Weight Management Medications for Chronic Use Clinical Recommendations for Treatment Selection August 2025

VA Pharmacy Benefits Management Services and National Formulary Committee

The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. THE CLINICIAN SHOULD USE THIS GUIDANCE AND INTERPRET IT IN THE CLINICAL CONTEXT OF THE INDIVIDUAL PATIENT.

The respective Product Information for phentermine/topiramate (QSYMIA), orlistat (XENICAL, ALLI), naltrexone/bupropion (CONTRAVE), liraglutide (SAXENDA), semaglutide (WEGOVY), or tirzepatide (ZEPBOUND) should be consulted for detailed prescribing information.

Abbreviations: BMI = body mass index; BP = blood pressure; CFU = Criteria for Use; CIV = Schedule IV Controlled Substance; CKD = chronic kidney disease; CrCl = creatinine clearance; DC = discontinue; DM = diabetes mellitus; ESRD = end-stage renal disease; FDA = Food and Drug Administration; HR = heart rate; HTN = hypertension; MAOI = monoamine oxidase inhibitor; PA-F = Prior Authorization Facility level; REMS = Risk Evaluation and Mitigation Strategies; VANF = VA National Formulary; WMM = weight management medications

Use of Chronic Weight Management Medications

Basic Principles of Pharmacotherapy[1]

1. Pharmacotherapy with weight management medications should always be in conjunction with a comprehensive lifestyle intervention (i.e., clinically supported weight management program that targets all three aspects of weight management: behavioral, dietary, physical activity). The MOVE! Weight Management Program offers a comprehensive lifestyle intervention and operational definition of comprehensive lifestyle intervention in VA (see Appendix A).
2. Weight management medications can be initiated any time during participation in a comprehensive lifestyle intervention.
3. The optimal duration for use of a weight management medication and outcomes beyond 2 to 4 years have not been established. Weight management medications should be viewed as long-term therapy, as short-term use results in weight regain. Long-term use (> 1 year), while not always associated with additional weight loss, results in significantly less weight regain compared to lifestyle interventions alone. It is also possible that long term use can improve other comorbid conditions.[21,37]
4. When selecting a weight management medication, a number of factors must be considered including each drug's efficacy, side effects, cautions, warnings, the patient's comorbidities, and should be a shared decision between patient and provider.
5. If sufficient weight loss is not achieved within the first 3 months of a maximally tolerated dose of a pharmacotherapy or significant weight gain or regain after initial loss occurs, then the weight management medication should be discontinued (See individual prescribing information or section on Treatment Selection, Table 1 for details). A trial of a different weight management medication may be warranted provided the patient continues to adhere to comprehensive lifestyle intervention.

Pharmacotherapy's Place in Chronic Weight Management[1]

- The VA/DoD Clinical Practice Guideline for the Management of Adult Overweight and Obesity suggests that weight management medications for long-term weight loss be offered to patients with a body mass index $\geq$ 30 kg/m^2 and to those with a BMI $\geq$ 27 kg/m^2 who also have obesity associated conditions, in conjunction with comprehensive lifestyle intervention.
- Six weight management medications are FDA approved for chronic weight management. Phentermine/topiramate, naltrexone/bupropion, and orlistat are available on VA National Formulary with Prior Authorization at the Facility level with Criteria for Use; semaglutide (WEGOVY), tirzepatide (ZEPBOUND), and liraglutide (SAXENDA) are available by non-formulary request.
- Common to all Criteria for Use of the chronic weight management medications are the following:
  - Exclusion Criteria

        - Pregnancy
        - Breastfeeding
        - Each weight management medication CFU has additional exclusion criteria pertaining to the drug's safety profile
    - Inclusion Criteria
        - Documented participation in a comprehensive lifestyle intervention that targets all three aspects of weight management (diet, physical activity, behavioral changes) (see operational definition of comprehensive lifestyle intervention, Appendix A)

Treatment Selection of a Weight Management Medication for Chronic Use

Considerations for Shared Decision-Making Regarding Pharmacotherapy for Weight Management[1,2]

