tipSC | Timely Information for Providers in South Carolina

October 2025

MEDICATION MANAGEMENT OF OBESITY

An outreach service for Medicaid providers to help identify and prevent potential gaps in evidence-based care, as well as detect fraud, abuse, overuse or inappropriate use.

https://www.schealthviz.sc.edu/tipsc-1

PICK UP QUICK TIPS ON... Treating obesity like any other chronic condition and offering evidence-informed pharmacotherapy when appropriate

Focus weight-loss conversations around patient-centered health outcomes, realistic lifestyle changes, and behavioral goal setting.

QUICK tipSC

Behavioral goal setting (e.g., 30 minutes of daily walking) is often more effective than outcome-focused goal setting (e.g., losing 2 pounds each week).

QUICK FACTS TO CONSIDER

- 82% of individuals with obesity feel they are alone in their efforts to manage their weight.
- Health risks increase with a 0.5 or higher waist-to-height ratio (a measure of excess abdominal fat that may be a better risk indicator than BMI).
- A patient with obesity is twice as likely to have a comorbid mood disorder than patients without obesity.
- Losing 1 to 2 pounds a week is considered healthier than more rapid weight loss that may increase the risk of muscle mass loss, gall bladder and biliary disease, nutritional deficiencies, and reduced metabolism.

CREATE A WEIGHT-FRIENDLY PRACTICE: PATIENTS NEED YOUR SUPPORT, NOT STIGMA

Focus weight loss conversations with patients on overall health and well-being. Help them overcome the myth that obesity is caused solely by a person's lack of willpower and failings to eat well or exercise. Together, identify how weight loss will personally benefit your individual patient (e.g., lowered risk of cardiovascular disease, reduced complications from diabetes, improved sleep apnea). Screen for and address factors contributing to obesity — such as medications associated with weight gain, poor sleep, and unhealthy alcohol use — during the initial visit and throughout ongoing care.

Identify current MEDICATIONS with increased risk of weight gain

- Talk early and often about potential weight gain related to meds – preventing and minimizing is easier than losing weight
- Encourage patients NOT to give up on important prescription meds that could be causing weight gain without reaching out to you for weight management options
- Offer patient information on prescription medications and weight gain

Patient Handout

https://www.obesityaction.org/ resources/ prescription-medications-weight-gain/

Ask about POOR SLEEP

- Discuss the importance of healthy sleep when trying to maintain or lose weight
- Screen for suspected obstructive sleep apnea (e.g., STOP-BANG) and other identified risks
- Offer patient information on sleep hygiene

Patient Handouts

Better Sleep – Better Health and Well-Being https://bit.ly/Healthy_Sleep_ Habits_Adults

Healthy Sleep Habits for Children and Teens https://bit.ly/Sleep_Habits_Kids

Screen for UNHEALTHY ALCOHOL USE

- Screen for alcohol consumption (e.g., AUDIT-C) at least annually
- Engage patients in conversations about weight gain related to unhealthy alcohol use (e.g., increased consumption of "empty calories," poor sleep)
- Offer patient information about healthy lifestyle changes

Patient Handouts

Drinking Alcohol https://bit.ly/Drinking_ Alcohol

A Healthier Liver, A Healthier You https://bit.ly/healthier_liver

Agree on timely, realistic goals that motivate your patient to succeed. Remind them even small changes from baseline can be beneficial (e.g., reduce from 7 sodas a week to 4 rather than stopping altogether).

SELECT FDA-APPROVED MEDICATIONS FOR OBESITY[1]

FDA-approved in combination with reduced calorie diet and increased physical activity for obesity (BMI ≥ 30 kg/m²) or over-

SCREEN at baseline and ongoing for depression and suicide (PHQ-9), anxiety (GAD-7), eating disorders, pregnancy, and comorbidities. Labs include: HbA1c, lipid panel, thyroid, kidney, and liver function tests.

PRE-SURGERY DISCONTINUATION recommendations vary. Consult surgeon 2 weeks prior to scheduled surgery for individualized instructions.

