# Clinical Guidelines for Primary Care to Support the Use of Tirzepatide for Weight Management

Version 1.0 – December 2025

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Key contributors:

Dr Lisa Wilkins - BM, MPH, MRCP, FFPH. Consultant in Public Health Medicine

Medicines Optimisation Support from Shalini Desai MPharm (hons), MRPharmS, I.P.

Expert Opinion provided by Dr Elizabeth Uchegbu, Consultant Diabetologist and Endocrinologist, SY Diabetes Clinical Lead, MBBS, FRCP, MPH

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## Section A: Overview of NICE Guidelines 246: Overweight and obesity management

In January 2025, NICE published updated guidance for obesity and weight management (NG246)[1], which focuses on the holistic approach and the importance of focusing on health and wellbeing as opposed to just focusing on weight.

Through extensive engagement with patients with lived experience, NICE has made several recommendations around communication when discussing weight management with patients and stresses the need to adopt a respectful, non-judgemental approach. The guidance sets out five Principles of Care which should be followed when consulting with patients:

- **Respect me**
- **Support me**
- **Know about my life**
- **Help me when we talk**
- **Understand how I feel**

When considering options to support weight management discuss all support available, consider any previous or ongoing overweight and obesity management interventions and agree the type and level of intervention required. Understand the impact of excess weight on the patient and discuss their expectations of weight loss.

NICE recommends that a higher level of intervention is offered to people with weight related comorbidities.

For information on non-pharmacological options, and specialist weight management service referral criteria, see appendix 5. For all pharmacological options see section B.

**Prior to** commencing either **weight loss medications in primary care or making a referral to a specialist weight management service**, NHS South Yorkshire requires the **patient to have had a supported attempt to lose weight within the preceding 24 months,** such as completing a locally commissioned tier 2 service, digital weight management programme or alternatives detailed in appendix 5.

This requirement applies to:

- Referrals to specialist weight management services from 24 October 2025

and

- To patients receiving weight loss drugs in primary care from Cohort two of NHSE priority cohorts (see section C).[1]

[1] The need to have had prior supported attempt to lose weight has not been applied to Cohort one for the LES as the ICB has not given practices prior notice that this would be required.

## Section B: Medication options for weight loss

For patients considering weight loss medication, careful patient selection and shared decision making with the patient is needed, balancing the risks and benefits of medication options available.

Special consideration should be given to older persons and those living with frailty, with appropriate intervention offered according to clinical need and in discussion with their primary and secondary care teams already involved in their care.[2]

A practical guide to using medicines to manage overweight and obesity (NICE) and table 1 gives an overview of the different drugs available to support weight loss and the settings in which these can be prescribed. NICE has also produced specific information to facilitate discussions with patients when prescribing tirzepatide.

NHSE's Interim Commissioning Guidance[3] notes that while the efficacy for weight loss of glucagon-like peptide-1 (GLP-1) receptor agonists and the novel gastric inhibitory polypeptide/glucagon-like peptide-1 (GIP/GLP-1) receptor agonist, tirzepatide, are well documented in clinical trials, there is a **need to establish whether outcomes achieved in trials aligned with real-world patient experiences.**

Long term follow-up studies of tirzepatide have not yet been reported. NICE noted that it was uncertain how quickly the benefits associated with tirzepatide would be lost after stopping treatment. In their modelling they assumed **weight would be regained in 2 years after stopping**, in line with the evidence for semaglutide.[4]

NHS South Yorkshire will fund **GLP1/Tirzepatide for weight loss for a maximum of two years from the date of commencement** (unless the patient is on an active waiting list for bariatric surgery). The ICB will keep the duration of treatment under review as further evidence of longer-term outcomes and safety becomes available.

All patients having tirzepatide for weight loss **must concurrently attend the behavioural support 'wrap around service'** (appendix 4) or be receiving similar support through a Specialist Weight Management Service.

**Prior to** commencing either **weight loss medications in primary care or making a referral to a specialist weight management service**, NHS South Yorkshire requires the **patient to have had a supported attempt to lose weight within the preceding 24 months,** such as completing a locally commissioned tier 2 service, digital weight management programme or alternatives detailed in appendix 5.

This requirement applies to:

- Referrals to specialist weight management services from 24 October 2025

and

- To patients receiving weight loss drugs in primary care from Cohort two of NHSE priority cohorts (see section C).[2]

[2] The need to have had prior supported attempt to lose weight has not been applied to Cohort one for the LES as the ICB has not given practices prior notice that this would be required.

| Table 1: Medicines options for weight management in adults | | | | |
|---|---|---|---|---|
| | **Tirzepatide** | **Semaglutide** | **Liraglutide** | **Orlistat** |
| For more information see: | NICE TA1026[4], Dec 2024 | NICE TA875[5], March 2023 | NICE TA664[6], Dec 2020 | No NICE TA |
| For adults with: | An initial BMI of at least 35 kg/m$^2$ and at least 1 weight-related comorbidity.<br><br>**However, only those in NHSE eligible cohorts should be offered treatment in primary care as detailed in Table 2.** | At least 1 weight-related comorbidity **and an**:<br>• initial BMI of 35.0 kg/m$^2$ or more,<br>**Or**<br>• initial BMI of 30.0 kg/m$^2$ to 34.9 kg/m$^2$ who meet the criteria for referral to specialist overweight and obesity management services | An initial BMI of 35 kg/m$^2$ or more **and** non-diabetic hyperglycaemia **and** a high risk of cardiovascular disease | A BMI of 30 kg/m$^2$ or more **or** a BMI of 28 kg/m$^2$ or more and associated risk factors. |
| Setting: | Prescribed in primary care, or a specialist overweight and obesity management service | Prescribed in a specialist overweight and obesity management service | Prescribed in a specialist overweight and obesity management service | Prescribed in all settings and available in a lower dose from a pharmacy. |
| Route and frequency: | Weekly subcutaneous injection | Weekly subcutaneous injection | Daily subcutaneous injection | Oral capsule up to Three times a day |
| Pregnancy and contraception – see SPCs for further detail: | Do not use in pregnancy or in women of childbearing potential not using contraception. Switch to a non-oral contraceptive method, or add a barrier method of contraception, for 4 weeks on initiation and after each dose escalation. | Do not use in pregnancy. Women of childbearing potential are recommended to use contraception. | Do not use in pregnancy. | Caution in pregnancy. The use of an additional contraceptive method is recommended to prevent possible failure of oral contraception that could occur in case of severe diarrhoea. |
| When to stop treatment: | Consider Stopping if less than 5% of the initial weight has been lost after 6 months on the highest tolerated dose | Consider stopping if less than 5% of the initial weight has been lost after 6 months of treatment | Stop after 12 weeks on the 3.0 mg/day dose if at least 5% of the initial body weight has not been lost | Stop after 12 weeks if at least 5% of the initial body weight has not been lost |
| Evidence of effectiveness (titrating up to maximum dose)* | 20.1% of body weight lost at 72 weeks; 96.3% lost at least 5% of body weight. | 12.4% of body weight lost at 68 weeks; 86.4% lost at least 5% body weight | 8% of body weight lost at 56 weeks; 63.2% lost at least 5% of body weight | 37% - 60% lost at least 5% of body weight at 12 weeks[7] |
| **All medicines for weight loss should be used alongside a reduced calorie diet and increased physical activity** | | | | |
| *Please note that the degree of weight loss varies between different cohorts of patients. For example, patients with type two diabetes tend to lose less weight and to lose it more slowly. The NICE Tirzepatide Discussion Guide for Health Care Professions provides some helpful infographics on average weight loss in people with and without type two diabetes. | | | | |

## Section C: Tirzepatide: Prioritisation of eligible patients in primary care and commencement of treatment

NHSE and NICE have agreed a 12-year phased implementation period for tirzepatide, prioritising access to patients who have the greatest clinical risk. NHSE interim commissioning guidance[3] details the roll out of tirzepatide during the **first 3 years of the funding variation** period including the eligible patient cohorts for prescribing in a primary care setting. NICE and NHSE will review the first three years of implementation, the results of which will inform the subsequent roll out of the drug.[3] Table 2 summarises the NHSE priority cohorts for the first three years of roll out. Please check the more detailed information on the qualifying co-morbidities given in Appendix 1. Patients not currently eligible to receive tirzepatide in primary care should be offered alternatives as detailed in section B.

See appendix two for patients querying whether they can move from private prescriptions to NHS prescriptions for tirzepatide.

**Table 2 NHSE Priority cohorts for years 1 – 3[3]**

| Funding Variation Year*/Cohort | Estimated Cohort Duration | Cohort Access Groups | |
|---|---|---|---|
| | | Number of qualifying Comorbidities** | BMI* |
| **Cohort 1** (Year one) | **12 months** | **≥4** | **≥40** |
| Cohort 2 (Year two) | 9 months | ≥4 | ≥35 – 39.9 |
| Cohort 3 (Year 2/3) | 15 months | ≥3 | ≥ 40 |

* Use a lower BMI threshold (reduced by 2.5 kg/m$^2$) for people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic backgrounds or for people of mixed race if their heritage includes any of the above ethnicities.

**Qualifying co-morbidities are type 2 diabetes, Atherosclerotic CVD, Hypertension, Obstructive sleep apnoea severe enough to be eligible for CPAP, Dyslipidaemia.

**Primary care MUST NOT move beyond NHSE Priority Cohort One, until informed by the ICB that they can do so.**

### Tirzepatide prescribing in SY and RTC NHS specialist weight management services (SWMS)

Patients who meet the new SY SWMS referral criteria (appendix 5) can be referred to SWMSs, where the specialists can assess whether treatment with tirzepatide or another weight loss is appropriate.

**Please note: Not all SY SWMS are currently commissioned to prescribe GLP-1 RAs/tirzepatide.** A review of SWMS in SY is underway

If a referral is made to a **Right To Choose (RTC) provider**, please:

- Note the **same SY referral criteria** apply (some may have additional criteria).
- Check, before referring, **which drugs** the RTC provider is using.

## Section D: Primary Care Tirzepatide for Weight Loss Pathway

The product licence, and a condition of NICE's[4] approval, requires tirzepatide to be prescribed alongside a reduced-calorie diet and increased physical activity in adults.

To receive NHS funded tirzepatide for weight loss, all patients must participate in 'wraparound support' which incorporates nutritional and dietetic advice as a minimum and access to behavioural change components, as a mandatory requirement to access treatment[3].

There are thus **two** key components to the clinical pathway (box one).

**Box one: Key components to the clinical pathway**

1. **Clinical support:** including identification of eligible patients; safe prescribing; identification, monitoring and treatment of comorbidities; and management of potential medication interactions.

and

2. **Wrap around behavioural support:** to drive sustainable lifestyle change through structured interventions, including diet and physical activity.

NHSE has commissioned nationally a wraparound support offer (see appendix 4) for patients meeting the NHSE priority cohort one.

The tirzepatide for Weight Loss Local Enhanced Service reimburses **practices for providing the clinical support element** of the pathway, which is set out below.

**Overview of the clinical support pathway**

Figure 1 gives an overview of the clinical support pathway and figure two a recommended appointment schedule.

**At the initial assessment:**

- Check they have completed, in the last 24 months, a supported attempt to lose weight (for NHSE priority cohorts two onwards)
- Check for eligibility and clinical appropriateness
- Undertake shared-decision making to decide if tirzepatide is appropriate for the patient

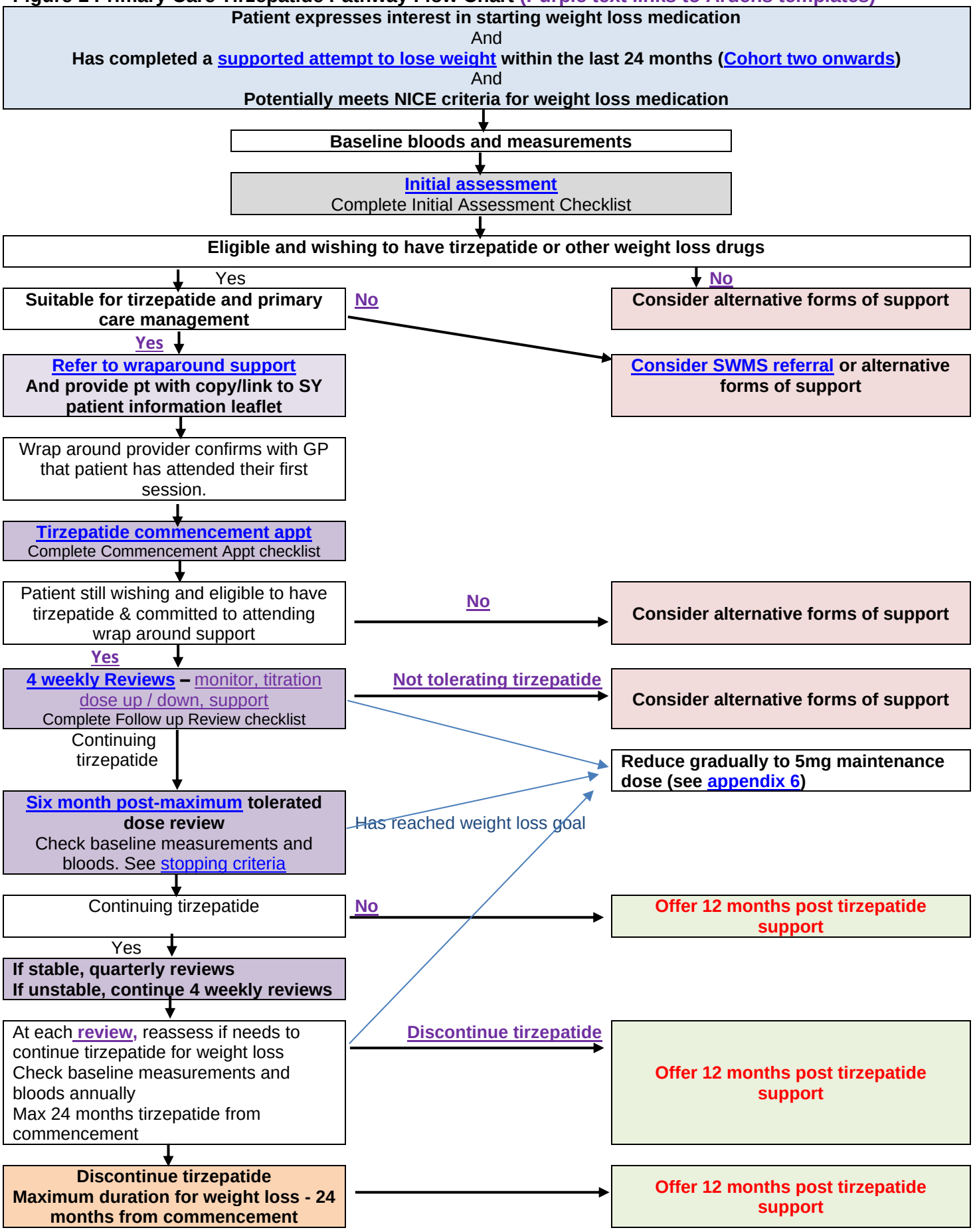
using the **Initial assessment before prescribing tirzepatide template.**

If a patient is clinically appropriate and wishes to start tirzepatide **refer them to the national wraparound** service and provide the patient with a copy of/link to the SY Patient Information leaflet.

