Weight Management FAQs

1. Can I continue prescribing weight loss medication to an existing patient after switching to the ECG weight management PGD?

Yes, patients can generally be switched from another PGD to ours, but the switch must be clearly recorded in the patient's notes, including which PGD each supply was made under, and the date the switch occurred.

Before continuing, you must also ensure the patient meets the inclusion and exclusion criteria of the ECG PGD. If they were eligible under a previous PGD but would be excluded under ours, due to a health condition or contraindication, you can only continue supplying medication until the previous PGD expires. After that, you'll need to reassess whether they can continue under ECG's criteria. **All patients receiving ongoing treatment under our PGD must meet our eligibility criteria.**

Some patients will have lost weight and may no longer meet the BMI criteria for initiating treatment, but this is not a problem as long as they met the inclusion criteria when they first started treatment, and this is documented.

2. Can patients switch providers during treatment?

Yes, you can take over a patient's treatment from another provider; however, you must conduct a **full consultation** (via video or in-person) **as if the patient were new**. This is essential for **professional accountability** and for verifying that the patient meets **all inclusion/exclusion criteria** under your PGD, which may differ from that used by the previous provider.

Key Considerations:

Starting BMI Verification

If the patient has lost weight and no longer meets the BMI threshold for initiating treatment, this is **not an issue**—as long as they can provide evidence that they met the criteria when treatment began. Acceptable evidence includes:

- A **dated photo** of their weight or BMI record
- A copy of **health records**
- Alternatively, you may contact the original provider, who should have verified the BMI at initiation

You must document:

- The **patient's starting weight and BMI**
- The **method of verification** (e.g. photo, records, or third-party confirmation)

Verifying Current Dose

To ensure continuity and safe prescribing:

- Request a **photo of the pharmacy label** from the patient's most recent box of medication (must be **dated within the last 8 weeks**)
- If unavailable, accept a **screenshot or documentation** showing the **date and dose** of their last prescription or order

Clinical Responsibility

Whether you are an **independent prescriber** or working under a **PGD**, you are responsible for making an independent clinical decision. You must not:

- Initiate or continue treatment **based solely on another provider's decision**
- Take over treatment **without a full clinical consultation**

3. Can patients switch between Mounjaro and Wegovy?

Yes, but dose escalation should be completed as though the patient were starting treatment anew.

Mounjaro is a dual GIP/GLP-1 agonist, while Wegovy is solely a GLP-1 agonist. The addition of GIP reduces GI side effects like nausea and vomiting caused by the GLP-1, making it easier for the patient to tolerate the medication at higher doses. Therefore, if a patient switches directly from the highest dose of Mounjaro to the highest dose of Wegovy, they will likely experience significant unwanted side effects. While this is less likely in patients switching from Wegovy to Mounjaro, we recommend that **all patients should complete dose escalation again, as if they were starting anew**.

Patients discontinuing either drug usually do not experience significant weight regain for a few weeks or months, so while weight loss may be slightly slower for a few weeks, this generally does not cause any significant issues with weight regain.

A **7-day interval** between the last dose of the original medication and the first dose of the alternative is recommended, as the half-life of these two drugs is similar.

Despite the change in medication, unless treatment is interrupted for more than 12 weeks, **there is no requirement to meet the original BMI threshold for initiation** specified in the PGD, as treatment would be considered continuous. However, this should be documented clearly in the patient's notes.

4. How long can patients continue weight loss treatment?

There is **no maximum duration** for treatment, and **no official lower BMI threshold** at which it must be discontinued. In fact, studies show that patients who stop treatment often experience **weight regain within a few months**, so continued use is generally recommended, even after achieving a healthy BMI.

GLP-1 medications can be used safely for **long-term weight maintenance**, provided the patient remains **clinically well** and does not show signs of **malnutrition**.

Dose Adjustment Based on BMI:

- **If BMI falls below 22.5 kg/m²**: Consider reducing the maintenance dose to the **lowest effective dose** to maintain weight and minimise side effects.
- **If BMI falls below 20 kg/m²**: Treatment should be **discontinued**, as the risk of underweight-related complications may outweigh the benefits.

In most cases, weight loss naturally **plateaus well before the patient reaches the lower end of the healthy BMI range**.