Class	Generic Name (Obesity Brand Name) Relative cost[2]	Dosage Form(s) Strengths	FDA Approved Age (years)	Mean % Weight Reduction from Baseline	Initial Weight Loss Dose	Dose Escalation Schedule	FDA Maximum Dose
GIP/GLP-1 RA	**Tirzepatide** (Zepbound™) $$$	Solution for SubQ injection: 2.5, 5, 7.5, 10, 12.5, 15 mg/0.5 mL single-dose pen or single-dose vial	≥ 18	15 – 21% at 72 weeks[3]	2.5 mg once weekly	After 4 weeks: 5 mg once weekly; May increase in 2.5 mg increments every 4 weeks	15 mg weekly
GLP-1 RA	**Liraglutide** (Saxenda®) $$$	Solution for SubQ injection: 18 mg/3 mL dial-a-dose pen (0.6, 1.2, 1.8, 2.4, 3 mg/dose)	≥ 12	~8% at 56 weeks on 3 mg daily	0.6 mg once daily	Increase by 0.6 mg weekly to 3 mg	3 mg daily
GLP-1 RA	**Semaglutide** (Wegovy®) $$$	Solution for SubQ injection: 0.25, 0.5, 1 mg/0.5 mL single-dose pen; 1.7, 2.4 mg/0.75 mL single-dose pen	≥ 12[8]	10 – 15% at 24 to 68 weeks on 2.4 mg weekly[3]	0.25 mg once weekly	Weeks 5 – 8: 0.5 mg; Weeks 9 – 12: 1 mg; Weeks 13 – 16: 1.7 mg; 17+ weeks: 2.4 mg	2.4 mg weekly
NON-GLP-1 RA (C-IV)	**Phentermine** (Adipex-P®)[11] $	Tablet, oral (scored): 37.5 mg Capsule, oral: 15, 30, 37.5 mg	≥ 17	3 – 8% at 28 weeks[12]	18.75 – 37.5 mg daily[13] 15 – 37.5 mg daily[13]	No dose escalation	37.5 mg daily[14]
NON-GLP-1 RA (C-IV)	**Phentermine** (Lomaira™) $	Tablet, oral: 8 mg			8 mg three times daily before meals		24 mg daily[14]
NON-GLP-1 RA (C-IV)	**Phentermine/ Topiramate** (Qsymia®) $$	ER capsule, oral: 3.75 mg/23 mg, 7.5 mg/46 mg, 11.25 mg/69 mg, 15 mg/92 mg	≥ 12	7.8 – 10.9% at 56 weeks	3.75 mg/23 mg every morning with or without food	After 14 days: 7.5 mg/46 mg; If < 3% weight loss from baseline (adults) or < 3% BMI reduction (pediatrics) after 12 weeks on 7.5 mg/46 mg: 11.25 mg/69 mg for 14 days then increase to 15 mg/92 mg	15 mg/ 92 mg daily
NON-GLP-1 RA	**Naltrexone/ Bupropion** (Contrave®) $$	ER tablet, oral: 8 mg/90 mg	≥ 18	5.4 – 8.1% at 56 weeks on 32/360 mg daily[20]	8 mg/90 mg (1 tab) in the morning	Week 2: 1 tab in the morning, and evening Week 3: 2 tabs in the morning, 1 tab in the evening Week 4+ : 2 tabs in the morning and evening	32 mg/ 360 mg total daily dose