Do NOT prescribe tirzepatide at the initial assessment.

Once the person has **attended their first session of the wrap around support programme,** go through the **commencement of tirzepatide checklist. (**The Wraparound provider will contact GP practices once the patient has attended the first session.

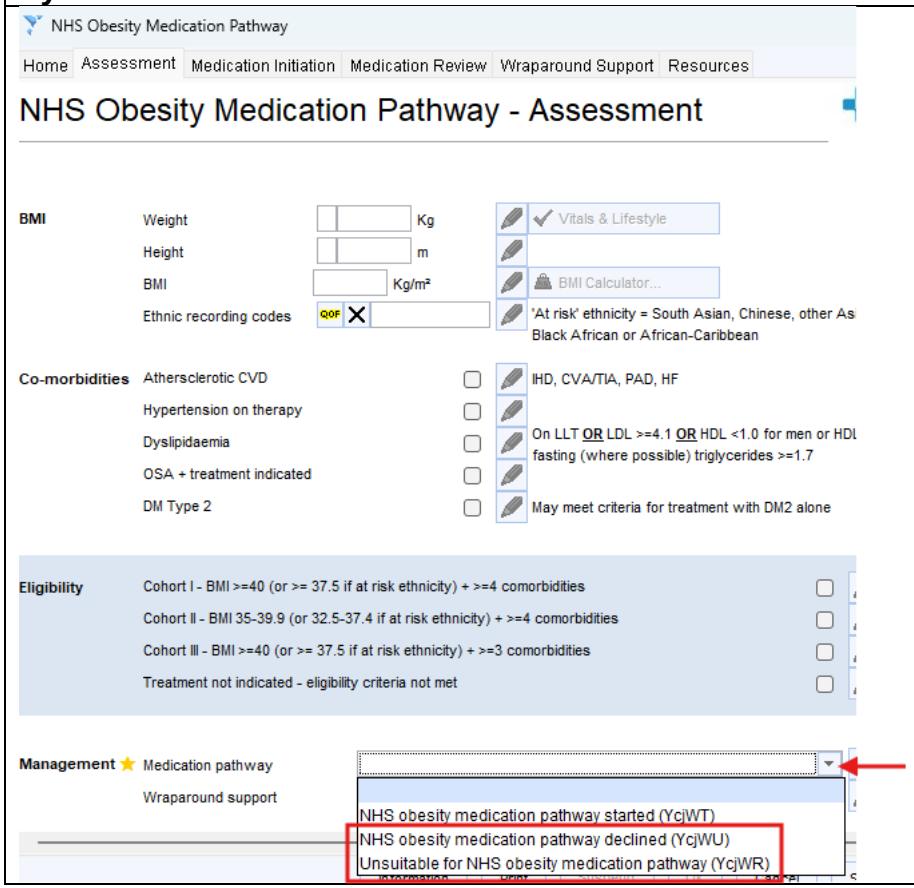
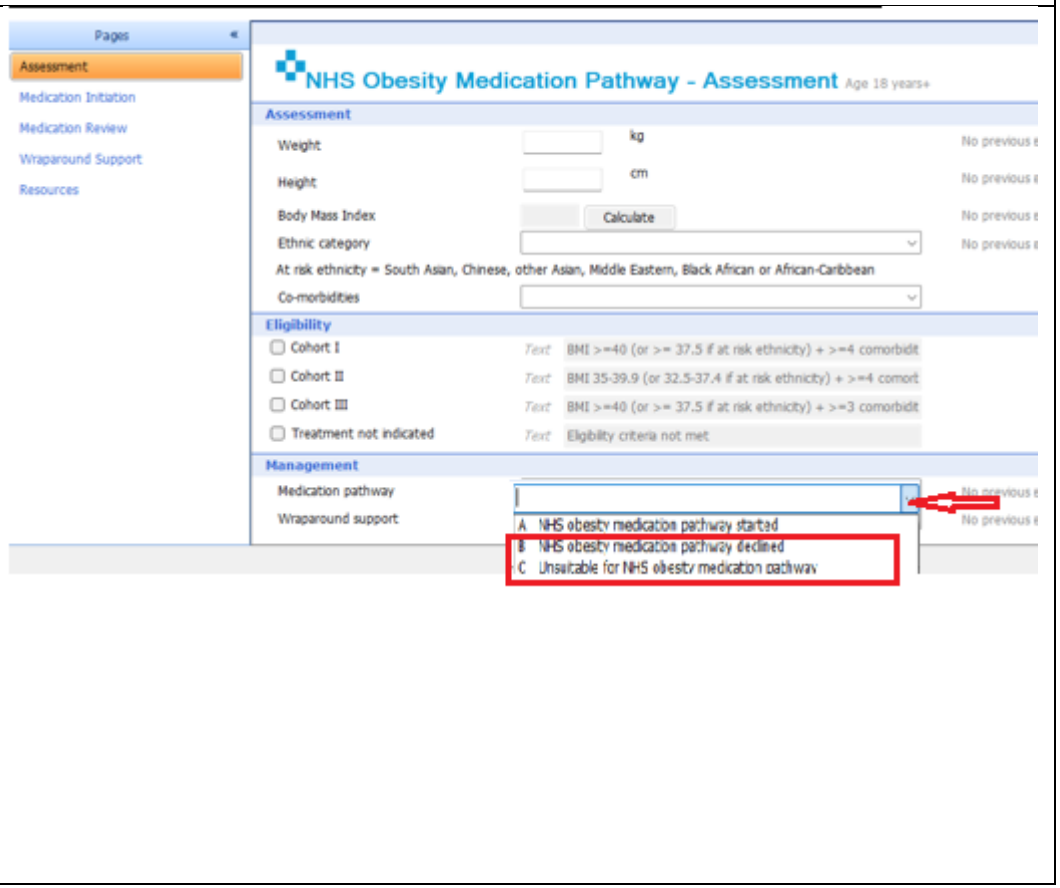
**Figure 1 Primary Care Tirzepatide Pathway Flow Chart (Purple text links to Ardens templates)**



**Codes embedded within Ardens Template**

Not eligible or declined tirzepatide

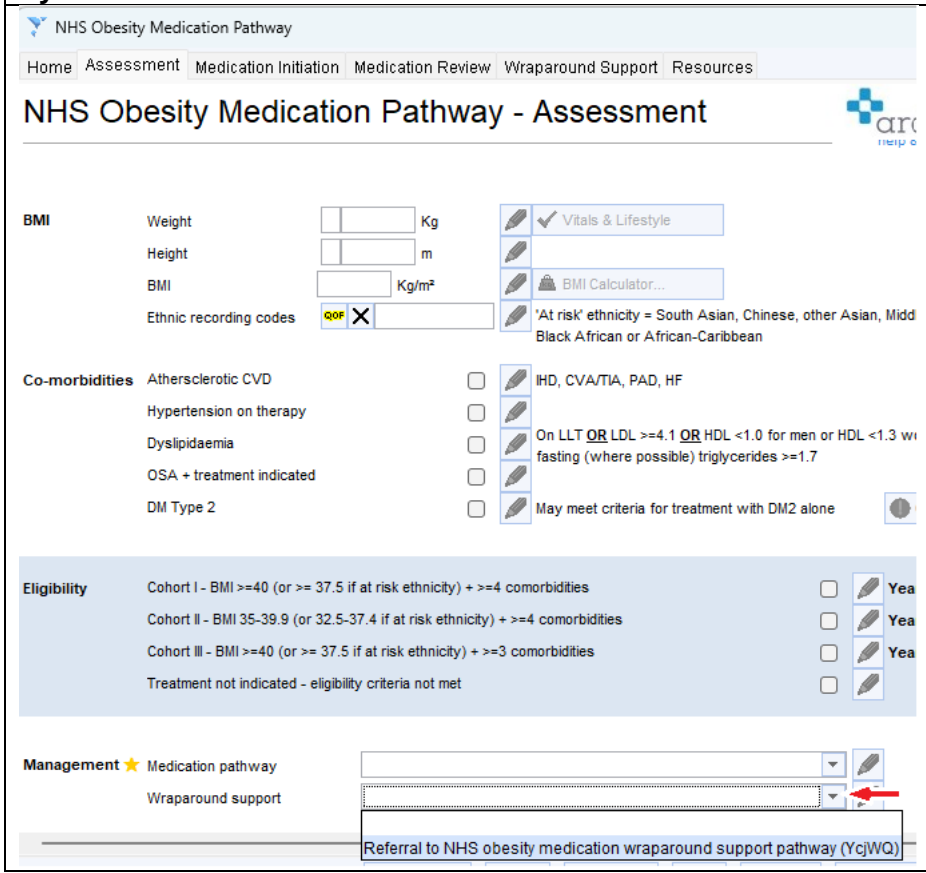
SNOMED CODE: National Health Service obesity medication pathway declined (situation) SCTID. 2386241000000105

| SystmOne | EMIS Web |
| --- | --- |
|  |  |

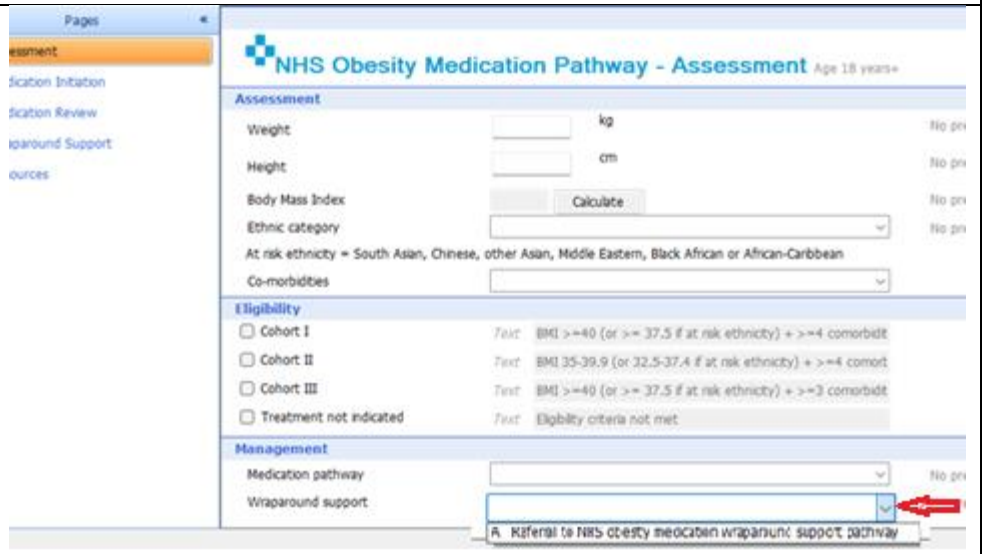
**Suitable for tirzepatide and primary care management**

SNOMED CODE: Referral to National Health Service obesity medication wraparound support pathway (procedure): SCTID: 2386201000000107