5. PGD Exclusions - Obesity *secondary* to endocrinological conditions and/or medications that cause weight gain

This PGD exclusion is based on **regulatory requirements**, rather than safety concerns. In patients with **underlying endocrinological conditions** or those taking **medications known to cause weight gain**, such as corticosteroids or atypical antipsychotics, **on-treatment weight loss may be reduced**. As a result, these patients may be **less likely to achieve the 5% weight loss efficacy threshold** required for continued use of weight loss medications*.

With the greater efficacy of Mounjaro and Wegovy compared to older medications, this is often **not a significant clinical issue**, but it may still impact the **speed and extent of weight loss**.

"*Secondary obesity*" refers specifically to cases where the **primary cause** of weight gain is the **endocrinological condition or medication**. In many cases, even when patients have conditions such as **polycystic ovarian syndrome (PCOS)** or **Cushing's syndrome**, or are on long-term **prednisolone** or **olanzapine**, these factors may **contribute** to weight gain rather than **cause** it.

To determine whether the exclusion applies, consider the following questions:

1. **Did the condition or medication *cause* the weight gain? -** If the patient was already overweight before diagnosis or starting the medication, it's likely that the condition or medication is not the primary cause, and the exclusion may not apply.
2. **Is the condition or medication still causing weight gain? -** If the patient's weight has stabilised and they are no longer gaining weight, GLP-1 treatment may still be effective.

3. **Has the patient achieved the required weight loss within the time frame*? -** If the patient loses at least 5% of their starting weight within the relevant time frame, they are considered a responder and can continue treatment, regardless of underlying conditions.

***Mounjaro and Wegovy both have a 6-month window in which patients must achieve ≥5% weight reduction. For Saxenda and Mysimba, the window is 12 weeks at the therapeutic dose (usually 16 weeks after initiating treatment, including the dose escalation period). The window for Orlistat is 12 weeks.*

6. My patient has a history of gallstones/cholecystitis/cholecystectomy – can I prescribe a GLP-1 medication for weight loss?

Under the PGD, the following apply:

- **Current gallstones (cholelithiasis)** or **cholecystitis** are exclusions. This includes patients with a known history of gallstones who have **not had them removed or treated**, even if they are currently asymptomatic.
- **Cholecystectomy (gallbladder removal)** is **not an exclusion**, provided the surgery took place **at least 3 months ago** and the patient has **no ongoing gastrointestinal symptoms**.
- Patients with a **history of cholecystitis** can be treated **if investigations confirmed no current gallstones** and the patient is now **fit and well**.

While GLP-1 medications are not contraindicated in these patients, there is a **higher risk of gallstone formation or recurrence**. Therefore, patients should be **advised to maintain good hydration**, especially during periods of rapid weight loss, to help reduce this risk.

7. My patient takes metformin. Can I initiate GLP-1 treatment?

Yes, **GLP-1 receptor agonists can be safely used alongside metformin**, provided the patient meets all other **inclusion and exclusion criteria** outlined in the PGD.

There is **no need for additional blood glucose monitoring**, as GLP-1 therapies stimulate insulin release in a **glucose-dependent manner**, making the risk of hypoglycaemia minimal—**unless** the patient is also taking insulin or sulfonylureas (e.g. gliclazide).

You should always **inform the patient's GP**, with their consent, to support continuity of care.

As both metformin and GLP-1 agonists can cause **gastrointestinal side effects**, it is advisable to ensure that any GI symptoms from metformin have **settled** before starting GLP-1 treatment, as overlapping side effects may affect tolerability and adherence.

8. Why does the PGD exclude patients over the age of 75?

This decision has been made by ECG's independent medical advisory team in line with patient safety priorities and substantial clinical evidence that the risk of severe adverse events is significantly increased in elderly and/or frail patients.

Malnutrition and dehydration are both more likely and more problematic in older adults. Serious complications arising from dehydration, such as **kidney failure, gall bladder problems, pancreatitis and cardiac problems**, are much more common in the elderly when using these medications. Even the common GI side effects seen with these medications are often much more severe in older people and can become debilitating.

Additionally, while patients lose fat rapidly, **they also often lose a significant amount of lean mass (muscle and bone density)**. This is relatively easy for a younger person to recover from, but studies show that recovery is slower and more difficult after the age of 70-75, particularly for women. Muscle wastage increases the risk of **falls**, and loss of bone density increases the risk of **serious fractures**. Recovery is often slow, and long-term disability is more likely, leading to reduced quality of life. In clinical practice, we have seen patients in their early 70s become quite frail whilst on medication, resulting in the decision to discontinue treatment.