- Review the patient's current treatment regimen for any medications with potential for weight gain and consider whether alternate therapy may be an option (see Appendix B).
- Discuss treatment expectations (see below and Tables 2 and 3), and importance of follow-up and adjustment of treatment plan as indicated:
    - Weight management medications offer the opportunity for increased weight reduction and should be used with comprehensive lifestyle intervention to provide optimal benefit.
    - Weight loss from clinical interventions, including with pharmacotherapy, will likely plateau around 6 to 9 months (this may be longer with GLP-1s especially if more time is taken for initial titration).
    - In clinical trials, high medication discontinuation rates (e.g., some over 30%) have been noted.
    - Weight is usually regained after the medication is discontinued.
    - Longer durations of treatment do not typically lead to greater weight loss, but instead help to prevent weight regain.
- In order to continue to receive prescriptions for a weight management medication, the patient is expected to reach the respective initial weight loss goal, as well as demonstrate continued weight loss towards the patient's goal weight or maintenance of their desired goal weight (refer to Table 1 below).
    - Initial refill after 12 to 24 weeks: the patient continues to participate in a comprehensive lifestyle intervention for weight management, or has previously participated in or completed one and has since received at least one follow-up visit with a clinician who is able to provide ongoing education and support to address elements of comprehensive lifestyle intervention.
    - Refills every 6 months: there are no specific requirements for documentation of continued participation in a comprehensive lifestyle intervention in order for the patient to obtain refills every 6 months for a weight management medication. However, maintenance of 67% initial weight loss or greater than 5% loss from baseline weight or continued weight loss is a reasonable goal for continued therapy. *Note: as continued participation in comprehensive lifestyle intervention is important for weight loss maintenance, this may be necessary in order for the patient to meet goals for weight loss maintenance or continued weight loss with chronic weight management medication.*

Table 1: Medication Initial Weight Loss and Weight Maintenance Goals

Medication	Initial Weight Loss	Weight Maintenance
Phentermine/topiramate	If 3% weight loss not achieved at 12 weeks on 7.5 mg/46 mg, increase dose as per prescribing information. If 5% loss of baseline body weight not achieved at 12 weeks on 15 mg/92 mg, it is unlikely the patient will achieve a clinically meaningful reduction in weight with further treatment. Taper to discontinue.	Provide counseling on need for ongoing participation in a comprehensive lifestyle intervention in conjunction with medication use. Maintenance of 67% initial weight loss or greater than 5% loss from baseline weight or continued weight loss are reasonable goals for continued therapy.
Orlistat	3% weight loss at 12 weeks	
Naltrexone/bupropion	5% weight loss by 12 weeks; per the prescribing information, discontinue if this goal is not achieved as it is unlikely that a clinically meaningful reduction in weight will be achieved and sustained with continued treatment.	
Liraglutide	4% weight loss at week 16; per the prescribing information, discontinue if this goal is not achieved as it is unlikely that a meaningful weight loss will be achieved and sustained with continued treatment.	
Semaglutide	5% weight loss after achieving dose titration to a maintenance dose of 2.4 mg (recommended) (approximately 20 weeks) or 1.7 mg once weekly. Per the prescribing information, if a dose is not tolerated during titration, the dose increase can be delayed for 4 weeks.	
Tirzepatide	5% weight loss after achieving dose titration to a maintenance dose of 5 mg, 10 mg, or 15 mg once weekly (titration duration ranges 4-16 weeks depending on maintenance dose). Per the prescribing information, if a maintenance dose is not tolerated, a lower maintenance dose should be considered.	

Prescribing Considerations[3-8]

- General considerations for prescribing chronic weight management medications are included in Table 2 below.

Table 2: Comparison of General Prescribing Considerations

Medication	Formulary Status	REMS	Controlled Substance	Boxed Warning	Administration
Phentermine / topiramate	VANF PA-F (CFU)	Yes [teratogenic risk]	CIV	No	Once daily oral capsule [initial dose titration]
Orlistat	VANF PA-F (CFU)	No	No	No	Three times daily oral capsule
Naltrexone / bupropion	VANF PA-F (CFU)	No	No	Yes [suicidal thoughts and behaviors]	Twice daily oral tablet [initial dose titration]
Liraglutide	Nonformulary	No	No	Yes [thyroid C-cell tumors]	Once daily subcutaneous injection [initial dose titration]
Semaglutide	Nonformulary	No	No	Yes [thyroid C-cell tumors]	Once weekly subcutaneous injection [initial dose titration]
Tirzepatide	Nonformulary	No	No	Yes [thyroid C-cell tumors]	Once weekly subcutaneous injection [initial dose titration]