**SystmOne**



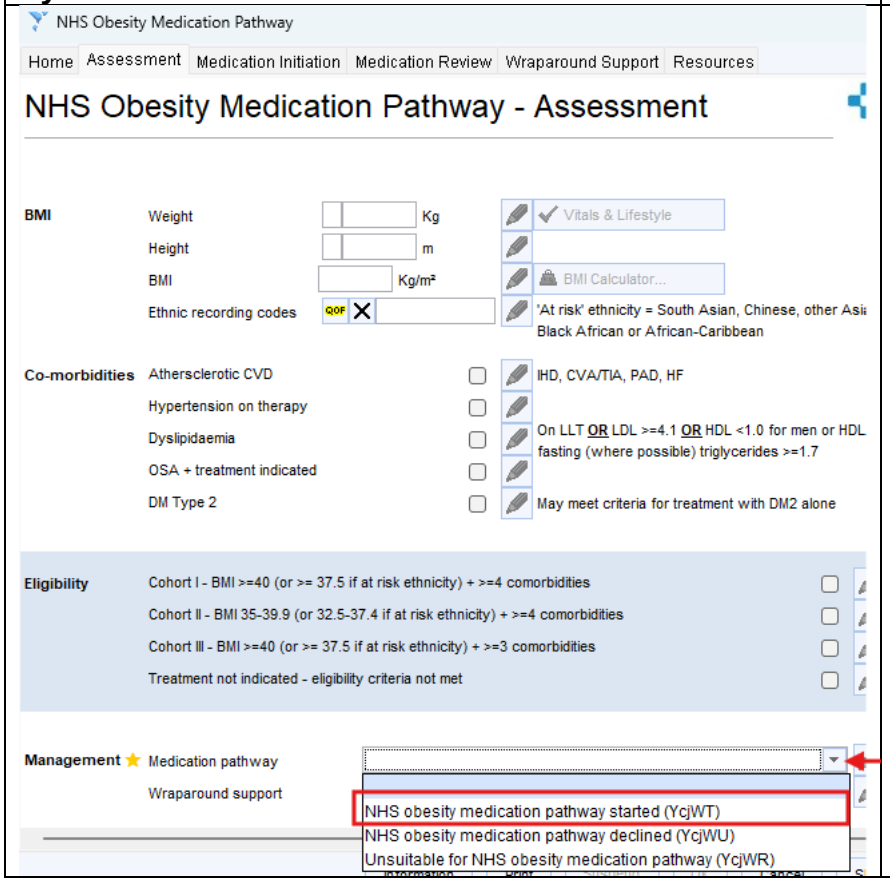

**EMIS Web**



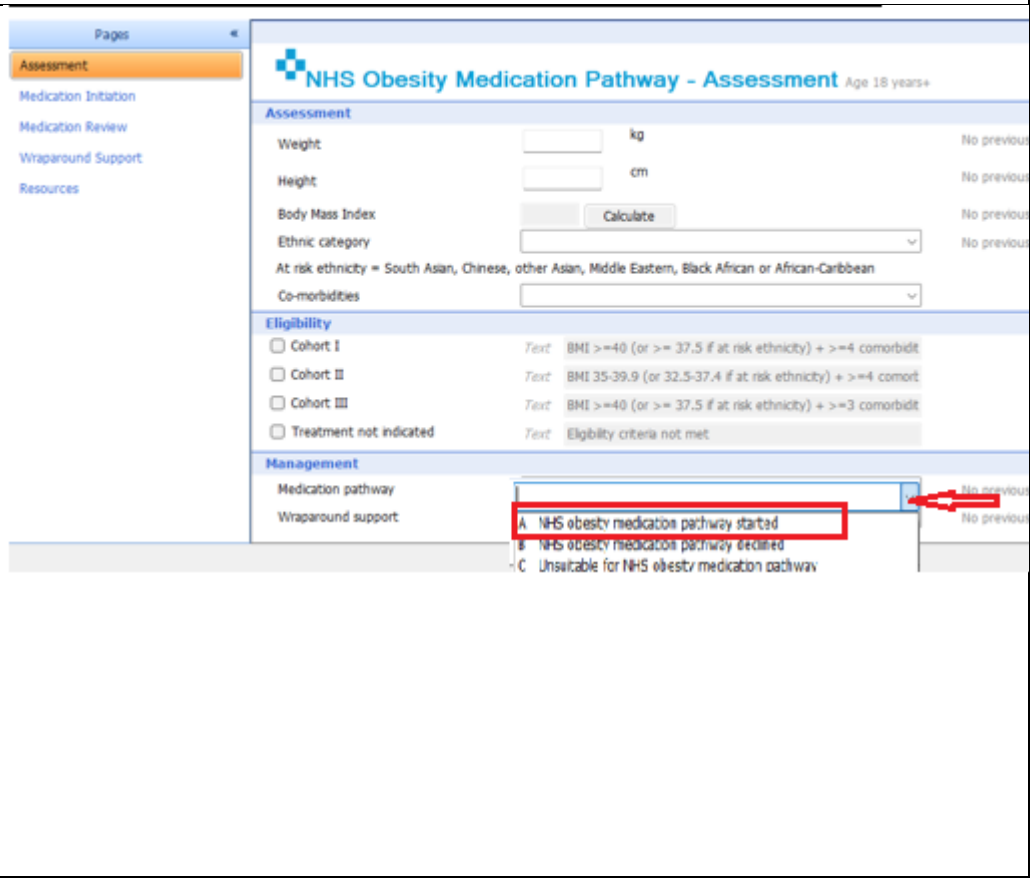
**Tirzepatide commencement appointment (Patient still wishing & eligible to have tirzepatide & committed to attending wraparound support)**

SNOMED CODE: National Health Service obesity medication pathway started (situation) SCTID: 2386231000000101

**SystmOne**



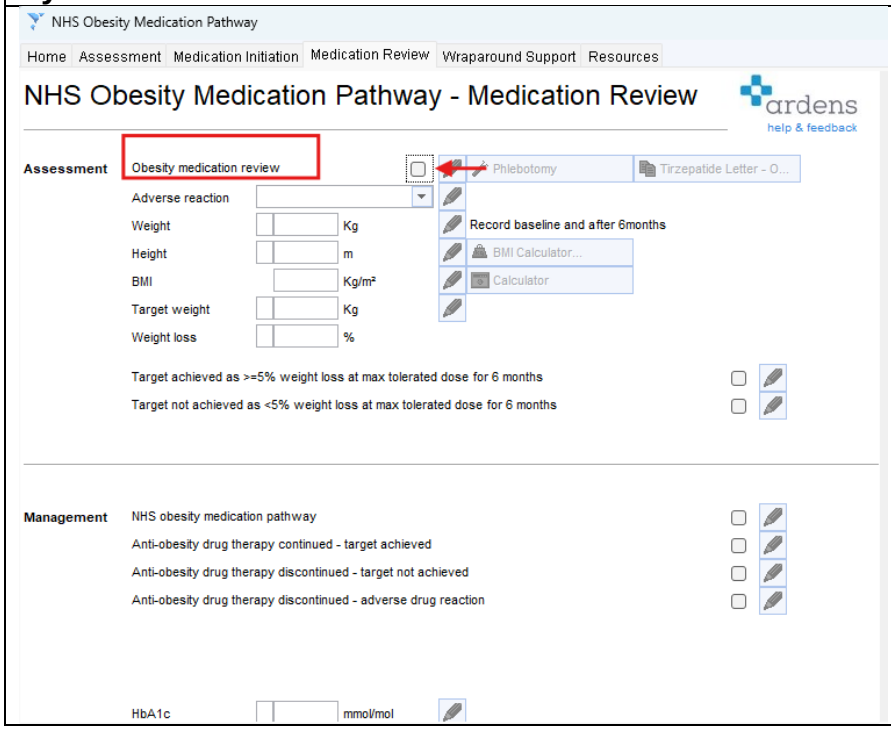

**EMIS Web**



## Reviews

SNOMED CODE: Obesity medication review: SCTID: 2386251000000108

### SystmOne



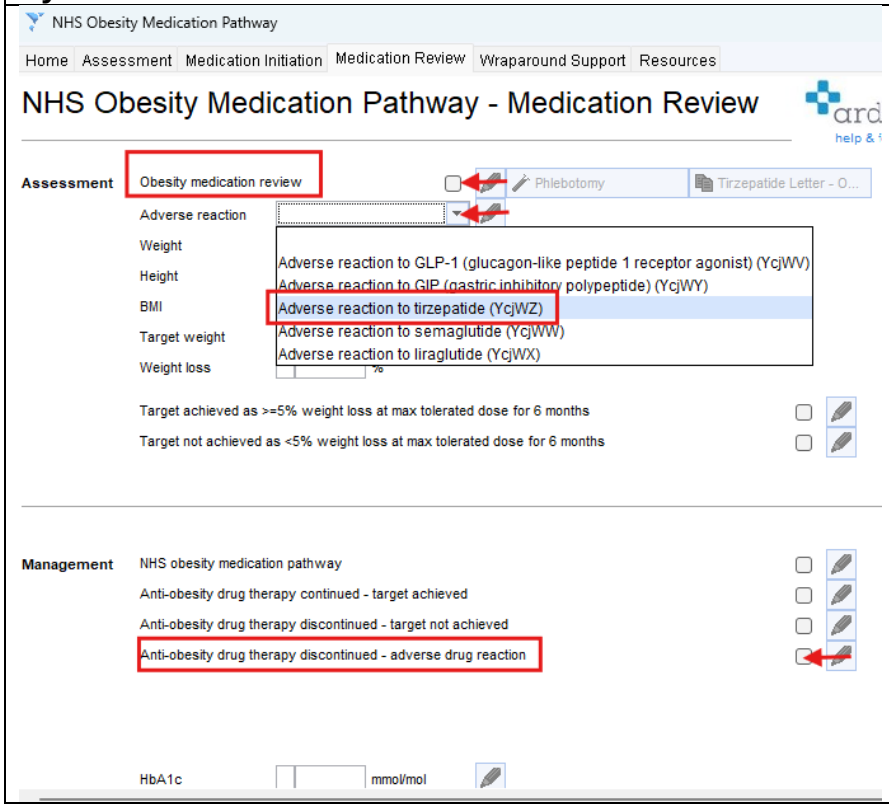

### EMIS Web

**Reviews and tirzepatide discontinued due to side-effect**

SNOMED CODE: Adverse reaction to tirzepatide (disorder) SCTID: 2385981000000100

SNOMED CODE: Obesity medication stopped SCTID: 914821000000103

**SystmOne**




**EMIS Web**

**Reviews and tirzepatide stopped**

SNOMED CODE: Obesity medication stopped SCTID: 914821000000103

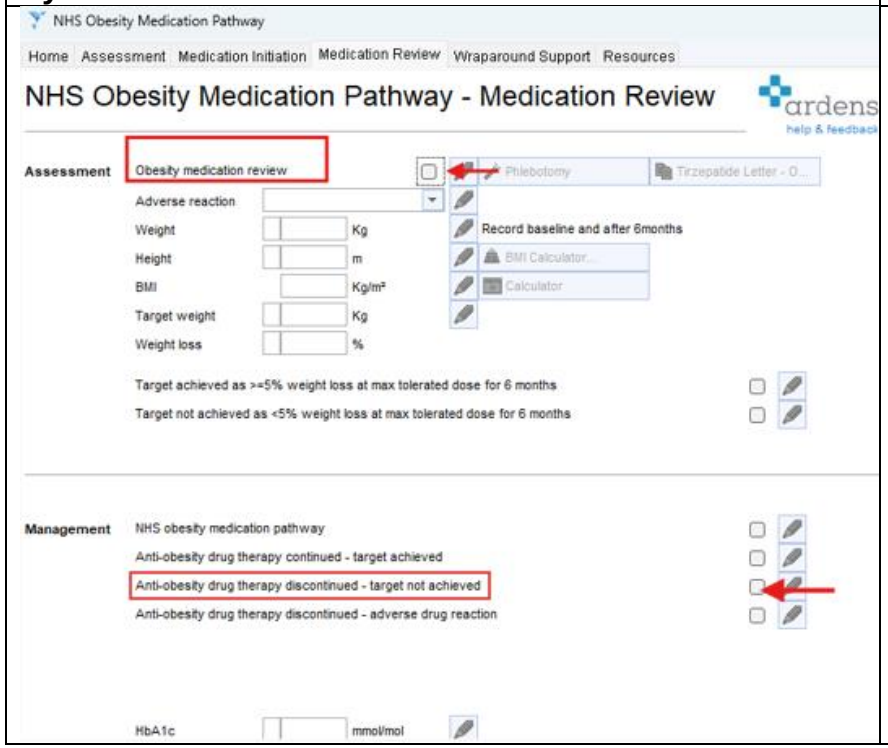
| SystmOne | EMIS Web |
| --- | --- |
|  |  |

**Figure two Recommended Appointment Schedule**

| Stage pathway | Mins | First 12 months (4 weekly) | | | | | | | | | | | | | Second 12 months (quarterly) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 3 | 6 | 9 | 12 |
| Initial Assessment | 30 | | | | | | | | | | | | | | | | | |
| Baseline measurements | 10 | | | | | | | | | | | | | | | | | |
| Commencement app | 30 | | | | | | | | | | | | | | | | | |
| Reviews & titration | 15 | | | | | | | | | | | | | | | | | |
| 6 months max tolerated review | 20 | | | | | | | | | | | | | | | | | |
| Maintenance reviews | 15 | | | | | | | | | | | | | | | | | |
| Measurements/bloods | 10 | | | | | | | | | | | | | | | | | |
| Annual review | 20 | | | | | | | | | | | | | | | | | |

NB: The timing of the six months post maximum tolerated dose review will vary between patients depending on how quickly they have been titrated and the maximum dose achieved.

The appts coloured:

- **Blue** must be **face to face** appts (unless exceptional circumstances).
- **Green** - for the remaining **4 weekly reviews**, it is up to clinical judgement and patient wishes as to whether **some of them could be done remotely**, with the patient recording their weight 4 weekly either at home or in the practice (e.g. if the practice has a weighing scale in the wating room). But as a **minimum, the patient must be reviewed face to face and have a HCP recorded weight documented at least three monthly**.
- **Orange** - If continuing tirzepatide **beyond the six-month maximum tolerated review**, a minimum of quarterly reviews face to face with HCP recorded weights are needed.

Bloods and baseline measurements may be undertaken by a healthcare assistant. All other appointments must be undertaken by **appropriately trained and qualified prescribing health care professionals.**

**Please ensure that the patient is aware of the following before they start tirzepatide**:

- They must attend and engage in the behavioural wraparound support (appendix 4).
    - If a participant misses a session, they will be offered the opportunity to attend a catch-up session.
      If they miss two consecutive sessions and do not complete the corresponding catch-up sessions, they will no longer be able to continue with the course, and a letter will be sent to their GP. Tirzepatide must be stopped.
- The practice will regularly review their dose of tirzepatide and whether it is appropriate for them to continue tirzepatide, considering the risks and the benefits of continuing.
- The maximum duration of having tirzepatide in SY is 24 months from the date of commencement.
- The other stopping criteria.

