Weight Management FAQs

These FAQs are designed to clarify key information about our Patient Group Directions (PGDs).

If you are an Independent Prescriber, you have some flexibility, as you are personally responsible for your prescribing decisions.

PGDs provide a structured framework that enables the supply of Prescription Only Medicines (POMs). They are written in accordance with the product licence and must therefore be followed precisely.

For complex patients who fall outside the scope of a PGD, supply cannot be made under that PGD. In such cases, the patient should be referred to their GP or specialist.

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

Yes. Patients may be switched from another PGD to ours, but the change must be **clearly documented** in the patient's notes, including which PGD each supply was made under, and the date of the switch.

Before continuing treatment, ensure the patient meets the inclusion and exclusion criteria of the ECG PGD. If they were eligible under your previous PGD, but would now be excluded under ours (e.g. due to a contraindication or new health condition), you may continue prescribing only until the previous PGD expires. After that point, the patient must be re-assessed against ECG's criteria.

Some patients may have lost weight, and no longer meet the BMI criteria for initiating treatment. This is not a barrier to ongoing prescribing, provided they met the inclusion criteria when they first started treatment, and this is recorded in their notes.

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2. Can patients switch providers during treatment?

Yes. You may take over a patient's treatment from another provider, but you must carry out a **full consultation** (via video or in person) as if the patient were new. This ensures professional accountability and confirms that the patient meets the ECG PGD inclusion/exclusion criteria, which may differ from their previous provider's.

Key considerations:

- **Starting BMI verification:** If the patient has lost weight and no longer meets the BMI initiation threshold, they remain eligible provided they can evidence meeting the threshold at the start of treatment. Acceptable evidence includes:
    - A dated photo of their weight or BMI record
    - Health records

    - Confirmation from the original provider
      You must document their starting weight/BMI and the method of verification.

- **Verifying current dose:** To ensure safe continuity:
    - Request a photo of the pharmacy label from their most recent box (dated within 8 weeks), or
    - Accept a screenshot/record confirming their last prescription and dose.
- **Clinical responsibility:** Whether prescribing independently or under a PGD, you must make an independent clinical decision. You must not:
    - Continue treatment solely on another provider's decision
    - Take over supply of medication without a full consultation

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3. Can patients switch between Mounjaro and Wegovy?

Yes, but **you must follow the PGD for Wegovy. The patient should to restart titration from the lowest dose** of the new drug. At this time, Novo Nordisk has not conducted studies to evaluate the safety and efficacy of switching between either Mounjaro and Wegovy, therefore the impact on possibility adverse events and weight are not fully understood.

The approach of a 7 day gap and one dose down is common, but 'off licence' and therefore cannot be used if supply is made under the PGD.

The following should be discussed with patients who want to switch from Mounjaro to Wegovy:

- Mounjaro's additional GIP component reduces the gastrointestinal side effects typically caused by GLP-1 drugs, meaning that patients switching **from Mounjaro to Wegovy** are at high risk of nausea/vomiting if they begin at a high dose.
- Most patients discontinuing Mounjaro do not regain weight for several months, so re-titration rarely causes a significant stall in progress.

When switching between products, a **7-day interval** is recommended between the last dose of the original medication and the first dose of the alternative, as both drugs have similar half-lives.

Unless treatment has been interrupted for more than 12 weeks, there is no need to re-check the BMI eligibility criteria. However, this must be clearly documented.

Some providers may choose to use **dose conversion** instead**. This may be useful for those who are Independent Prescibers, and therefore responsible for their prescribing decisions**, It is 'guidance' and not based on clinical data produced by the manufacturer. For those using the dose conversion, medication is usually tolerated and may only result in a short period of increased nausea. However, if this approach is taken, the decision must be based on **individual clinical judgment** and clearly documented in the patient's notes. Dose conversion guidance is provided below.

Switching from Wegovy to Mounjaro – Recommended Starting Doses

Wegovy Dose	Starting Mounjaro Dose	Recommendation
0.25 mg	Re-titrate from 2.5 mg	Re-titrate in full
0.5 mg	5 mg	Reduce by one increment
1 mg	7.5 mg	Reduce by one increment
1.7 mg	10 mg	Reduce by one increment
2.4 mg	12.5 mg	Reduce by one increment

Switching from Mounjaro to Wegovy – Recommended Starting Doses

Mounjaro Dose	Starting Wegovy Dose	Recommendation
2.5 mg	Re-titrate from 0.25 mg	Re-titrate in full
5 mg	0.5 mg	Reduce by one increment
7.5 mg	0.5 mg	Reduce by one increment
10 mg	1 mg	Reduce by one increment
12.5 mg	1 mg	Reduce by one increment
15 mg	1.7 mg	Reduce by one increment

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4. How long can patients continue weight loss treatment?