Comparison of Efficacy and Safety[9-15]

- As there are comparative trials of weight management medications, the choice of drug can be determined by several factors including efficacy, tolerability, previous response, patient preferences, and comorbidities. Table 3 organizes the six weight management medications for chronic therapy based on their extent of weight loss and odds ratio (OR) of patients able to achieve a 5% or greater weight loss, or discontinuation due to an adverse event in clinical trials compared to lifestyle modification. Note as no meta-analysis at time of revision contained tirzepatide with the other five medications, the tirzepatide data comes from a meta-analysis of only the tirzepatide clinical trials for overweight and obesity treatment. Thus comparison of tirzepatide's outcomes to any other medication's in Table 3 would be an indirect comparison.

Table 3: Chronic WMM Comparison of Weight Loss and Discontinuation Due to Adverse Events

Medication for Weight Loss	% Weight Loss vs Baseline	≥ 5% Weight Loss (OR)	≥ 10% Weight Loss (OR)	Discontinuation Due to Adverse Events (OR)
Orlistat [14]	-3.06%	2.73	2.43	1.71
Naltrexone/bupropion[14]	-4.11%	5.04	5.19	2.69
Liraglutide [14]	-4.67%	4.91	4.80	2.45
Phentermine/topiramate[14]	-7.98%	8.02	9.74	2.40
Semaglutide[14]	-11.4%	9.82	13.32	1.98
Tirzepatide[15]	-18.73%	19.28	18.99	3.27

Treatment Considerations and Comorbidities[3-8,10-25]

- Therefore, treatment selection should be individualized and based on efficacy, potential for adverse effects and patient tolerability, patient preferences, and comorbidities. Treatment considerations depending on comorbidities are noted in Table 4 below.

Table 4: Comorbidities and Chronic Weight Management Medication Treatment Considerations

Comorbidity	Phentermine/topiramate	Orlistat	Naltrexone/bupropion	Liraglutide, Semaglutide, or Tirzepatide
Hypertension	↓ BP in HTN[16] **Warning/Precaution** Risk of hypotension in patients on antihypertensive medications	↓ BP in HTN[16]	**Contraindication** Uncontrolled HTN **Warning/Precaution** May ↑BP/cause HTN	↓ BP in HTN reported in ADRs of semaglutide and tirzepatide[7,8]
Cardiac or Cerebrovascular Disease	**Warning/Precaution** ↑ HR, monitor (especially in cardiac or cerebrovascular disease); ↓ or DC if sustained *Not recommended or studied in recent or unstable disease*		**Warning/Precaution** ↑ HR or BP, monitor *Unknown impact on listed comorbidity as several conditions excluded from clinical trials*	**Warning/Precaution** ↑ HR, monitor per usual practice; DC if sustained *No specific precaution for listed comorbidity* Semaglutide: ↓ risk of death from CV cause, nonfatal MI, or nonfatal stroke in preexisting CV disease without diabetes[21]
Diabetes **Risk of Diabetes**	Improved glycemic parameters in DM[17,19] ↓ risk of DM[18,19]	Improved glycemic parameters in DM[20] ↓ risk of DM[20]	Improved glycemic parameters in DM[17]	Improved glycemic parameters in DM[11,24] Avoid use of a concurrent DPP-4 inhibitor due to lack of additive efficacy[30] Liraglutide: ↓ risk of DM[25,26] Semaglutide and Tirzepatide: Improved glycemic parameters in preDM[10,15,27-29]
Mental Health Conditions / Suicidality	Dose related ↑ depression, anxiety adverse events[19] **Warning/Precaution** ↑ risk for recurrent depression, other mood disorders; risk for suicidal behavior or ideation		**Boxed Warning** Suicidal behavior or ideation **Warning/Precaution** As bupropion is an antidepressant, monitor patients especially during initial months, dose changes	**Warning/Precaution** Monitor for emergence or ↑ depressive symptoms, suicidal thoughts or behavior; Prescribing Information recommend avoiding if history of suicide attempts or active suicidal ideation. However, multiple post-marketing meta-analyses support no increased risk in suicidal ideation and/or behavior[33-36]
Seizure disorder	**Warning/Precaution** Abrupt DC may cause seizures (regardless if history of seizure disorder); taper if DC		**Contraindication** **Warning/Precaution** ↑ risk for seizures	