Provide the patient with a copy or a link to the **South Yorkshire patient information leaflet**.

Once a patient is on tirzepatide, they need to be **reviewed 4 weekly** and the dose of tirzepatide titrated up in 2.5mg increments at a frequency clinically suitable and agreed with the patient (taking account of how well they are tolerating the drug, rate of weight loss, agreed weight loss goals and impact on comorbidities). The minimum time between dose increases is 4 weeks. **4 weekly reviews should continue at least until the patient has had their six months post maximum tolerated dose review.**

Patients will take a variable length of time to reach their **maximum tolerated dose of tirzepatide** depending on their experience of side effects and whether they continue to lose weight on the lower doses.

If they are stable at the **6 months post maximum tolerated dose review,** and continuing tirzepatide, the frequency of the reviews can be reduced to quarterly.

Advise the patient to continue to **monitor their weight at least monthly** and to let the practice know their weight. If their weight begins to increase, review the patient's management, reinforce diet and physical activity advice and support, step up the frequency of reviews.

Once weight loss goals have been reached, titrate the dose of tirzepatide down gradually to 5mg.

**Criteria to suggest the patient is stable, at the 6 months post maximum tolerated dose review.**

| **Stable** |
|---|
| 5% or more weight lost |
| Good compliance with wraparound support |
| No/manageable adverse effects |
| Safe rate of weight loss (0.5kg or 1lb per week) |
| No new contra-indications |
| Weight related comorbidities (eg diabetes, hypertension) management stable |

See stopping criteria for further details. If a clinically meaningful amount of weight has already been lost, maintaining that weight loss may be an acceptable outcome.

Where patients have more rapid or greater than anticipated weight loss, consider the presence of other co-morbidities.

The ICB will fund a **maximum of 24 months** of tirzepatide for weight loss from the date of commencement.

- Unless the patient is on an active waiting list for bariatric surgery.
- If the patient still has type two diabetes after losing weight, see below.

**See additional stopping criteria below**.

**Criteria for stopping tirzepatide**

| **Consider stopping tirzepatide:** |
|---|
| • Patient has met their weight loss goal - If patient has T2DM, see below. If patient does not have T2DM consider stopping or reducing dose, discontinue within maximum of 24 months. |
| **Tirzepatide must be stopped if:** |
| • Less than 5% of the initial weight has been lost after 6 months on the highest tolerated dose, unless any exceptional circumstances. |
| • Patient has **been on tirzepatide for weight loss for 24 months since date of commencement** (maximum duration) unless the patient is on an active waiting list for bariatric surgery. See below if the patient still has type two diabetes once they have lost weight and reached 24 months. |
| • Patients do not engage with wraparound care (miss 2 or more sessions in the absence of exceptional circumstances). |
| • Patients who miss more than one review meeting in the absence of exceptional circumstances or do not attend for face-to-face practice/HCP weight at least 3 monthly. |
| • Patients who were waiting for bariatric surgery, stop once they have the surgery. |
| • The clinician and/or patient does not feel the clinical improvement or benefits of the treatment are satisfactory. |
| • The patient develops intolerance, significant side effects or complications. |
| • Any signs or symptoms of pancreatitis. |
| • Patients become pregnant or are planning pregnancy (discontinue at least 1 month but preferably 3 months before a planned pregnancy). |

**Patients can only have one cycle of tirzepatide, for up to 24 months from commencement.**
**Patients who disengage with the programme or put on weight after coming off tirzepatide for weight loss cannot restart it again for weight loss.**

If tirzepatide **is ineffective, unsuitable or not tolerated**, discuss alternative weight management options with the patient. If tirzepatide was discontinued due to inefficacy, then there is no evidence to date to suggest it will work if tried again. Patients may be referred into a tier 3 weight management service for consideration of alternative support and review to see if semaglutide or liraglutide clinically appropriate (for example, due to injection site reactions or if patients require 1:1 psychological or dietetic support).

There is currently no guidance or limitation in NICE on **how long tirzepatide should be taken for,** however there is growing evidence that when other GLP-1 receptor agonists are stopped weight is regained.[3] There are also **no long-term studies published to confirm long term safety and outcomes**. Over the next 3 years NICE will be reviewing this evidence and recommendations around the duration of treatment may alter. Until this is available, NHS SY ICB will only fund a maximum of 24 months of tirzepatide for weight loss from the date it was commenced.

If a patient **still has type two diabetes** after they have lost weight, they may continue 2.5mg – 5mg (depending on HbA1c control) of tirzepatide or another GLP1-RA in line with local formularies. GLP1-RA/tirzepatide should only be continued for diabetes in line with NICE/local guidance and should be reviewed and de-prescribed if ineffective. In some patients it may be appropriate to consider changing to semaglutide, as semaglutide is the only GLP-1 RA with proven cardioprotective benefits. NICE is currently consulting on new clinical guidelines for type two diabetes and practices are advised to review and consider the new recommendations once the guidelines are published.

NICE Quality Standards for Management of Overweight and Obesity, require patients to be **supported for 12 months after discontinuing weight loss medication**. Practices are asked to ensure that patients continue to monitor their own weight at least monthly and that they are offered / have access to **routine primary care weight loss support** e.g. from Health and Well-being coaches, during this period, with clinicians informed if the patient's weight starts to increase. Patients should be encouraged to keep appropriate weighing scales at home and to report weight increase, which would trigger a follow-up review.

**Mode of delivery**

The following appointments must be done **face-to-face** (unless there are exceptional circumstances):

- Initial assessment and commencement appointment
- First 2 four weekly reviews
- Six-month maximum tolerated dose review.

After the first 2 four weekly reviews, it is up to clinical judgement and patient wishes as to whether some of the four weekly reviews could be done remotely, with the patient recording their weight either at home or in the practice 4 weekly (e.g. if the practice has a weighing scale in the wating room). But as a **minimum, the patient must be reviewed face to face and have a HCP recorded weight documented at least three monthly**.

If continuing tirzepatide **beyond the six-month maximum tolerated review**, a minimum of quarterly reviews face to face with HCP recorded weights are needed. Reviews will need to be more frequent if the patient is unstable.

Bloods and baseline measurements may be undertaken by a healthcare assistant. All other appointments must be undertaken by **appropriately trained and qualified prescribing health care professionals.**

**Pathway checklists**

The checklists on the following pages provide a summary of the actions and assessments required at each appointment/review. For further details see the NICE practical guide to using medicines to manage overweight and obesity. Not all actions / assessments will be needed; it will depend on the person's clinical circumstances. Results of previous assessments could be used if they are available and within an appropriate timeframe.

- Initial assessment before prescribing tirzepatide
- Commencing tirzepatide appointment – once patient has attended the first session of the wrap around programme.
- Follow up and monitoring – 4 weekly/quarterly reviews

**Clinical coding**

At the end of each pathway, the key clinical codes needed are given

Please see the LES for the clinical coding flow diagram and details of what codes are needed for each payment stage.

Arden's templates are being developed to capture the codes.

## A. Initial assessment before prescribing tirzepatide

| Action / assessment | Completed |
|---|---|
| **Baseline measurements and assessments** | |
| • Height | ☐ |
| • Weight | ☐ |
| • Calculate BMI | ☐ |
| • Blood pressure | ☐ |
| • Bloods<br>  ○ Lipids, HbA1c, blood glucose<br>  ○ Others depending on history/examination (e.g., renal, LFT, FBC, TFT, Folate, B12, ferritin/iron). | ☐ |
| • **If diabetic, confirm if eye screening is in date** and ensure **that all nine key diabetes care processes are up to date,** if not ensure they are completed before commencing tirzepatide. See appendix three for advice regarding starting tirzepatide in people with retinopathy. | ☐ |
| **Eligibility for tirzepatide:** | |
| • SY Pre-requisite: Has the person completed a supported weight loss programme (equivalent to a tier two programme) in the preceding 24 months (see appendix 5). **Not needed for cohort one patients.** | ☐ |
| • Meets current or previous NHSE priority cohort being implemented in SY or any other SYICB primary care priority cohorts (information on these will be provided separately if applicable). | ☐ |
| • Commitment to engage with reduced-calorie diet, increased physical activity and wraparound care. **Advise that tirzepatide will be stopped if not engaging with wraparound care for the duration of the programme.** | ☐ |
| **Suitability for tirzepatide:** | |
| • Pregnancy status (do not use in pregnancy or if planning pregnancy), counsel on contraception | ☐ |
| • Contraindications, including past history of pancreatitis | ☐ |
| • Cautions | ☐ |
| • Thyroid function tests if clinically indicated | ☐ |
| **Medical history:** | |
| • Identify weight-related comorbidities including those currently undiagnosed, especially consider undiagnosed OSA. Manage co-morbidities in line with relevant guidance prior to commencing weight loss intervention[2]. For patients with diabetes see below and appendix 3. | ☐ |
| • Other comorbidities – consider if causing weight gain. | ☐ |
| • Consider whether any evidence of frailty, malnutrition or impaired mobility/muscle weakness. | ☐ |
| • Psychological assessment. | ☐ |
| • Consider undiagnosed eating disorders. If an eating disorder is suspected, assess the person in line with the section on identification and assessment in the NICE guideline on eating disorders. Refer to local eating disorder services if suspected. A screening tool for binge eating can be found here. **Patients with suspected/ a recent history of binge eating disorder should be referred to SYEDA for assessment and therapy but may be considered for tirzepatide once therapy is complete. Seek A&G as needed.** | ☐ |

| | |
|---|---|
| • Concomitant medication (be aware of medicines which may cause weight gain and those that may need adjusting if starting tirzepatide). | ☐ |
| • Discuss previous private treatment for weight loss and any history of weight loss medication or bariatric surgery. | ☐ |
| **Shared decision making** | |
| • Explore with patient how the excess weight is affecting them.<br>• Discuss their expectations and weight loss goals. | |
| • Counsel on risk of pancreatitis (advise tirzepatide will be stopped and cannot be restarted if this develops) and other side effects. | ☐ |
| • Advise that tirzepatide should be stopped at least 1 month before (but preferably at least 3 months) pregnancy and not used during pregnancy. | ☐ |
| • Counsel about the uncertainty of the absorption of OCP and the need for alternative forms of contraception. | ☐ |
| • Advise no long-term follow-up studies have been published on the safety or outcomes of using tirzepatide for weight loss. | ☐ |
| • Advise that weight regain is likely after stopping tirzepatide unless they make changes to diet and levels of physical activity. Tirzepatide will be stopped if they do not engage in the wraparound support programme. | ☐ |
| • Advise dose of tirzepatide will be regularly reviewed and titrate up/down based on how well tolerating, rate of weight loss and whether reached weight loss goal. | ☐ |
| • Advise of the stop criteria and that maximum duration of tirzepatide for weight loss in SY is 24 months from commencement. | ☐ |
| • Discuss and consider overall risks and benefits of being on tirzepatide. | ☐ |
| **Management plan** | |
| Patient eligible and suitable for tirzepatide in primary care | ☐ |
| Patient wishing to proceed with tirzepatide in primary care.<br>Do not use **'**Commenced NHS weight loss pathway' code until tirzepatide is prescribed and wraparound support has commenced (i.e. following the commencement appointment). | ☐ |
| Referral made for wraparound support<br>**This code will be used for the stage one LES payment** | ☐ |
| Agree with patient that the **patient will contact the practice to make the commencement appointment once** they have had their first session of the wrap around support programme (the practice will also be contacted direct by the wraparound provider that the patient has attended their first session). | ☐ |
| **Medication plan** made (to be enacted when the person starts tirzepatide), that includes any changes that will be needed to existing medications and their monitoring; any changes to contraception. | ☐ |
| **Dietary and physical activity advice given** | ☐ |
| Provide patient with copy of / link to the SY weight loss medication patient leaflet | ☐ |
| A&G to be obtained (tick if A&G sought): | |
| a) Advice needed on patient suitability | ☐ |
| b) Advice needed on medication changes | ☐ |
| Referral made to (tick if referral made): | |
| a) SWMS - Patient has complex needs that require full MDT support | ☐ |
| b) SWMS – Patient specifically requested alternative wt loss medication not able to be prescribed in primary care | ☐ |

| | |
|---|---|
| c) SWMS – Other | ☐ |
| d) Diabetes specialist nurses/consultants | ☐ |
| e) Eating disorder service | ☐ |
| f) Mental health / psychology | ☐ |
| g) Sleep apnoea investigations or services | ☐ |
| h) Other medical or surgical specialities | ☐ |
| i) Social prescribing | ☐ |
| j) Exercise on referral or equivalent | ☐ |
| k) Physiotherapy / OT | ☐ |
| | |
| **SNOMED codes** | |
| Please ensure that the following are accurately coded (needed to ensure eligibility of practice payment for the LES and NHSE reporting):<br>• Height, weight, BMI<br>• Weight related comorbidities<br>• If the patient<br>  ○ was referred to the National Health Service Obesity Wraparound Support Pathway (procedure) 2386201000000107)<br>  ○ was unsuitable for the NHS obesity medication pathway (2386221000000103)<br>  ○ declined the obesity pathway (23862410000000105)<br>• Demographic details including ethnicity<br>• Whether they are on SMI and / or LD registers | |

**Patients with Type 2 Diabetes**

1. Consider pathway to remission for patients diagnosed within the past 6 years.
2. Advise patients that weight loss on tirzepatide will be less and slower than in non-diabetic patients. See NICE discussion guide for infographics.
3. Ensure all nine care processes are up to date. See appendix three regarding diabetic retinopathy and the initiation of tirzepatide.
4. If baseline test show previously undiagnosed T2DM, start metformin in line with NG28. Tirzepatide may be initiated concurrently for obesity.
5. Advise patients that if tirzepatide is de-prescribed or not tolerated then other GLP1-RA will only be prescribed for obesity by SWMS, or for diabetes in line with NG28 and local formularies.
6. Consider interactions, and need to change dose, of insulin or sulfonylureas.
7. Patients must engage with wraparound care even if they have previously attended NDPP/structured education for diabetes.
8. For advice on how to swap from one GLP-1 TA to tirzepatide and back, seek specialist advice and guidance.

