Pharmacy Pearls

December 2023

Updates on pharmacological treatments for obesity: All eyes on tirzepatide.

Contributors: Bailey Soper, PharmD, Samantha Heacock, PharmD, BCACP, BC-ADM
Contact: AHPPharmacist@urmc.rochester.edu

Who to treat: Consider pharmacologic treatment for patients with a BMI >30 kg/m2 OR >27 kg/m2 with at least 1 weight-related comorbidity

- Weight-related comorbidities include HTN, T2DM, HLD, obstructive sleep apnea, cardiovascular disease, metabolic syndrome, etc.

General Considerations for the Treatment of Overweight and Obesity:

- ADA Standards of Care state that larger, sustained, weight losses (>10% of total body weight) usually confer greater benefits; including disease-modifying effects, possible remission of T2DM, and may potentially improve long-term cardiovascular outcomes and mortality
- Pharmacotherapy should be viewed as adjunct to diet/lifestyle modifications as opposed to stand-alone treatment
- Glucagon-like Peptide-1 Receptor Agonists (GLP-1 RA) have become the preferred option for the treatment of overweight and obesity
  - Additional information regarding non-GLP-1 RA pharmacotherapy options for the treatment of obesity is available here

Comparison of GLP-1 RAs approved for the treatment of overweight and obesity					
Drug	Route	Frequency	Other Approved Indications	Average weight reduction (kg)*	CV benefits?
Liraglutide (Saxenda®)	SubQ	Once daily	T2DM (Victoza®)	-12.2	Yes (in T2DM)
Semaglutide (Wegovy®)	SubQ	Once weekly	T2DM (Ozempic®)	-15.0	Yes (w/ & w/o T2DM)
Tirzepatide# (Zepbound®)	SubQ	Once weekly	T2DM (Mounjaro®)	-22.0	Studies ongoing

*Based on maximum dose of GLP-1 RA, # Specific information regarding mechanism, dosing, and monitoring of tirzepatide can be found here

- Assess efficacy and safety of anti-obesity medications at least monthly for the first 3 months and at least quarterly thereafter

Tirzepatide for the Treatment of Overweight and Obesity:

	Study	Comparator	Patient Population	Duration	Change in weight (kg)	
Published Studies:	SURMOUNT-1	Placebo	BMI >30 kg/m^2 OR >27 kg/m^2 and ≥1 weight-related complication	72 weeks	Tirzepatide (10 mg or 15 mg): -23.6 Placebo: -2.4	
	SURMOUNT-2	Placebo	BMI ≥27 kg/m^2 and T2DM	72 weeks	Tirzepatide 10 mg: -12.8, Tirzepatide 15 mg: -14.7 Placebo: -3.2	
	SURMOUNT-3	Placebo	BMI >30 kg/m^2 OR >27 kg/m^2 and ≥1 weight-related complication	72 weeks	Tirzepatide (10 mg or 15 mg): -23.1 Placebo: 3.6	
Ongoing Studies:	Study	Comparator	Patient Population	Duration	Outcomes	Expected Completion
	SURMOUNT-MAINTAIN	Placebo	Overweight/obese	112 weeks	Maintenance of body weight reduction	May 2026
	SURMOUNT-MMO	Placebo	BMI ≥27 kg/m2 and ≥40 yrs old with established CVD	5 years	Time to first major adverse cardiovascular event	October 2027

Medication Access:

- Cost and formulary coverage for tirzepatide (Zepbound) is expected to be similar to other GLP-1 RAs
  - Links to manufacturer coupon programs for these agents can be found here: Zepbound®, Wegovy®, Saxenda®
- Many insurance companies require patients to complete ≥3 months of a lifestyle-based weight loss program (i.e. Weight Watchers, Noom, etc.), in addition to meeting BMI requirements, to obtain approval for these agents
  - GLP-1 RA's indicated for T2DM (Ozempic®, Trulicity®, Mounjaro®, Victoza®, Bydureon®) will NOT be approved for off-label treatment of obesity – PA requests will be automatically denied if these agents are ordered for patients without a diagnosis of T2DM
  - Medications indicated for the treatment of obesity are completely excluded from Medicare and Medicaid insurance formularies

Practice Pearls:

1. Generally, recommend titrating GLP-1 RAs every 4 weeks (Zepbound® & Wegovy®)/weekly (Saxenda®), as tolerated, up to the max dose.
   a. Highest dosages result in the most weight loss and outcomes data is based on long-term treatment with these dosages.
   b. Maintaining a dose below the maximum should only be considered if patients cannot tolerate a higher dose or if they have achieved a healthy BMI prior to reaching the maximum dose.
2. If <5% weight loss is achieved after 3 months of treatment with anti-obesity medication, consider increasing dose and continuing for another 12 weeks. If after 24 weeks, ≥5% weight loss has not been achieved, it is recommended to discontinue and consider other options.
3. Unless clinical circumstances (i.e. poor tolerability) or other considerations (i.e. financial limitations or patient preference) suggest otherwise, those who achieve sufficient weight loss (>5% of total body weight) with chronic use of an anti-obesity medication should continue pharmacotherapy treatment long-term due to risk of weight regain after discontinuation.