Nephrolithiasis	**Warning/Precaution** Risk may be ↑ with ketogenic diet or concomitant carbonic anhydrase inhibitors; may ↓ risk with ↑ fluid intake	**Warning/Precaution** May ↑ urinary oxalate and risk of oxalate nephrolithiasis and oxalate nephropathy; caution in renal impairment, history hyperoxaluria or calcium oxalate stones. DC if oxalate nephropathy develops		
Glaucoma	**Contraindication** **Warning/Precaution** Acute myopia with secondary angle closure glaucoma may occur; DC if acute onset ↓ visual acuity or ocular pain		**Warning/Precaution** Pupillary dilation may lead to attack in those at risk for narrow angle glaucoma	

Additional Safety Considerations [3-7] In addition to treatment comparisons based on comorbidities as per Table 4, additional contraindications and warnings and precautions are included in Table 5 below.

Table 5: Contraindications and Warning for the Weight Management Medications for Chronic Use

Medication for Weight Loss	Contraindications	Warnings and Precautions
Phentermine/ topiramate	• Pregnancy* • Glaucoma • Hyperthyroidism • MAOI use during or within 14 days	• Fetal toxicity [Risk Evaluation and Mitigation Strategies (REMS)] • Increased heart rate • Suicidal behavior and ideation • Acute myopia and secondary angle closure glaucoma; visual field defects • Mood and sleep disorders • Cognitive impairment • Metabolic acidosis • Hypokalemia • Elevated creatinine; adjust dose per CrCl, avoid in ESRD • Nephrolithiasis • Adjust dose in moderate hepatic impairment • Hypoglycemia with use of antidiabetic medications • Hypotension with use of antihypertensive medications • Oligohidrosis and hyperthermia • Serious skin reactions • Avoid abrupt withdrawal due to potential for seizures • Contains phentermine, which is related to amphetamines that have potential for abuse
Orlistat	• Pregnancy* • Chronic malabsorption syndrome • Cholestasis	• Interference with absorption of fat-soluble vitamins, cyclosporine, warfarin, amiodarone, thyroid hormone, antiepileptic drugs, and antiretroviral drugs • Hepatotoxicity • Cholelithiasis • Oxalate nephrolithiasis and oxalate nephropathy with renal failure • Gastrointestinal events if taken with a diet high in fat
Naltrexone/ Bupropion*	• Uncontrolled hypertension • Seizure disorder • Bulimia or anorexia nervosa • Chronic opioid use or acute opioid withdrawal • Abrupt discontinuation of alcohol, benzodiazepines, barbiturates, antiepileptic drugs • MAOI use during or within 14 days	• Suicidal behavior and ideation [Boxed Warning] • Neuropsychiatric adverse events and suicide risk (in smoking cessation) • Seizures; increased risk with factors that decrease seizure threshold • Vulnerability to opioid overdose; precipitated opioid withdrawal • Increased blood pressure and heart rate • Hepatotoxicity; adjust dose in hepatic impairment, not recommended in severe hepatic impairment • Activation of mania • Angle-closure glaucoma • Hypoglycemia with use of antidiabetic medications • Adjust dose in moderate to severe renal impairment, avoid in ESRD

Liraglutide, Semaglutide, or Tirzepatide	• Pregnancy* (liraglutide only) • Personal or family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)	• Thyroid C-cell tumors (medullary carcinoma) [Boxed Warning] • Acute pancreatitis • Acute cholelithiasis or cholecystitis • Hypoglycemia; may need to adjust concomitant DM agents • Increased heart rate • Renal impairment, use with caution in existing CKD (liraglutide); acute kidney injury (semaglutide and tirzepatide) • Suicidal behavior and ideation • Diabetic retinopathy complications in patients with type 2 diabetes (semaglutide and tirzepatide)

Refer to the respective prescribing information for comprehensive list and accompanying information. *Note: use of weight loss medications are not recommended during pregnancy[2,31]