**B. Commencing tirzepatide appointment (once patient has attended their first wraparound session).**

Where there has been a significant delay between initial assessment and commencement of tirzepatide, consider repeating baseline tests and the initial assessment to highlight new contra-indications or interactions.

| **Commencing tirzepatide checklist** | **Completed** |
|---|---|
| Review history and initial assessment. Confirm not pregnant. | ☐ |
| Confirm patient still wishes to start tirzepatide | ☐ |
| Check patient has **attended the first wrap around session**.<br>Wraparound care to started (date)___ | ☐ |
| **Dietary and nutritional assessment** | |
| Assess and discuss the patients current: | |
| • Dietary intake | ☐ |
| • Levels/type of physical activity | ☐ |
| Provide personalised: | |
| • Dietary advice for a reduced calorie diet (considering requirements of someone on tirzepatide) | ☐ |
| • Advice to increase physical activity (including increasing resistance exercise) | ☐ |
| **Goal setting:** | |
| • Enquire as to why they want to lose weight and use to inform setting of: | |
| ○ Weight loss goal | ☐ |
| ○ Advise patient and record their 5% weight loss target | _____ |
| ○ Personal goals | ☐ |
| ○ Comorbidity goals. Ensure appropriate referrals have been made. | ☐ |
| **Tirzepatide administration** | |
| • **How to administer injections** | ☐ |
| • Dose to administer | ☐ |
| • How to handle, store and dispose of sharps waste<br>• **Prescribe 5l sharps bin and formulary needles** | ☐ |
| **Concomitant medication:** | |
| • Additional contraceptive measures | ☐ |
| • Adjustment of concomitant **medication** for comorbidities (if control changes with weight loss) | ☐ |
| • Advice on OTC vitamin and mineral supplementation - if any likelihood of reduced intake advise patient to obtain OTC supplements that include 100% of daily requirements | ☐ |
| **Pregnancy:** | |
| • Pregnancy and planning pregnancy (tirzepatide should not be used in pregnancy and should be stopped at least 1 month but ideally 3 months before a planned pregnancy) | ☐ |
| **Adverse effects:** | |
| • Acute pancreatitis symptoms requiring immediate help (sudden, severe stomach pain) | ☐ |

| | |
|---|---|
| • Gastrointestinal adverse effects and staying hydrated | ☐ |
| • Risk of pulmonary aspiration[8] during general anaesthesia or deep sedation | ☐ |
| **Follow up and monitoring:** | |
| • Frequency of follow up – advise dose may not be increased each time | ☐ |
| • Advise people with a BMI below 35 kg/m$^2$ to measure their waist, calculate their waist-to-height ratio and bring the results to their next appointment (following the advice in box 1 in the NICE guideline on overweight and obesity management) | ☐ |
| • Remind possible duration of treatment and why it might be stopped. including the maximum duration prescribing for weight loss of 24 months from commencement<br><br>Advise that people who stop tirzepatide there is no long-term data for what happens to weight after stopping it however they are **likely to regain the weight they had lost**[4]. With a similar medicine, people usually regain weight lost during treatment within 2 years of stopping it, and weight regain is likely to be greatest in the first year after stopping. | ☐ |
| **Management plan** | |
| • Patient **commencing NHS weight management pathway** (i.e. commencing tirzepatide for weight loss). | Yes/no |
| • **Prescription** given for **tirzepatide, needles and sharps bin.** | ☐ |
| • Reinforce **need to attend wraparound support.** | ☐ |
| • **Medication plan enacted**, including any changes to contraception. | ☐ |
| • Ensure that appropriate arrangements are made for **monitoring of any comorbidities** that will be impacted by weight loss and the patient understands the need for increased monitoring of these e.g. BP, diabetes. | ☐ |
| • If appropriate, inform **diabetes specialist team** patient is commencing tirzepatide. | ☐ |
| • Advise the patient on **how they can seek help/advice between appointments.** | ☐ |
| • Provide **patient with copy of/link SY weight loss medication patient leaflet** and go through **the steps they can take to decrease side effects.** | ☐ |
| • Next appointment date …… | ☐ |
| • Referrals made:<br>As per for initial appointment | |

**One tirzepatide pen will last for four weeks.**
**28 day prescribing is recommended.**

| **SNOMED codes for commencement appointment** | |
|---|---|
| Please ensure the following are accurately coded (needed for practice LES payment and NHSE returns):<br>• Weight, BMI<br>• Weight loss goal<br>• Whether:<br>  ○ National Health Service obesity medication pathway started (situation) 2386231000000101<br>  ○ was unsuitable for the NHS obesity medication pathway (2386221000000103)<br>  ○ declined the obesity pathway (23862410000000105) | |

**C. Follow up and monitoring – 4 weekly, six months post-maximum tolerated dose and quarterly reviews.**

| Action/Counselling | Completed |
|---|---|
| **Physical measurements and assessments:** | |
| • Height | ☐ |
| • Weight | ☐ |
| • Calculate BMI and waist circumference if BMI <35 kg/m$^{2.}$<br><br>Advise people with a BMI below 35 kg/m$^2$ to measure their waist, calculate their waist-to-height ratio and bring the results to their next appointment (following the advice in box 1 in the NICE guideline on overweight and obesity management) | ☐ |
| • Blood pressure | ☐ |
| • Any other assessments to measure comorbidities | ☐ |
| • Calculate percentage weight loss from baseline | ☐ ..... |
| **Discuss:** | |
| • Impact and progress in terms of **initial goals** set – encourage to discuss positive impacts seen. | ☐ |
| • If weight loss has been less than expected, explore the possible reasons why.<br>Note: People with type two diabetes tend to lose weight slower than people who do not have type two diabetes.<br>If the **weight loss has been greater than expected**, consider other causes for the weight loss e.g. cancer. | ☐ |
| • Any **psychological issues.** | ☐ |
| • Any difficulties with the injections. | ☐ |
| • Any adverse effects (report suspected reactions to the MHRA Yellow Card reporting site[9]). Manage if required, for example, no dose titration, dose reduction, dietary/hydration advice, short term pharmacological management). Practical advice for patients e.g. on managing GI side effects can be found in the SY weight loss medication patient leaflet. | ☐ |
| • **Nutritional intake**. If any concerns about inadequate micronutrient intake advise patient to take OTC vitamin and mineral supplement (that provides 100% of daily recommended intake). | ☐ |
| • Any additional support required with reduced-calorie diet and increased physical activity. | ☐ |
| **Check** | |
| • Attendance at wraparound support. | ☐ |
| • Any plans for pregnancy (tirzepatide should not be used in pregnancy and should be stopped at least 1 month before a planned pregnancy). Confirm pregnancy status if appropriate. Review contraception. | ☐ |
| • Additional contraceptive measures if required. | ☐ |

| **Management plan** | |
|---|---|
| • Reinforce reduced-calorie diet and increased physical activity advice. | ☐ |
| • Reinforce engagement with wraparound care. | ☐ |
| • Consider **impact on weight related comorbidities** (e.g. diabetes, hypertension) and whether any changes are needed to their management. | ☐ |
| • Adjust **concomitant medication plan** as needed, considering dose and need for monitoring of those with oral narrow therapeutic window and whether alternative contraception is needed. | ☐ |
| • Review any weight loss in the context of the **safe and sustainable weight loss goals** set at the initial assessment. | ☐ |
| • Discuss and agree with patient whether **continuing tirzepatide and any change in tirzepatide dose**, considering weight loss, side effects and duration been on tirzepatide. | ☐ |
| • Assess and refer, if required, to **other services** (for example, social care, physiotherapy, other physical or mental health support). | ☐ |
| **At Review after 6 months on highest tolerated dose and annual reviews:** | |
| **Repeat baseline measurements and bloods**: | |
| • Height | ☐ |
| • Weight | ☐ |
| • Calculate BMI | ☐ |
| • Waist circumference if BMI < 35 | ☐ |
| • Blood pressure | ☐ |
| • Bloods<br>○ Lipids, HbA1c, blood glucose<br>○ Others depending on history/examination (eg renal, LFT, FBC, TFT, Folate, B12, ferritin/iron). | ☐ |
| **Review as per 4 weekly /quarterly reviews above** | |
| **Plus:** | |
| • Has at least a 5**% weight reduction been achieved** | Y/ N |
| • If < 5%, discuss with the person the reasons **why weight loss may have been less** than desired. | ☐ |
| • **If less than 5% of weight loss** compared to baseline, **stop tirzepatide** (unless there are exceptional circumstances).<br><br>Explain to the person that, at this rate of weight loss, the risk of adverse effects continues while any benefits are minimal. | ☐ |
| • **Agree next step** (continue at current dose, continue at a different dose or stop prescription).<br>If stopping, then **reinforce continued adherence to physical and dietary changes** and / or consider alternative options or referral.<br>**Provide primary care based support (e.g. by Health and Wellbeing coaches) for a year after people stop weight loss medications**. | ☐ |

| **SNOMED Codes for reviews** | |
|---|---|
| **Please ensure that the following are accurately coded** (needed to trigger practice LES payment and NHSE reporting):<br>• Weight, waist to height circumference<br>• % weight loss to baseline<br>• Review of anti-obesity drug therapy (regime/therapy) 2386251000000108<br>• If applicable:<br>  ○ Anti-obesity drug therapy discontinued (situation) 914821000000103<br>  ○ Adverse reaction to tirzepatide (disorder) 2385981000000100<br>• NHS obesity medication wraparound support programme completed (situation) 23862610000000106 (If the pt has completed the 9-month programme)<br>• NHS obesity medication wraparound support programme **NOT** completed (situation) 2612191000000103 (If the pt does **NOT** complete the 9-month wrap around programme) | |

## Section E: Clinical Particulars of Tirzepatide (Mounjaro®)

Adverse events should be reported via the MHRA Yellow Card reporting site[9]. Please use the SNOMED CT code '2385981000000100 Adverse reaction to tirzepatide' to record any tirzepatide related side-effect.

| | |
|---|---|
| ***Overview and indication*** | Tirzepatide (Mounjaro®, Eli Lilly) is a long-acting dual glucose-dependent insulinotropic polypeptide (GIP) and glucagon-like peptide-1 (GLP-1) receptor agonist administered by **subcutaneous injection weekly** with a pre-filled pen. Patients can **self-administer** the drug.<br><br>It is licensed for weight management as an **adjunct to a reduced-calorie diet and increased physical activity in adults** with specified initial body mass index (BMI).<br><br>Tirzepatide's (Mounjaro®) has been classified by the MHRA as a **Black Triangle medication**. **All suspected adverse events MUST be reported via the yellow card process - Yellow Card \| Making medicines and medical devices safer**. |
| ***Key information*** | • Tirzepatide solution for injection is provided as a prefilled Kwikpen (2.4ml) containing four doses of 0.6ml solution per pen (sufficient for 28 days' supply). **One tirzepatide pen will last for four weeks. 28 days prescribing is recommended.**<br>• Each strength has a different coloured pen.<br>• Patients/carers should be counselled on injection technique and administration sites for injection (thigh, abdomen or upper arm). Further information is available in the user manual.<br>○ Tirzepatide solution for injection (Mounjaro® is to be injected subcutaneously in the abdomen, thigh or upper arm.<br>○ The dose can be administered at any time of day, with or without meals.<br>○ Injection sites should be rotated with each dose. If a patient also injects insulin, they should inject tirzepatide solution for injection (Mounjaro®) into a different injection site.<br>○ Patients should be advised to carefully read the instructions for use and the package leaflet for the pre-filled KwikPen before administering the medicinal product.<br>○ Patients should be provided with suitable needles from the formulary and a Sharpsguard yellow sharps bin 5L for safe disposal of used needles. The yellow sharps bins should be disposed of through agreed place-based arrangements. |
| ***Dosage*** | The starting dose of tirzepatide is 2.5mg once weekly for 4 weeks. The patient should be reviewed for efficacy, compliance with tirzepatide (and lifestyle modifications and wraparound care) and tolerability at a minimum of every 4 weeks and the dose increased in 2.5mg intervals once there is no further weight loss at the current dose.<br>Patients should be on a dose for a minimum of 4 weeks before any dose increase is considered. The usual maintenance doses are 5mg, 10mg or 15mg, with 15mg weekly being the maximum dose. A checklist to support follow-up and monitoring is available here. |

***Dose adjustments for patient factors***

- No dose adjustment is needed based on age, gender, race, ethnicity or body weight.
- No dose adjustment is required for patients with renal impairment, including end-stage renal disease (ESRD). Experience with the use of tirzepatide in patients with severe renal impairment and ESRD is limited. Caution should be exercised when treating these patients with tirzepatide.
- No dose adjustment is required for patients with hepatic impairment. Experience with the use of tirzepatide in patients with severe hepatic impairment is limited. Caution should be exercised when treating these patients with tirzepatide.

***Missed dose***

If a dose is missed, it should be administered as soon as possible within 4 days after the missed dose. If more than 4 days have passed, skip the missed dose and administer the next dose on the regular scheduled day. In each case, the patient should resume their regular once weekly dosing schedule.

***Changing the dose schedule***

The day of weekly administration can be changed, if necessary, providing the time between two doses is at least 3 days.

