of CEP combining HbA1c<7%, no glycemic events and >3% weight loss: 92% patients treated with DAPA+MET and 8% with SU+MET achieved it and the probability was 11 times higher with DAPA+MET. And in CEP combining HbA1c <6.0 ± 0.5, weight loss >3% SBP reduction >3 mmHg: 91% patients treated with DAPA+MET achieved it and 9% with SU+MET and the probability was 10 times higher. The cost per patient achieved different CEP was between €3.058 and €3.386 with DAPA+MET, whereas SU+MET showed a difference between €3.385 and €3.506. The cost of hypoglycemic noluxures were recorded episodes of hypoglycemia during the last month. The patients without hypoglycemia had the average utility for patients with corresponding type of hypoglycemia. Coincidence and disutility for patients receiving insulin therapy were obtained from the clinical utility for patients with T2DM. Disutility for different types of hypoglycemic events was an important component of cost-utility analysis. The aim of this study was to determine the disutility for T2DM patients receiving insulin therapy as if you were reading it naturally.