References

1. VA/DoD Clinical Practice Guideline for the Management of Adult Overweight and Obesity. Washington, DC: VA/DoD Evidence-Based Practice Work Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, 2020. Office of Quality, Safety and Value and Office of Evidence Based Practice Publication Version 3.0-2020.
2. Garvey WT, Mechanick JI, Brett EM, et al. American Association of Clinical Endocrinologists and American College of Endocrinology comprehensive clinical practice guideline for medical care of patients with obesity. Endocrin Pract 2016;22(Suppl 3):1-203.
3. QSYMIA (phentermine and topiramate extended-release) capsules, for oral use, CIV [prescribing information]. Campbell, CA: Vivus, Inc. November 2024.
4. XENICAL (orlistat) capsules for oral use [prescribing information]. Montgomery, AL: H2-Pharma. November 2022.
5. CONTRAVE (naltrexone HCl and bupropion HCl) extended-release tablets [prescribing information]. San Diego, CA: Nalpropion Pharmaceuticals, Inc. May 2024.
6. SAXENDA (liraglutide) injection, for subcutaneous use [prescribing information]. Bagsvaerd, Denmark: Novo Nordisk.May 2024.
7. WEGOVY (semaglutide) injection, for subcutaneous use [prescribing information]. Plainsboro, NJ: Novo Nordisk. November 2024.
8. ZEPBOUND (tirzepatide) injection, for subcutaneous use [prescribing information]. Indianapolis, IN: Eli Lilly and Company. December 2024.
9. Khera R, Murad MH, Chandar AK, et al. Association of pharmacological treatments for obesity with weight loss and adverse events: a systematic review and meta-analysis. JAMA 2016;315:2424-34.
10. Wilding JPH, Batterham RL, Calanna S, et al., for the STEP 1 Study Group. Once-weekly semaglutide in adults with overweight or obesity. N Engl J Med 2021;384:989-1002.
11. Davies M, Færch L, Jeppesen OK, et al., for the STEP 2 Study Group. Semaglutide 2.4 mg once a week in adults with overweight or obesity, and type 2 diabetes (STEP 2): a randomized, double-blind, double-dummy, placebo-controlled, phase 3 trial. Lancet 2021;397:971-84.
12. Wadden TA, Bailey TS, Billings LK, et al.; for the STEP 3 Investigators. Effect of subcutaneous semaglutide vs placebo as an adjunct to intensive behavioral therapy on body weight in adults with overweight or obesity: the STEP 3 randomized clinical trial. JAMA 2021;325:1403-13.
13. Rubino D, Abrahamsson N, Davies M, et al.; for the STEP 4 Investigators. Effect of continued weekly subcutaneous semaglutide vs placebo on weight loss in adults with overweight or obesity: the STEP 4 randomized clinical trial. JAMA 2021;325:1414-25.
14. Shi Q, Wang Y, Hao Q, et al. Pharmacotherapy for adults with overweight and obesity: a systematic review and network meta-analysis of randomised controlled trials. Lancet 2024;403:e21-31.
15. Liu L, Shi H, Xie M. Efficacy and safety of tirzepatide versus placebo in overweight or obese adults without diabetes: a systematic review and meta-analysis of randomized controlled trials. Int J Clin Pharm. 2024 Dec;26(6):1268-80.