***Side-effects, cautions, contraindications and interactions***

**The details below of side-effects, cautions, contraindications and interactions are not a complete list and the current BNF and the summary of product characteristics (SPC) [10,11,12,13,14,15] remain authoritative.**

***Drug Interactions***

| Concomitant/Interacting medicine | Interaction/notes |
|---|---|
| Metformin and/or SGLT2 inhibitor | Current dose of metformin and/or SGLT2 inhibitor may be continued. |
| Sulfonylurea and/or insulin therapy | Patients taking a sulfonylurea or insulin in combination with tirzepatide are at an increased risk of hypoglycaemia. A reduction in the dose of sulfonylurea or insulin may be considered to reduce the risk of hypoglycaemia. Blood glucose self-monitoring is necessary to adjust the dose of sulfonylurea and insulin. A personalised stepwise approach to insulin reduction is recommended. As the responses will be variable it is suggested that patients on these medications (particularly insulin) be given guidance by specialists with the knowledge to safely titrate sulfonylureas / insulin.<br><br>See Appendix 3 for advice around reviewing and reducing insulin and sulfonylurea doses for T2DM patients prescribed tirzepatide. |

| | | |
|---|---|---|
| | DPP-4 inhibitors (Gliptin) | Adding tirzepatide therapy to gliptin therapy is not recommended as it has not been studied by the manufacturer. Tirzepatide and gliptins use similar pathways in the body by affecting incretin. It is thought that using them together may increase side effects such as acute pancreatitis. If tirzepatide is started, the DPP-4 inhibitor should be stopped. |
| | Existing GLP-1 receptor agonist | Adding tirzepatide to a GLP-1 receptor agonist is not recommended. If switching from a GLP1 RA then seek advice and guidance from the specialist. |
| | Orlistat | Stop orlistat when starting tirzepatide and discuss any reasons why orlistat may not have been effective (e.g. not used alongside lifestyle modifications) at the initial assessment. |
| | Drugs with a narrow therapeutic index | Tirzepatide delays gastric emptying and thereby has the potential to impact the rate of absorption of concomitantly administered oral medicinal products. Monitor all patients taking oral medicinal products with a narrow therapeutic index (e.g. warfarin, digoxin, lithium, theophylline) especially on initiation of tirzepatide treatment and following dose increases. |
| | Oral Contraception | In overweight or obese women, it is advisable to switch to a non-oral contraceptive method or add a barrier method of contraception upon initiating tirzepatide therapy (for 4 weeks), or after each dose increase (for 4 weeks). This is in case vomiting or malabsorption occurs. |
| ***Contraindications*** | This list is not exhaustive, see BNF and SPC for full details. Hypersensitivity to the active substances or any of the excipients. Cases of anaphylactic reaction and angioedema have been rarely reported with tirzepatide during post-marketing surveillance. | |
| ***Cautions*** | ***Tirzepatide delays gastric emptying*** MHRA Drug Safety Update January 2025 [8] advises that delayed gastric emptying may increase the risk of residual gastric contents despite preoperative fasting, leading to the potential risk of pulmonary aspiration. Delayed gastric emptying also has the potential to impact the rate of absorption of concomitantly administered oral medicinal products. This effect, resulting in decreased Cmax and a delayed Tmax, is most pronounced at the time of tirzepatide treatment initiation. | |

***Acute pancreatitis***
Acute pancreatitis has been reported in patients treated with tirzepatide. Patients should be informed of the symptoms of acute pancreatitis. If pancreatitis is suspected, tirzepatide should be discontinued. If the diagnosis of pancreatitis is confirmed, tirzepatide should not be restarted. **At the time of writing, Yellow Card Biobank is investigating whether the risk of acute pancreatitis from GLP-1 injections for weight loss and type 2 diabetes may be influenced by an individual's genes. Healthcare professionals are also being asked to help recruit for the study by reporting Yellow Cards on behalf of patients experiencing acute pancreatitis while taking GLP-1 medicines.**

***Hypoglycaemia in patients with type 2 diabetes mellitus***
Patients receiving tirzepatide in combination with an insulin secretagogue (for example, a sulfonylurea) or insulin may have an increased risk of hypoglycaemia. The risk of hypoglycaemia may be lowered by a reduction in the dose of the insulin secretagogue or insulin (see sections 4.2 and 4.8 of the SPC). Clinically significant hypoglycaemia (blood glucose < 3.0 mmol/L (< 54 mg/dL) or severe hypoglycaemia (requiring the assistance of another person) occurred in 10 to 14 % (0.14 to 0.16 events/patient year) of patients when tirzepatide was added to sulfonylurea and in 14 to 19 % (0.43 to 0.64 events/patient year) of patients when tirzepatide was added to basal insulin. See appendix 3 for supporting information when starting tirzepatide in patient on sulfonylurea or insulin.

***Gastrointestinal effects***
Tirzepatide has been associated with gastrointestinal adverse reactions, which include nausea, vomiting, and diarrhoea (see section 4.8 of the SPC). These adverse reactions may lead to dehydration, which could lead to a deterioration in renal function including acute renal failure. Patients treated with tirzepatide should be advised of the potential risk of dehydration due to the gastrointestinal adverse reactions and take precautions to avoid fluid depletion and electrolyte disturbances. This should particularly be considered in the elderly, who may be more susceptible to such complications. Patient advice on how to manage GI side effects can be found in the SY weight loss medication patient leaflet.

***Severe gastrointestinal disease***
Tirzepatide has not been studied in patients with severe gastrointestinal disease, including severe gastroparesis, and should be used with caution in these patients.

***Diabetic retinopathy***
Tirzepatide has not been studied in patients with non-proliferative diabetic retinopathy requiring acute therapy, proliferative diabetic retinopathy or diabetic macular oedema, and should be used with caution in these patients with appropriate monitoring.

An early worsening phenomenon can occur when a person with diabetes has a sudden improvement in their diabetic control which can lead to an increased risk of diabetic retinopathy. Please see
**Appendix 3: Tirzepatide and people with type two diabetes: Diabetic retinopathy.**

***Elderly***
Only very limited data are available from patients aged ≥ 85 years.

<table>
<tr><td></td><td>Hypertension<br><br>Whilst tirzepatide does not interact with antihypertensive medication, rapid weight loss can reduce the need for antihypertensives. Prescribers should monitor patients to avoid hypotension and adjust medication doses as appropriate.<br><br>Muscle loss and malnutrition<br>Clinical feedback and emerging evidence that muscle loss and malnutrition can be seen in patients who have rapid weight loss. Report any concerns via the yellow card[9] scheme and seek dietetic advice and advise patients to increase resistance-based exercise.<br><br>Benzyl Alcohol [E1519]<br>This medicine contains 5.4 mg Benzyl Alcohol [E1519] in each 0.6 ml dose. Benzyl alcohol may cause allergic reactions. Patients with hepatic or renal impairment should be informed of the potential risk of metabolic acidosis due to accumulation of benzyl alcohol over time.</td></tr>
<tr><td>Pregnancy and breast feeding</td><td>Pregnancy<br>There are no or a limited amount of data from the use of tirzepatide in pregnant women. Studies in animals have shown reproductive toxicity (see SPC). Therefore, tirzepatide is not recommended during pregnancy and in women of childbearing potential not using contraception. If a patient wishes to become pregnant, tirzepatide should be discontinued at least 1 month (but preferably at least 3 months) before a planned pregnancy due to the long half-life of tirzepatide. Tirzepatide should not be used during pregnancy. Overweight or diabetic patients should be referred to pre-conception services, where applicable, or promptly to antenatal services once pregnant. Patient information can be found on the NHS Bumps website.<br><br>Breast feeding<br>It is unknown whether tirzepatide is excreted in human milk. A risk to the newborn/infant cannot be excluded. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from tirzepatide therapy considering the benefit of breast-feeding for the child and the benefit of therapy for the woman.<br><br>Fertility<br>The effect of tirzepatide on fertility in humans is unknown.</td></tr>
<tr><td>Side effects<br>This list is not exhaustive, see BNF and SPC for full details.</td><td>Tirzepatide is classified as a Black Triangle drug and is therefore subjected to additional safety monitoring. ALL suspected adverse drug reactions must be reported to the MHRA via the yellow card reporting site.[9] The 7 completed phase 3 trial using tirzepatide alone or in combination with other glucose lowering medication showed that the most frequently reported adverse reactions were gastrointestinal disorders (nausea, constipation, diarrhoea and vomiting). In general, these reactions were mostly mild or moderate in severity and occurred more often during dose escalation and decreased over time.<br><br>
<table>
<tr><th>Very Common</th><th>Common</th></tr>
<tr><td>Hypoglycaemia when used with sulfonylureas or insulin</td><td>Hypersensitivity reactions and injection site reactions</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td>GI - Nausea, diarrhoea, vomiting, constipation</td><td>Hypoglycaemia when used with metformin and SGLT2</td></tr>
<tr><td></td><td></td><td>Decreased appetite • Abdominal pian, dyspepsia, flatulence, GORD</td></tr>
<tr><td></td><td></td><td>Hair loss</td></tr>
<tr><td></td><td></td><td>Fatigue</td></tr>
<tr><td>Monitoring</td><td colspan="2">See initial assessment and follow up checklists for monitoring requirements.</td></tr>
<tr><td>Patient Information</td><td colspan="2">Patients should be counselled by the initiating prescriber as follows and provided with a drug patient information leaflet. The patient may also wish to follow the ‘How to use Mounjaro® Kwikpen® step by step instructions online.<br><br>Practical advice for patients on using tirzepatide, including tips on diet, exercise and how to cope with side effects can be found in SY weight loss medication patient leaflet.<br><br>
<table>
<tr><td>Priming</td><td>Each Kwikpen contains 4 doses. To prime the device, slowly turn the knob until two clicks are heard. Hold the pen with the needle pointing up and tap the cartridge gently to collect air bubbles at the top. Release some medicine by pushing the dose knob until it stops. Count to 5 whilst holding the knob. The dose window should now read zero.</td></tr>
<tr><td>Injecting</td><td>Dial the dose by turning the knob until it stops at ‘1’. This is equivalent to a dose of 0.6ml.<br><br>Correct injection technique. Injection site rotation.</td></tr>
<tr><td>Storage</td><td>Store in fridge. Tirzepatide (Mounjaro®) may be removed from fridge 30 minutes prior to injecting to help reduce stinging at injection site on administration of injection.</td></tr>
<tr><td>Hydration</td><td>Drinking enough water (Minimum 6-8 glasses per day) to minimise side effects.</td></tr>
</table></td></tr>
</table>

**Diabetes services contact names and details**

Most patients in the first 3 NHSE priority cohorts have type 2 diabetes (T2DM), please use the usual referral /contact routes to seek support if any queries regarding impact on T2DM management.

If requesting Consultant Advice and Guidance please ensure that the following are included in the query:

- A clear and specific question
- Height, weight, BMI, BP
- Latest HbA1c & renal function,
- Relevant clinical information.
    - Diagnosis
    - Past medical history (? History pancreatitis, thyroid cancer of MEN2)
    - Current medications,
    - where applicable other recent results (e.g. lipids, liver function if relevant).
- If the patient is living with diabetes, please provide details of duration of diabetes, any diabetes-related complications, diabetes medication/insulin (dose, start date)

| | Consultant Advice and Guidance<br>Clinical queries other than insulin/diabetes medication dose titration | Insulin/diabetes medication dose titration |
|---|---|---|
| Barnsley | Contact diabetes consultants via A&G | Primary care diabetes specialist nurse team: barnsleydiabetes.spa@nhs.net |
| Doncaster | Contact diabetes consultants via A&G | Primary care diabetes specialist nurse team: RDASH.DiabetesYASReferrals@nhs.net |
| Rotherham | A&G from Consultants | Diabetes Medication, switching GLP1s, insulin titration guidance - DSN team. Rdial professional only phone line 01709 427927 |
| Sheffield | Contact the diabetes consultants via A&G | Contact the diabetes consultants via A&G |

For advice regarding wraparound support contact see appendix 4.

For advice regarding general medicines contact **syicb-sheffield.syicb.medsopt1@nhs.net**

**Equality and diversity**

NICE TA 1026 advises using lower BMI thresholds (usually reduced by 2.5kg/$m^2$) for people from South Asia, Chinese, other Asian, middle Eastern, Black African or African-Caribbean family backgrounds. Further information regarding BMI can be accessed via the indication section of the document.

# Appendices

### Appendix 1: Detailed Definitions of Qualifying Co-morbidities.

| Qualifying Comorbidities | Definition for Initial Assessment (Interim Commissioning Guidance) | NHSE FAQ clarification |
|---|---|---|
| Atherosclerotic cardiovascular disease (ASCVD) | Established atherosclerotic CVD (ischaemic heart disease, cerebrovascular disease, peripheral vascular disease, heart failure). | A patient could have all four diagnoses in the ASCVD definition. However, this would only qualify as one comorbidity for the purposes of the Funding Variation. |
| Hypertension | Established diagnosis of hypertension and requiring blood pressure lowering therapy. | Also includes patients diagnosed with hypertension in line with NICE guideline [NG136] who choose not to take BP lowering medication. |
| Dyslipidaemia | Treated with lipid-lowering therapy, OR with low-density lipoprotein (LDL) ≥ 4.1 mmol/L, OR high-density lipoprotein (HDL) <1.0 mmol/L for men or HDL<1.3 mmol/L for women, Or fasting (where possible) triglycerides ≥1.7 mmol/L. | Includes patients on lipid lowering therapy (statins) due to higher QRISK even if lipid levels not high at the start of treatment. |
| Obstructive Sleep Apnoea (OSA) | Established diagnosis of OSA (sleep clinic confirmation via sleep study) and treatment indicated i.e. meets criteria for continuous positive airway pressure (CPAP) or equivalent. | |
| Type 2 diabetes mellitus | Established type 2 diabetes mellitus. | |
| *People with type 2 diabetes can be prescribed tirzepatide (Mounjaro®) for obesity or for glycaemic management in type 2 diabetes if they meet the criteria set out in the recommendations in either:<br>a) NICE's technology appraisal guidance on tirzepatide (Mounjaro®) for managing overweight and obesity (NICE TA1026)<br>or<br>b) Tirzepatide (Mounjaro®) for treating type 2 diabetes (NICE TA924). | | |

**Appendix 2: Patients who have been receiving tirzepatide privately**

The NICE BMI thresholds for eligibility are higher than stated in the product licence, as shown in the table below. This means that some people currently accessing tirzepatide privately will never be eligible for it on the NHS for weight loss and some will not be eligible within the first 3 years. Patients should be made aware of this and advised that they will need to continue to access treatment privately, should they choose to do so.