1. Orlistat not listed due to side effects and low relative efficacy; Phentermine monotherapy approved for obesity as adjunct to exercise, behavioral modification, and caloric restriction. **2.** Relative cost from lowest ($) to higher ($$$) based on GoodRx pricing. **3.** More weight loss observed with higher doses. **4.** Improved liver enzymes, reduction in liver fat, increased rates of MASH resolution (MASH the more definitive new term for NASH), and liver fibrosis improvement. **5.** Improvement in renal biomarkers in short-term substudies. **6.** Reduction in liver fat and increased rates of NASH resolution (NASH the less definitive term replaced by MASH); mixed results on liver fibrosis improvement. **7.** Reductions in macroalbuminuria and slower eGFR decline in patients with T2DM. **8.** Pediatric patients ≥ 12 with baseline BMI ≥ 95 percentile for age and weight. **9.** Conditional FDA approval for noncirrhotic MASH with F2 – F3 fibrosis in adults. **10.** Reduced risk of sustained eGFR decline, end stage kidney disease, and CV disease in patients with T2DM and CKD. **11.** FDA-approved generics available. **12.** 4% to 19% mean body weight loss seen in chart reviews of patients taking 60 - 112 mg daily. **13.** Maximum dose (30 or 37.5 mg) may be given once daily or in divided doses depending on patient needs. **14. FDA usual dose.** **15.** It is unclear whether observed hepatic benefits are the direct result of phentermine, med-associated weight loss, or a combination of the two **16.** Maximum daily dose in severe impairment is 15 mg; avoid use in ESRD. **17.** Reduced HbA1c. **18.** Benefit shown with topiramate monotherapy. **19.** Maximum daily dose in severe impairment is 7.5/46 mg; avoid use in ESRD. **20.** More weight loss with behavioral program. **21.** Benefit shown with naltrexone monotherapy at higher dose. **22.** Moderate to severe renal impairment: 1 tablet twice daily; avoid in ESRD.

weight (BMI ≥ 27 kg/m²) adults with at least one weight-related comorbid condition (hypertension, hyperlipidemia, T2DM)

FOLLOW-UP QUICKLY (within one month) after initiating therapy and slowly titrate dose or continue on same dose based on response and tolerability.

KNOW RISKS AND BENEFITS of all weight-loss medications. Refer to package inserts for more detail and latest package labeling: http://dailymed.nlm.nih.gov/dailymed/.

Discontinuation Guidance	SELECT NON-WEIGHT LOSS BENEFITS						Comments
	T2DM	Alcohol Misuse	MACE	Hepatic	Renal	Sleep Apnea	
Discontinue at 16 weeks if < 5% weight loss from baseline (clinical consensus)	✓	¥	✓	✓[4]	✓[5]	✓ FDA	GI side effects may be prevalent during dose escalation and improve over time; hypotension may occur with GI side effects and dehydration; First GLP-1 to show reduced CV death; Mounjaro™ is the FDA-approved brand name for T2DM
Discontinue at 16 weeks if < 4% weight loss from baseline	✓	¥	✓	✓[6]	✓[7]	¥	Victoza® is the FDA-approved brand name for T2DM and MACE
Discontinue at 16 weeks if < 5% weight loss from baseline	✓	✓	✓ FDA	✓[4,9] FDA	✓[10]	¥	Most reported adverse effects; Most FDA approvals and most studied for non-weight loss benefits in patients with T2DM; Ozempic® (injection) is the FDA-approved brand name for T2DM, MACE, and CKD; Rybelsus®(tablets) is the FDA-approved brand name for T2DM and MACE
FDA labeling states to discontinue when tolerance to anorexiant effect develops	— / —	—	—	—[15]	—[16]	—	Take Adipex-P® before breakfast or 1-2 hours after; Take Lomaira™ 30 minutes before meals; Establish baseline CV health prior to initiation (e.g., EKG, BP, HR); Contraindicated in patients with CV disease or uncontrolled hypertension; Use caution in patients with increased risk of CVD, anxiety, bipolar disorder and older adults; May have trouble sleeping for first 2-3 nights after initiation or dose increase
Gradually taper to reduce seizure risk at 12 weeks on maximum dose if < 5% weight loss from baseline (adults) or < 5% BMI reduction (pediatrics)	+[17]	—[18]	—	—[15]	—[19]	—	Side effects may limit use; Contraindicated in pregnancy; See comments for phentermine; Gradually taper over at least 1 week when at max dose to avoid withdrawal and prevent seizures
Discontinue at 12 weeks on maintenance dose if < 5% of weight loss from baseline	+[17]	—[21]	—	—	—[22]	—	Side effects may limit use; Be aware of contraindications including patients with seizure disorder (dose-related risk with bupropion) and patients taking opioids (naltrexone is opioid antagonist); Avoid taking with high fat meals to reduce seizure risk; Avoid use in patients at risk of abruptly stopping alcohol (seizure risk with bupropion); False-positive urine drug screens for amphetamines possible