There is a lot of variation in the general health/frailty of one 75-year-old compared with another, and we understand the frustration that a fixed threshold can cause. However, PGDs must set the threshold somewhere. As community pharmacies are unable to provide the degree of patient monitoring needed to ensure safety in this patient group, our PGD errs on the side of caution.

9. Why are patients with hepatic impairment excluded from the new PGD?

Patients with hepatic impairment are excluded due to the **challenges of accurately assessing and classifying liver function** in community pharmacy and private clinic settings. Even when medical records are available, it is often difficult to determine whether liver impairment is **mild, moderate, or severe** unless this has been clearly documented by a consultant.

In addition, some weight loss medications can occasionally cause **elevations in liver enzymes**. While this is usually not a concern in patients with normal liver function, it may require **additional monitoring** in those with existing hepatic impairment.

For safety reasons, patients with liver impairment should be managed under the supervision of their **GP or specialist consultant**, where appropriate monitoring and dose adjustments can be made if necessary.

10. My patient has a history of bariatric/bowel surgery. Can I supply GLP-1 treatment?

Yes, GLP-1 receptor agonist treatment can generally be considered **if the surgery took place at least 3 months ago** and the patient has **no ongoing gastrointestinal symptoms or post-surgical complications**.

However, patients with a history of bariatric/bowel surgery may be more prone to **gastrointestinal side effects**, particularly during **dose escalation**. It's important to approach dose increases with caution:

- **Do not escalate the dose** until any side effects (e.g. nausea, bloating, diarrhoea) have resolved.
- Consider maintaining the current dose longer if the patient is still experiencing **ongoing weight loss**.
- It is not always necessary to escalate to the maximum maintenance dose.

Both the **Mounjaro** and **Wegovy** *Summary of Product Characteristics (SPCs)* allow **flexible dosing**, and patients can remain on any tolerated dose **as long as they achieve at least 5% weight loss within 6 months** of starting treatment.

11. Why does the PGD exclude patients with type 1 diabetes?

Although GLP-1 receptor agonists are not formally contraindicated in patients with type 1 diabetes, they are excluded from use under this PGD for **safety reasons**.

Patients with type 1 diabetes are typically treated with **injectable insulin**, and the addition of GLP-1 therapy can increase the risk of **hypoglycaemia**. Safe initiation and ongoing use of GLP-1 receptor agonists in this group require **close blood glucose monitoring** and **adjustments to insulin doses**, which should be carried out under the supervision of a **diabetes specialist nurse or consultant**.

For this reason, treatment in patients with type 1 diabetes should remain within specialist care and is not suitable for supply under this PGD.

12. How do I know whether my patient has severe renal impairment?

Severe renal impairment is defined as an **estimated glomerular filtration rate (eGFR) of less than 30 mL/min/1.73m²**.

If your patient's most recent eGFR result is close to this threshold and is more than 3 months old, a **repeat test should be arranged before initiating treatment** to ensure it is safe to proceed.

If treatment is started, it's important to **advise the patient on maintaining adequate hydration**, especially in those with chronic kidney disease (CKD), as they are at higher risk of **acute kidney injury** and other complications related to dehydration.

13. Under a PGD, can the medication be supplied or dispensed by someone other than the healthcare professional who carried out the consultation?

No. A key principle of using a PGD is that **the same healthcare professional authorised under the PGD must carry out the entire process** — this includes:

- **Assessing** the patient's suitability for treatment,
- **Making the decision to supply** (or administer) the medicine, **and**
- **Personally supplying** the medicine.

Even if both individuals are named on the PGD, **you cannot split the responsibilities across two professionals for the same episode of care**. So, one healthcare professional cannot assess the patient and decide on treatment, then pass the supply task to another professional.

14. My patient is going on an extended holiday. Can I supply extra medication to cover this?

Patients must be monitored at least monthly, and the PGD allows a maximum 4-week supply of medication to be dispensed per patient appointment. However, you may wish to bring forward the patient's next monitoring appointment by a few days to allow them to collect the following month's medication just before their trip, to allow flexibility.

To demonstrate compliance with the PGD and dispensing guidelines, you must document this clearly in the patient's notes.