Any patient who started tirzepatide treatment privately could be considered to be moved to the primary care NHS pathway **only** if the follow criteria are met:

- Primary care LES for tirzepatide for weight loss is in place and being delivered

  **And**
- The patient at the time of seeking a swap to NHS prescriptions (once LES is active) meets the eligibility criteria for the current NHSE priority cohort being implemented in South Yorkshire **at that time**
  - For cohort 1, the patient must have 4 or more of the 5 eligible comorbidities

    **AND at that time** BMI of ≥40kg/m2 (or 37.5kg/m2 if from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic background)

  **And**
- The patient must attend the NHS commissioned wraparound support programme.

At the time of writing (Sept 2025) no local or RTC SWMS are using tirzepatide. If in future they do, the patient must meet the referral criteria for the SWMS and NICE eligibility criteria (and any future local criteria) for the medication at the time they are seeking referral. Patients should be warned that the SWMS would make their own assessment as to eligibility and clinical appropriateness of offering them tirzepatide or alternative weight loss medications.

<table>
<tr><th colspan="2">Comparison of NICE recommendations for tirzepatide for weight loss & the product licence.</th></tr>
<tr><th>NICE TA1026</th><th>Product Licence for Overweight & Obesity</th></tr>
<tr><td>Tirzepatide is recommended as an option for managing overweight and obesity, alongside a reduced-calorie diet and increased physical activity in adults, only if they have:<br>• an initial BMI ≥ 35 kg/m2<br>AND<br>• at least 1 weight-related comorbidity.<br>Use a lower BMI threshold (usually reduced by 2.5 kg/m2) for people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic backgrounds.</td><td>For weight management, including weight loss and weight maintenance, as an adjunct to a reduced-calorie diet and increased physical activity in adults with an initial BMI of<br>• ≥ 30 kg/ m2 (obesity)<br>OR<br>• ≥ 27 kg/m2 to < 30 kg/m2 (overweight) in the presence of at least one weight-related comorbid condition (e.g. hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, prediabetes, or type 2 diabetes mellitus).</td></tr>
<tr><td colspan="2">If less than 5% of the initial weight has been lost after 6 months on the highest tolerated dose, decide whether to continue treatment, taking into account the benefits and risks of treatment for the person.</td></tr>
</table>

## Appendix 3: Tirzepatide and people with type two diabetes

People with type 2 diabetes who do not meet the NHSE criteria for primary care prescribing of tirzepatide for weight loss can be prescribed:

- Tirzepatide for glycaemic control following NICE TA 924[16], NICE NG28[18] and the SY ICB Tirzepatide Amber G Guideline[17].
- A GLP-1 receptor agonist for glycaemic control in line with NICE NG28[18].
- A GLP-1 receptor agonist or tirzepatide for obesity from SWMS in line with TAs.

Most patients in the first three cohorts for tirzepatide for weight management have type 2 diabetes. Although there is an overlap in pathways, diabetic specialist services will only initiate and up-titrate tirzepatide in line with NICE diabetes guidelines: NICE NG28[18] or NICE TA924. The diabetes specialist teams may be contacted for advice and guidance if primary care clinicians are uncertain about the **appropriateness** of using tirzepatide for weight loss in people with type two diabetes or for advice on **altering diabetes medications** when the patient starts tirzepatide/loses weight. **Please do not expect diabetes teams to initiate or titrate tirzepatide for weight loss purposes.**

NICE NG28[18] advises switching rather than adding drugs for diabetes management where possible so the addition of tirzepatide for weight management could facilitate the de-prescribing of an existing antidiabetic medication where clinically appropriate. Co-prescribing tirzepatide and insulin/ sulfonylureas can lead to hypoglycaemia and advice and guidance should be sought to manage interactions; further information is available below.

### Cardiovascular Outcome Data

There is currently no cardiovascular outcome data available for tirzepatide in weight management and, so far, the data is limited for type 2 diabetes. Tirzepatide has only been shown to be non-inferior to dulaglutide for MACE in a single study (SURPASS-CVOT trial) [23]. Several cardiovascular outcome trials are ongoing, but no interim results have been published yet. In contrast, semaglutide has extensive cardiovascular evidence, including the SELECT trial[24], SOUL trial[25], and STEP-HFpEF trial[26].

Clinicians should therefore consider the cardiovascular benefits of different GLP-1 therapies when selecting treatment for patients who fall in the tirzepatide rollout criteria. For patients with diabetes, renal or cardiovascular disease who are prescribed tirzepatide, the addition of an SGLT2 inhibitor may proffer cardiovascular and renal protective benefits. However, SGLT2 inhibitors do not have evidence for stroke or cerebrovascular disease, unlike semaglutide which offers a broader spectrum of cardiovascular protection. Patients should be advised of this as part of shared-decision making.

**Diabetic retinopathy**

Tirzepatide has not been studied in patients with non-proliferative diabetic retinopathy requiring acute therapy, proliferative diabetic retinopathy, or diabetic macular oedema, and should be used with caution in these patients with appropriate monitoring.[3]

Rapid improvement in glucose control (from range of means) has been associated with a worsening of diabetic retinopathy.

The clinical trials to date have excluded patients with retinopathy so there is a lack of clear clinical evidence on the topic.

While clinical experience is gained and in the absence of a UK/international consensus guidelines, the British Association of Clinical Diabetologists and the Primary Care Diabetes Society suggest the following for initiation of Mounjaro® (tirzepatide) (figure one):

• **HbA1c less than 86mmol/mol (10%) with normal eye screening (R0M0) or background changes (R1) in the last two years** can continue with usual interval for eye screening. Discuss/educate person about risks, including asking them to report significant visual changes prior to initiation of treatment, and prompt importance of continued attendance for eye screening.

• **Significantly elevated HbA1c, e.g. 86mmol/mol (10%) or higher, in a person with normal eye screening (R0M0) in the last 2 years** - discuss/educate person about risks, including asking them to report significant visual changes prior to initiation of treatment, and prompt importance of continued attendance for eye screening.

• **Significantly elevated HbA1c, e.g. 86mmol/mol (10%) or higher, in a person with established background retinopathy (R1)** - consider discussion (or Advice & Guidance) with local diabetes team prior to initiation of treatment.

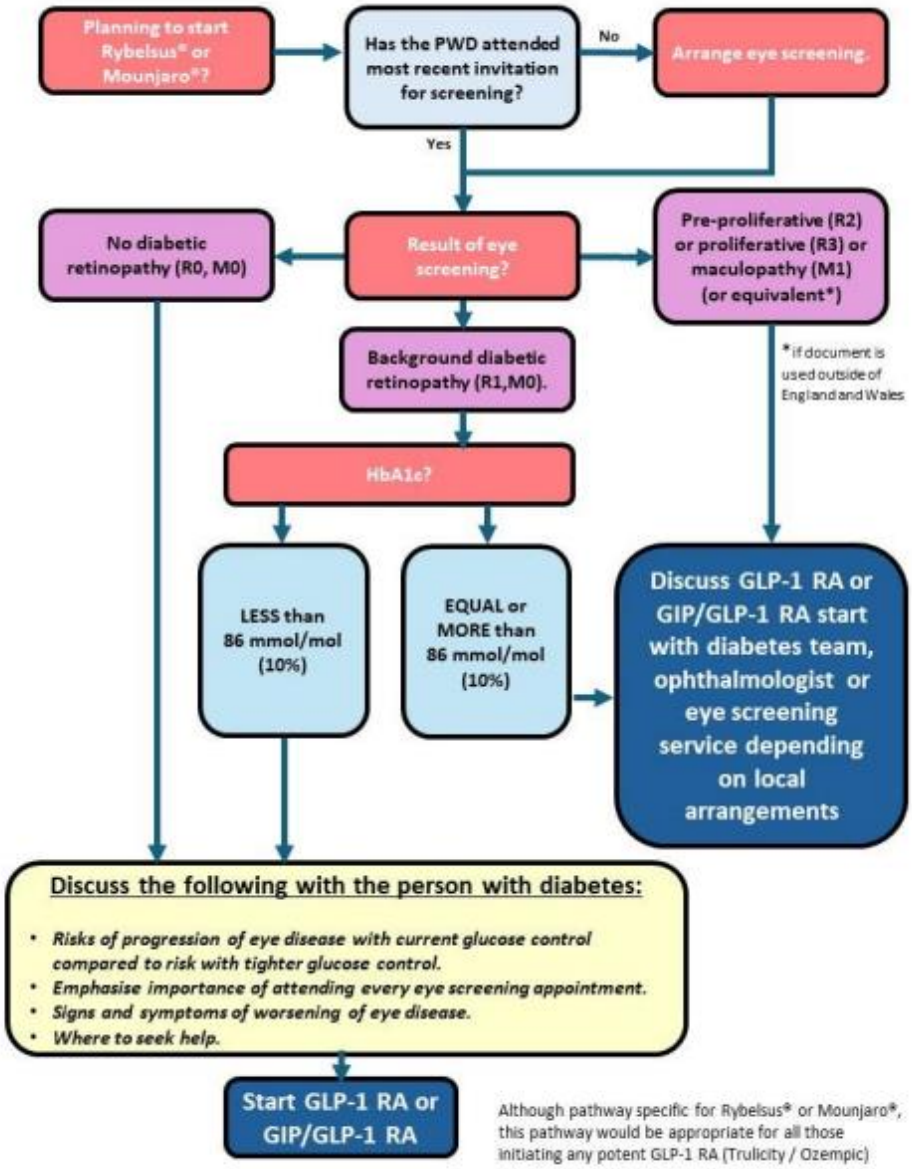
• **Active eye disease (R2/R3 or M1), under specialist ophthalmology services** - should be discussed with their specialist team prior to initiation to allow an individualised risk/benefit approach to treatment and monitoring to be formulated.

For South Yorkshire patients, please seek diabetes specialist advice in the first instance for patients with active eye disease. The diabetes team can then liaise with ophthalmology if they feel that starting tirzepatide is appropriate.

[3] Update March 2024: Glucagon-Like-Peptide 1 Receptor Agonist National Shortage Guidance from the Primary Care Diabetes Society (PCDS) and Association of British Clinical Diabetologists (ABCD)

**Figure one: Suggested pathway for diabetic retinopathy in people starting tirzepatide.**

Source: Association of British Clinical Diabetologists & the Primary Care Diabetes Society [GLP-1-RA-Shortage-2024-ABCD-PCDS-FINALISED-170324.pdf]




For South Yorkshire patients, please seek diabetes specialist advice in the first instance for patients with active eye disease. The diabetes team can then liaise with ophthalmology if they feel that starting tirzepatide is appropriate.

**Guidance for patients prescribed tirzepatide and insulin or sulfonylurea**

**Patients on insulin**

As patients lose weight, insulin requirements may reduce, often rapidly. NICE NG28[18] advises that patients prescribed GLP-1 RA and insulin concomitantly should be under the supervision of a clinician with specialist knowledge in the management of diabetes who can provide suitable advice and guidance. It would be prudent to apply the same principles to tirzepatide. Patients on insulin who are initiated on tirzepatide will require a review of their insulin as part of the initial assessment and commencement appointments. At these appointments, insulin doses should be adjusted (or a plan made to adjust upon commencement), and a follow-up plan should be agreed to ensure that ongoing review of insulin is undertaken during tirzepatide therapy.

Prescribers may wish to contact their local diabetic specialist services via advice and guidance/ DSNs for advice on managing insulin. However, in places where the specialist services do not have capacity to support primary care prescribing, the following is a practical guide based on local expert opinion, to support primary care clinicians to adjust insulin doses. Please note that this is for guidance only and individual patients may require a different regime, depending on their individualised targets, co-morbidities and insulin regime. When adjusting insulin doses, patients should be reminded of the blood glucose measurements recommended for their individual regime. Prescribers should follow their place-based guidelines for blood glucose testing of glucose and continuous glucose monitoring.

For patients on insulin who are starting tirzepatide, it is recommended to proactively reduce the total daily insulin dose by around 20–30% at the time of initiation. This helps minimise the risk of hypoglycaemia, particularly if the patient's glycaemic control is near target (HbA1c < 64 mmol/mol or 8%).

**Principles and Method - Initial Dose Reduction**

a. **Well-controlled patients (HbA1c < 64 mmol/mol / 8%)**

- Reduce the total daily insulin dose by 20–30% at the time Tirzepatide is started.

b. **Poorly controlled patients (HbA1c > 64 mmol/mol / 8%)**

- Reduce the total daily insulin dose by a more modest 10–15%. Very rapid HBA1c reduction in these patients can worsen retinopathy.

c**. Basal-Bolus Regimens** - For patients on a basal-bolus insulin regimen,

- reduce both basal and bolus doses, with a greater reduction in bolus insulin.

e.g. If basal insulin is reduced by 10%, bolus insulin may need to be reduced by up to 30%. A staged approach may be required i.e. reduce the bolus insulin and after a few days reduce the basal instead of reducing both at the same time.