KEY: ✓ Clinical benefit favorable with T2DM dosing; **+** Clinical benefit potentially favorable; **FDA** FDA approved use/benefit for obesity brand name; ¥ Potential class effect; no high-quality studies identified for this indication; — ≤ 2 studies on benefits identified

BMI Body Mass Index; **BP** Blood Pressure; **CKD** Chronic Kidney Disease; **CV** Cardiovascular; **CVD** Cardiovascular Disease; **eGFR** Estimated Glomerular Filtration Rate; **EKG** Echocardiogram; **ER** Extended-Release; **ESRD** End-Stage Renal Disease; **F2 – F3 (fibrosis)** Moderate to Advanced Liver Fibrosis; **FDA** Food and Drug Administration; **GAD-7** Generalized Anxiety Disorder-7-item Screening Tool; **GI** Gastrointestinal; **GIP** Gastric Inhibitory Polypeptide; **GLP-1 RA** Glucagon-like Peptide Receptor Agonist; **HbA1c** Glycated Hemoglobin; **HR** Heart Rate; **MACE** Major Cardiovascular Events; **MASLD** Metabolic Dysfunction-Associated Steatotic Liver Disease; **MASH** Metabolic Dysfunction-Associated Steatohepatitis; **NASH** Non-Alcoholic Steatohepatitis; **PHQ-9** Patient Health Questionnaire-9; **SUBQ** Subcutaneous; **T2DM** Type 2 Diabetes Mellitus

TIPS FOR PATIENTS TAKING DUAL GIP/GLP-1 OR GLP-1 RAs

Help patients meet behavioral goals (e.g., nutritious, reduced calorie diet, increased physical activity, improved sleep) that can and should continue after med changes or discontinuation. Remind patients that meds are just a part of an overall wellness plan.

MINIMIZE MUSCLE MASS LOSS AND MUSCLE WASTING

- Lose weight gradually rather than rapid reductions (no more than 1 to 2 pounds per week)
- Aim for protein intake of at least 0.8 - 1.2 grams/day/kg of body weight
- Eat protein first during meals and snacks
- Add resistance and strength training exercises 3 times per week

Tracking tools help you follow and support patient progress and long-term lifestyle changes.

GET AHEAD OF GASTROINTESTINAL SIDE EFFECTS

- Titrate meds slowly
- Eat small, frequent meals
- Stay hydrated (at least 64 oz of water or sugar-free beverages per day)
- Increase daily fiber intake along with good hydration to reduce constipation and stabilize blood sugar
- Consider short-term use of proton pump inhibitor or H2-blocker for heartburn

MONITOR MEDICATIONS, VITAMINS, AND MINERALS THAT MAY BE IMPACTED BY DELAYED GASTRIC EMPTYING

- Adjust narrow therapeutic index medications (e.g., warfarin, levothyroxine) as needed
- Discuss risk of reduced effectiveness of oral contraceptives and consider adding a second form of birth control
- Consider offering vitamin and mineral supplementation when needed

DISCUSS RISKS OF OTHER SIDE EFFECTS

- Increased risk of gall bladder and biliary diseases – *Increased risk may be associated with higher doses, longer duration, and when prescribed for weight loss*
- Rare but serious ophthalmic risks – *Patient should receive an in-person, comprehensive, dilated ocular fundus exam at baseline and annually*
- Contraindicated in patients with a personal or family history of medullary thyroid carcinoma or in patients with Multiple Endocrine Neoplasia syndrome type 2

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