There is no maximum duration. Discontinuation often leads to weight regain within a few months, so long-term use is generally recommended if the patient remains clinically well.

- **If BMI <22.5 kg/m^2:** Consider reducing to the lowest effective maintenance dose.
- **If BMI <20 kg/m^2:** Treatment should be stopped, as risks may outweigh benefits.

Most patients' weight loss will plateau well before reaching underweight ranges.

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5. PGD Exclusions - Patients with obesity caused by an endocrinological disorder.

This PGD exclusion is based on **regulatory requirements**. In patients with underlying endocrinological conditions, **weight loss during treatment may be reduced**. As a result, these patients may be **less likely to achieve the 5% weight loss 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**. However, it may still impact the **speed and extent of weight loss**.

This exclusion specifically refers to cases where the **primary cause** of weight gain is the **endocrinological condition**. In some cases, even when patients have conditions such as polycystic

ovarian syndrome (PCOS) or Cushing's syndrome, these factors may only contribute to weight gain rather than cause it.

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

1. **Did the condition *cause* the weight gain? -** If the patient was already overweight before diagnosis, it's likely that the condition is not the primary cause, and the exclusion may not apply.
2. **Is the condition 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. **Does the patient achieve 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 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.*

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6. My patient has a history of gallstones, cholecystitis, or cholecystectomy – can I prescribe a GLP-1?

Under the PGD, the following apply:

- **Current gallstones or cholecystitis:** Excluded.
- **Cholecystectomy:** Eligible if surgery was >3 months ago and no GI symptoms persist.
- **History of cholecystitis with no current gallstones:** Eligible.

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.

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

Yes. GLP-1 receptor agonists can be safely used with metformin, provided the patient meets other PGD criteria. No additional blood glucose monitoring is required. Note that if working under the PGD, patients on insulin or sulfonylureas are excluded because of the additional monitoring required.

Always inform the GP (with consent) to support continuity of care. Ensure GI symptoms from metformin have stabilised before starting, as overlapping side effects may reduce adherence.

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8. Why does the PGD exclude patients over 75?

This decision has been made by ECG's independent medical advisory team, in line with patient safety priorities and substantial clinical evidence, which indicates 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.

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9. Why are patients with hepatic impairment excluded?

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 a consultant has clearly documented this.

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, patients with existing hepatic impairment require **additional monitoring**.

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.

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

The PGD states under ‘exclusions’: ‘For patients who have inflammatory bowel disease or diabetic gastroparesis. GLP-1 agonists may cause an exacerbation of these conditions, and/or increase the risk of ileus’

Therefore, yes, if surgery was >3 months ago and there are no ongoing GI symptoms. However, dose escalation should be approached cautiously:

- Delay escalation until GI side effects such as nausea, bloating and diarrhoea have resolved
- Consider maintaining a lower dose if weight loss is ongoing

- Maximum dose escalation is not always necessary. Patients can remain on any tolerated dose provided they achieve ≥5% weight loss within 6 months.

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11. Why does the PGD exclude patients with type 1 diabetes and patients with type 2 diabetes taking insulin and/or sulfonylureas?

GLP-1s are not contraindicated but carry safety risks when used in conjunction with insulin and/or sulfonylureas. Due to an increased risk of hypoglycaemia, safe use requires close monitoring and dose adjustment by a specialist team. Therefore, treatment under this PGD is neither safe nor appropriate.

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12. How do I know whether a patient's renal impairment is severe?

Severe renal impairment is defined as an **estimated glomerular filtration rate (eGFR) of less than 30 mL/min/1.73m^2**. 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, **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.

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13. Can I supply extra medication for holidays or stock-up?

For safety, monthly monitoring is required when supplying medication under this PGD, with a maximum 4-week supply per consultation. Stockpiling (e.g. due to price changes) is not permitted.

To cover patient holidays, you may bring forward the patient's next appointment by a few days so they can collect their next month's supply before travel. This must be clearly documented in the notes.

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14. Under a PGD, can supply be made by someone other than the healthcare professional who carried out the consultation?

No. The same healthcare professional must:

- Assess the patient's suitability
- Make the decision to supply
- Personally supply/administer the medicine

These steps cannot be divided between different healthcare professionals for the same episode of care.