16. Siebenhofer A, Jeitler K, Horvath K, et al. Long-term effects of weight-reducing drugs in people with hypertension. Cochrane Database Syst Rev 2016;3:CD007654. Epub 2016 Mar 2.
17. Garvey WT, Ryan DH, Bohannon NJV, et al. Weight-loss therapy in type 2 diabetes: effects of phentermine and topiramate extended release. Diabetes Care 2014;37:3309-16.
18. Garvey WT, Ryan DH, Henry R, et al. Prevention of type 2 diabetes in subjects with prediabetes and metabolic syndrome treated with phentermine and topiramate extended release. Diabetes Care 2014;37:912-21.
19. Gadde KM, Allison DB, Ryan DH, et al. Effects of low-dose, controlled-release, phentermine plus topiramate combination on weight and associated comorbidities in overweight and obese adults (CONQUER): a randomized, placebo-controlled, phase 3 trial. Lancet 2011;377:1341-52.
20. Aldekhail NM, Logue J, McLoone P, Morrison DS. Effect of orlistat on glycaemic control in overweight and obese patients with type 2 diabetes mellitus: a systematic review and meta-analysis of randomized controlled trials. Obes Rev 2015;16:1071-80.
21. Lincoff AM, Brown-Frandsen K, Colhoun HM, et al. Semaglutide and cardiovascular outcomes in obesity without diabetes. N Engl J Med. 2023 Dec 14;389(24):2221-2232.
22. Torgerson JS, Hauptman J, Boldrin MN, Sjöström L. Xenical in the prevention of diabetes in obese subjects (XENDOS) study: a randomized study of orlistat as an adjunct to lifestyle changes for the prevention of type 2 diabetes in obese patients. Diabetes Care 2004;27:155-61.
23. Hollander P, Gupta AK, Plodkowski R, et al., and for the COR-Diabetes Study Group. Effects of naltrexone sustainedrelease/bupropion sustained-release combination therapy on body weight and glycemic parameters in overweight and obese patients with type 2 diabetes. Diabetes Care 2013;36:4022-9.
24. Davies MJ, Bergenstal R, Bode B, et al., NN8022-1922 Study Group. Efficacy of liraglutide for weight loss among patients with type 2 diabetes: the SCALE diabetes randomized clinical trial. JAMA 2015;314:687-99.
25. le Roux CW, Astrup A, Fujioka K, et al., SCALE Obesity Prediabetes NN8022-1839 Study Group. 3 years of liraglutide versus placebo for type 2 diabetes risk reduction and weight management in individuals with prediabetes: a randomized, double-blind trial. Lancet 2017;389:1399-1409.
26. Pi-Sunyer X, Astrup A, Fujioka K, et al., SCALE Obesity and Prediabetes NN8022-1839 Study Group. A randomized, controlled trial of 3.0 mg of liraglutide in weight management. N Engl J Med 2015;373:11-22.
27. Garvey WT, Frías JP, Jastreboff, et al., for the SURMOUNT-2 Investigators. Tirzepatide once weekly for the treatment of obesity in people with type 2 diabetes (SURMOUNT-2): a double-blind, randomized, multicentre, placebo-controlled, phase 3 trial. Lancet 2023; doi.org/10.1016/S0140-6736(23)01200-X.
28. Wadden TA, Chao AM, Machineni S, et al. Tirzepatide after intensive lifestyle intervention in adults with overweight or obesity: the SURMOUNT-3 phase 3 trial. Nat Med 2023; doi.org/10.1038/s41591-023-02597-w.
29. Aronne LJ, Sattar N, Horn DB, et al. Continued treatment with tirzepatide for maintenance for weight reduction in adults with obesity. JAMA Published online December 11, 2023
30. American Diabetes Association Professional Practice Committee; 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2025. Diabetes Care 1 January 2025; 48 (Supplement_1): S181–S206.
31. ACOG Practice Bulletin, Number 230. Obesity in Pregnancy. Obstetrics & Gynecology 2021;137:e128-e144 doi: 10.1097/AOG.0000000000004395
32. U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans, 2nd edition. Washington, DC: U.S. Department of Health and Human Services; 2018.
33. Bezin J, Benard-Laribiere A, Hucteau E, et al. Suicide and suicide attempt in users of GLP-1 receptor agonists: a nationwide case-time-control study. EClinicalMedicine. 2024 Dec 31:80:103029.
34. Breit S, Hubl D. The effect of GLP-1RAs on mental health and psychotropics-induced metabolic disorders: A systematic review. Psychoneuroendocrinology. 2025 Jun:176:107415.
35. Ebrahimi P, Batlle JC, Ayati A, et al. Suicide and self-harm events with GLP-1 receptor agonists in adults with diabetes or obesity a systematic review and meta-analysis. JAMA Psychiatry. 2025 Mar 19:e250091.
36. Valentino K, Teopiz KM, Cheung W, et al. The effect of glucagon-like peptide-1 receptor agonists on measures of suicidality: A systematic review. J Psychiatr Res. 2025 Mar:183:112-126.
37. Malhorta A, Grunstein RR, Fietze I, et al. Tirzepatide for the treatment of obstructive sleep apnea and obesity. N Engl J Med 2024;391:1193-1205

Note: VA Academic Detailing Service Weight Management Documents and Resources are available at: https://vaww.portal2.va.gov/sites/ad/SitePages/WeightManagement.aspx

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Contact person: E. Furmaga, PharmD/N.Antonovich, PharmD, BCPS National PBM Clinical Pharmacy Program Manager, va Management, VA Pharmacy Benefits Management Services (12PBM)

Appendix A. Participation in a Comprehensive Lifestyle Intervention

Chronic Weight Management Medication Inclusion Criterion: Issues for Consideration

All *Inclusion Criteria* for use of the chronic weight management medications includes the following:

- Documented participation in a comprehensive lifestyle intervention that targets all three aspects of weight management (diet, physical activity, behavioral changes)

Veterans who have documentation of comprehensive lifestyle intervention participation within the past year on at least one occasion (as part of a course of intervention) are eligible for consideration of a weight management medication according to the criteria for use. The intent is to allow for use in patients who may be at the initial period of their weight management program, as well as those who have completed a weight management program within the past year.

Comprehensive Lifestyle Intervention

Participation in a comprehensive lifestyle intervention is an essential component to overall weight management. Use of weight management medications should be prescribed in conjunction with comprehensive lifestyle intervention.

- The operational definition of comprehensive lifestyle intervention for weight management can be used to determine if non-VA weight management programs meet the definition of a comprehensive lifestyle intervention.
  - Note that a comprehensive lifestyle intervention should be tailored to the individual, including adaptation of the physical activity component to address any limitations due to a chronic condition or disability.[32]
- Remote patient monitoring-home telehealth version of MOVE! (sometimes called TeleMOVE! or L2 Weight Management) is considered the equivalent of participation in a comprehensive lifestyle intervention.
- Clinically supported web-based or mobile application weight loss programs are acceptable. There must be some form of clinical contact, for example face-to-face or telephone encounters, secure messaging with a clinician or clinically supervised coach, or home telehealth interaction with a clinician.
- Weight management treatment programs that target only one or two aspects of weight management (e.g., diet and physical activity only), do not fulfill the requirements for the weight management medication criteria for use for an initial prescription.
- Lifestyle education/coaching delivered as part of routine clinical care that does not use a standardized curriculum delivered over a series of sessions is not considered a comprehensive lifestyle intervention and does not fulfill the requirements for weight management medication criteria for use for an initial prescription.
- The most common nationally supported MOVE! CLI-equivalent modalities that offer a series of 12 intervention sessions over a 12-month period using the standardized MOVE! curriculum are:
  - MOVE! Individual (In-person, phone, video, secure message)
  - MOVE! Group CLI (In-person, phone, video)
  - Remote patient monitoring home telehealth weight management (TeleMOVE! or L2)
  - MOVE! Coach **with Clinician Contact**
- The most common forms of **documentation** in the electronic health record include:
  - CPRS:
    - MOVE! CLI Note Template
    - MOVE! Maintenance Note Template
    - Note documenting participation in remote patient monitoring home telehealth weight management protocol (TeleMOVE! or L2)
    - Note documenting participation in MOVE! CLI, MOVE! Maintenance, or a non-VA program that meets the operational definition of comprehensive lifestyle intervention
  - Oracle
    - MOVE! CLI note generated by the MOVE! CLI Visit form
    - MOVE! CLI note generated by the MOVE! CLI Maintenance form
    - Note documenting participation in remote patient monitoring home telehealth weight management protocol (TeleMOVE! Or L2)
    - in MOVE! CLI, MOVE! Maintenance, or a non-VA program that meets the operational definition of comprehensive lifestyle intervention
- Ideally, patients should continue to actively participate in an ongoing comprehensive lifestyle intervention; however, it is understood that ongoing comprehensive lifestyle intervention may need to be tailored to the individual patient.

Appendix B. Medications and Potential for Weight Gain

Considerations of Medications and Effect on Weight[1]

In the overall management of patients with obesity or overweight, it is critical to consider the impact of prescribed medications on the potential for weight gain and whether alternate medications may be a more appropriate option for patients who are overweight, obese, or at risk. Providers should review the patient's current medications for any that may be contributing to increased weight and/or hindering intentional weight loss. The side effects of weight gain should be considered when prescribing a medication for a patient where weight gain may be of concern. If an alternate medication is not an option, participation in a weight management program may benefit the patient whose only option is a medication associated with weight gain. The information in the table below is provided as only one aspect of medication selection for a patient with overweight or obesity (or at risk for transition to overweight or obesity). Optimal medication management should consider the potential effect on weight, as well as other patient factors, efficacy, safety, and available long-term outcome data.

Abbreviations: ACEI = angiotensin-converting enzyme inhibitor; ARB = angiotensin receptor blocker; BPH = benign prostatic hyperplasia; DMARD = disease-modifying antirheumatic drugs; DPP-4 = Dipeptidyl-peptidase 4; GLP-1 = glucagon-like peptide-1 receptor; HTN = hypertension; IUD = intrauterine device; MAOI = monoamine oxidase inhibitor; NSAID = nonsteroidal anti-inflammatory drug; SGLT2 = sodium-glucose transport protein 2; SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic anti-depressant; TZD = thiazolidinediones *Note: the information provided in the table is not to be considered all-inclusive and is a compilation of information from the medical literature (systematic reviews, meta-analyses, subgroup analysis of clinical trials, cohort studies, reviews), some of which may have included differing comparators with variable results based on length of follow-up, baseline weight, patient comorbidities, etc.; medical and* pharmacy resources; and select product information (adverse events, post-marketing and case reports)

* Weight gain and weight loss have been reported

Appendix Table 1 Selected Medications and Potential Effect on Weight

Medication Classes	Medications with Potential for Weight Gain	Medications that may be Weight Neutral or have Potential for Weight Loss
Antipsychotics	• Clozapine • Olanzapine • Quetiapine • Risperidone • Thioridazine	• Aripiprazole • Haloperidol • Ziprasidone
Antidepressants	• Mirtazapine • MAOIs (e.g., phenelzine) • SSRIs (e.g., paroxetine, sertraline, citalopram*, escitalopram*, fluoxetine*) • TCAs (e.g., amitriptyline, clomipramine, doxepin, imipramine, nortriptyline, protriptyline*)	• Bupropion • Desvenlafaxine • Venlafaxine
Antiepileptic drugs or mood stabilizing agents	• Gabapentin • Pregabalin • Carbamazepine • Divalproex • Valproic acid • Vigabatrin • Lithium	• Lamotrigine • Topiramate • Zonisamide

Antihyperglycemic agents	• Insulin • Meglitinides (e.g., nateglinide, repaglinide) • Sulfonylureas (e.g., chlorpropamide, glimepiride, glipizide, glyburide) • TZDs (e.g., pioglitazone, rosiglitazone)	• Metformin • GLP-1 agonists (e.g., semaglutide, liraglutide, exenatide, dulaglutide, lixisenatide) • SGLT2 inhibitors (e.g., empagliflozin, canagliflozin, dapagliflozin, ertugliflozin) • Alpha-glucosidase inhibitors (e.g., acarbose, miglitol) • DPP-4 inhibitors (e.g., alogliptin, linagliptin, saxagliptin, sitagliptin) • Pramlintide
Beta-blockers	• Metoprolol • Atenolol • Propranolol	• Carvedilol • Nebivolol Note: other alternative classes of antihypertensive medications may be an option depending on the indication (e.g., angina, heart failure, HTN, migraine) consider calcium channel blockers, ACEIs, ARBs, and thiazide or loop diuretics, as indicated
Alpha-blockers	• Terazosin	• For BPH (e.g., doxazosin; alfuzosin, tamsulosin)
Glucocorticoids	• Hydrocortisone • Methylprednisolone • Prednisone	Alternatives for rheumatologic disorders: • NSAIDs • Biologics/DMARDs • Nontraditional therapies
Hormonal agents	• Progestins (e.g., medroxyprogesterone or megestrol acetate)	For contraception, consider alternative methods (e.g., copper IUD)
Antihistamines	• Cetirizine • Cyproheptadine	Depending on symptoms, consider ipratropium nasal spray, decongestants, inhalers, nonpharmacologic measures (e.g., nasal irrigation)