**Principles and Method - Ongoing Dose Reductions**

- After the initial reduction, it is necessary to continue titrating down insulin every few days to weekly based on prevailing glucose profile. Do not wait for the dose titration of tirzepatide to adjust insulin dose.
- Adjustments should be tailored to each patient, considering their meal patterns and risk of hypoglycaemia, particularly nocturnal hypos.
    - If fasting glucose overnight is between 4 and 6 mmol/L for two consecutive days, reduce the basal insulin dose by 10%.

- If pre-meal glucose is between 4 and 6 mmol/L, reduce the pre-meal bolus insulin by 20–30%.

Close monitoring of blood glucose is needed, and early morning readings may be required.

If the patient is on insulin, consider the appropriateness of CGM or capillary glucose monitoring in line with local guidance.

**For patients on a basal–bolus regimen**:

- Basal insulin: Reduce the basal dose by 10–20% if overnight fasting glucose readings are consistently between 4 and 6 mmol/L for three consecutive days.
- Bolus insulin: Reduce bolus doses by 20–30% if pre-meal glucose levels are between 4 and 6 mmol/L.

**For patients on twice-daily pre-mixed insulin:**

- Use pre-bed and fasting to titrate evening dose and pre-lunch and pre-evening meal readings to guide adjustments to the morning dose.
- Evening dose: If overnight fasting glucose i.e. morning glucose level is between 4 and 6 mmol/L, on three consecutive occasions decrease the evening insulin dose by 10–20%.
- If pre-meal glucose pre-lunch and /or pre-evening meal is between 4 and 6 mmol/L, reduce the PM insulin by 10 to 20%.

**Patients on Sulfonylureas**

**If patients discontinue tirzepatide e.g. due to lack of tolerability or clinical inefficacy, insulin doses may need to be re-adjusted if weight is gained.**

If HbA1c is near target i.e. < 58mmol/mol (7.5%) and overnight fasting glucose is consistently between 5 and 7 mmol/L, the sulfonylurea can be stopped when starting Tirzepatide.

If glucose levels are higher, reduce the SU dose by 50% at initiation and discontinue completely once overnight glucose drops below 6mmol/L on 2 consecutive occasions.

If using finger-prick monitoring and taking a sulfonylurea, blood glucose should be checked four times daily - before each meal and at bedtime when starting Tirzepatide if they are not already doing so. Blood glucose diary should be provided to record readings.

If a hypoglycaemia-inducing medication (e.g. sulfonylurea or insulin) is discontinued, blood glucose monitoring can be reduced to checking only if feeling unwell. If patient is on SGLT2 inhibitor, it is necessary they are counselled about risk of DKA.

**Switching patients from alternative GLP-1 receptor agonists**

Seek specialist advice and guidance for switching from other GLP-1RAs.

**Remission of Type 2 Diabetes**

Whilst tirzepatide is more likely to increase the chance of remission of type 2 diabetes by leading to normoglycaemia, this could be described as 'pharmacological remission' rather than true remission because it has been shown that patients put on weight after stopping tirzepatide[19,20]. This weight gain can increase insulin resistance and HbA1c. There is no definitive evidence that tirzepatide will induce remission in patients with type 2 diabetes mellitus[19,20]. There is also no significant difference between tirzepatide and GLP-1 RAs in this field as the mechanism of HbA1c reduction is weight loss and reduced insulin resistance[20,21].

Stopping tirzepatide or GLP-1 RAs causes rebound weight gain, and it is thought that this can be partially mitigated by lifestyle modification. The STEP1 trial extension states that participants regained two-thirds of previously lost weight within the first year of stopping semaglutide (and lifestyle modifications) and that any cardiometabolic benefits achieved whilst taking semaglutide were similarly reversed[21]. The SURMOUNT-4 trial suggests that participants regained 14% of weight in the first year after stopping tirzepatide[22]. The key methodological difference in these trials was the continuation of a low-calorie diet, physical activity, and health counselling from a healthcare professional alongside the maximal tolerated dose of tirzepatide in the SURMOUNT-4 trial [21] compared to the discontinuation of both semaglutide and lifestyle modifications in the STEP1 trial [22]. Patients should, therefore, be advised that discontinuing tirzepatide will lead to weight regain but that this can be reduced by adherence to lifestyle modification.

**Appendix 4: Wraparound care**

In line with NICE TA1026 and NHSE Interim Commissioning Guidance, to receive NHS funded tirzepatide for weight loss all patients must participate in 'wraparound support' which incorporates nutritional and physical activity advice, as a minimum, and access to behavioural change components, as a mandatory requirement to access treatment[4].

**All patients receiving tirzepatide through primary care will need to attend the 'wraparound support' concurrently with the tirzepatide even if they have previously attended a tier two or similar programme.**

Only patients meeting the **current NHSE eligibility cohort** can be referred to the nationally commissioned wraparound support offer.

Patients are required to have **attended the first session of the wraparound programme before** they have their **first prescription of tirzepatide**.

The provider's contract with NHSE expects patients to be offered a place on the programme within 5 weeks of referral.

Places will be allocated on first come first served basis.

In the event of higher referrals levels than places, the 'wraparound' provider will maintain a waiting list. If the waiting list becomes very long the ICB will set parameters for the wrap around care provider to prioritise patients. Primary care colleagues will be informed of any prioritization process.

If the number of referrals begins to far outweigh the number of 'wraparound' places, the ICB will ask practices to pause making new referrals until the waiting times have reduced.

**Tirzepatide must be stopped if patients do not engage with the wraparound care i.e. miss 2 or more sessions in the absence of exceptional circumstances. The provider will inform practices if a patient has not attended two sessions.**

All patients referred should have SNOMED code 'Referral to National Health Service obesity medication wraparound support pathway 2386201000000107'.

NB: This code is the trigger for stage one payment to the Practice under the LES.

**Overview of Healthier You Wrap Around Support, also known as Behavioural Support for Obesity Prescribing (BSOP)**

**What is the course, and who provides it?**

This is an NHSE-commissioned and fully funded, nine-month, evidence-based lifestyle change programme for people who have been prescribed Mounjaro® for weight loss.

The course is based on the Healthier You, National Diabetes Prevention Programme (NDPP), with some adaptations.

It is currently delivered by the same provider as the Healthier You NDPP in South Yorkshire – Reed Wellbeing.

NHSE will be undertaking a national procurement for the service over the next year. We will inform practices of any future changes to the provider.

**What does the course cover?**

Built on evidence-based behavioural change methods and psychoeducational principles, it aims to:

- support patients to develop sustainable habits that improve metabolic health, physical wellbeing, and quality of life.
- promote balanced nutrition, energy regulation, and satiety through informed dietary choices, moving beyond outdated weight loss models.
- equip individuals with practical tools to make informed decisions about movement, food and self-care.
- build understanding of how nutrition influences health and body composition, not just weight.
- acknowledge obesity as a chronic, relapsing condition shaped by biology, environment and psychology.
- foster non-stigmatising engagement, health literacy, and personal agency in managing weight related health.
- provide accessible, non-clinical support alongside prescribing pathways, distinct from medical monitoring, with signposting to local services where appropriate.

**What happens after a patient is referred?**

After a patient has been referred by a GP or Health Care Provider, they will be contacted by the wrap-around provider within five to ten working days for an initial assessment via telephone.

The initial assessment will cover data confirmation, a review of NICE guidance, and a discussion around smoking cessation where applicable. It will also include a digital access check to ensure participants can engage with the programme, signposting to Reed Wellbeing for further support, and booking onto the programme.

Once they have had an initial assessment, if there is no immediate availability of the course, they will be placed on a waiting list and contacted by provider when a space becomes available (Note: The providers contract requires them to offer a place within 5 weeks of referral).

Following attendance at the first session of the programme, the wrap around provider will inform the GP that the patient attended and is able to commence tirzepatide.

The standard programme:

- Participants attend 13-group session (90 minutes long) over 9 months via Microsoft Teams. This is a version of the National Diabetes Prevention Programme that has been tailored to tirzepatide.

Other options, that are available to patients, but not tailored to tirzepatide include:

- Digital Programme via the Second Nature app, participants will have access via the app to a health coach and peer support group over 40 weeks.

- Face-to-face programme, these sessions will be for the core Healthier You Diabetes Prevention Programme. While the core content is consistent, these sessions include additional guidance tailored to diabetes prevention. Patients will, therefore, receive

digital/paper copies of BSOP content to supplement their learning. This is still 13 sessions over 9 months.

Remote sessions (of the usual, untailored, NDPP) are also available for:

- People with a hearing impairment, supported by Clarion,
- Visually impaired sessions with support from RNIB
- Bangladeshi/Pakistani sessions, which will feature cultural adaptations, with support provided by coaches who speak community languages. The sessions will be hosted on Teams and available in Urdu, Punjabi, Bengali, Pashto and Gujarati.

**Who can be referred?**

**Eligible:** People aged 18 and over who fulfil the current NHSE priority cohort.
For cohort one, the person needs to fulfil all of:

1. Will be prescribed Mounjaro® by their primary care provider for weight loss
2. BMI 40+
3. Have at least four of the following comorbidities:
    - Hypertension
    - Dyslipidaemia
    - Obstructive sleep apnoea (severe enough to be eligible for CPAP)
    - Heart disease – atherosclerotic CVD
    - Type 2 diabetes

**Referral Process**
The South Yorkshire referral form can be found on local clinical systems.
If downloading the form, please complete and send to **healthieryou.syandb@nhs.net**

**What happens if someone misses their sessions?**
If a participant misses a session, they will be offered the opportunity to attend a catch-up session.

If they miss two consecutive sessions and do not complete the corresponding catch-up sessions, they will no longer be able to continue with the course, and a letter will be sent to the referring GP requesting that prescribing be stopped. Tirzepatide should be stopped.

NB: The wraparound provider will contact the practice with the GP code given on the referral form. If the practice is providing the service on behalf of another practice, please give the GP code of the practice providing the Service (not their usual GP practice).

**Where can HCPs and participants find out more information**
For participants, more information can be found on the Reed Wellbeing website:
**Behavioural support for obesity prescribing | Healthier You | Diabetes Prevention**

**Resources**

- Participants A5 leaflet BSOP
- GP Leaflet

**Appendix 5: Specialist weight management services and other services which support weight management**

Practices signed up to the NHSE enhanced service specification for weight management are entitled to £11.50 per referral to the Digital Weight Management Programme, Local Authority funded Tier 2 services, Diabetes Prevention Programme, Pathways to Remission Programme and Tier 3 services.

A North East and Yorkshire summary of Overweight and obesity management resources includes a useful flowchart to help clinicians identify which of the following services the patient may be eligible for. Primary care can refer eligible patients to the following services

| Programme | Length | Mode of Delivery | Eligibility |
|---|---|---|---|
| **NHS Digital Weight Management Programme** | 12 weeks | Online via computer or smartphone | Adults living with obesity who also have a diagnosis of diabetes, hypertension or both, to manage their weight and improve their health. |
| **Healthier You: NHS Diabetes Prevention Programme** | 13 sessions over 9 months | Gace to face, group based | Patients at risk of type 2 diabetes (people with non-diabetic hyperglycaemia or a history of gestational diabetes). |
| **NHS Type 2 Diabetes Path to Remission Programme** | 12 months (in 3 phases) | Digital or face to face | Eligibility Criteria and referral resources available online |

Specialist weight management referral criteria are listed in the table below.

## Other services available to support people to lose weight

Local authority support offers that patients can self-refer to for healthy lifestyle support include:

- Sheffield (free) Sheffield - Morelife UK
- Rotherham (free) Rotherham Healthwave - Helping Boost Health and Wellness
- Doncaster (free) 1:1 Coaching | Well Doncaster

Barnsley Premium Leisure will shortly be piloting a free exercise on referral programme.

**Referral criteria for specialist weight management services in South Yorkshire (also known as tier three)**

These new criteria come into effect for all of South Yorkshire from 24 October 2025.

They will be reviewed in November 2026.

## Prerequisite prior to referral

1. Adults **aged 18 years and over** registered with **South Yorkshire ICB general practices**

AND

2. The person must have demonstrated **significant commitment to lose weight** and have **engaged in a supported attempt to modify diet and exercise levels prior to referral**, as indicated by **undertaking one of more of the following within 24 months of referral to the SWMS**:

    - A locally commissioned **tier two weight management service**
    - An equivalent NHS **nationally commissioned tier two programme** (such as National Diabetes Prevention Programme, Digital Weight Management Programme, Type two diabetes Pathway to Remission)
    - Attended a **commercial weight loss service**
    - Primary care / Local authority **health coaching, dietetic or practice nursing support to enhance diet/nutrition +/- increase physical activity +/- weight management**
    - Completed the 12 week free **NHS Weight Loss Plan app**

AND

3. Patients must **understand the requirements** and demonstrate a **commitment to actively participating** in the SWMS and to be **able to fully engage** with the program requirements.

## Eligibility criteria

Note: There is an increased risk of health conditions at lower BMI thresholds in certain populations. Reduce all BMI thresholds by 2.5 kg/m$^2$ in people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic backgrounds to ensure equitable clinical prioritisation and access to appropriate treatment. This also applies to people of mixed race who have one of these backgrounds.

1. People with a **BMI above 50** kg/m$^2$

OR

2. People who meet the **current NHSE/NICE Funding Variation cohort eligible** for tirzepatide in primary care as set out in the NHS England Interim Commissioning Guidance (NHS England » Interim commissioning guidance: implementation of the NICE technology appraisal TA1026 and the NICE funding variation for tirzepatide (Mounjaro®) for

the management of obesity)* This applies only to *Cohort 1* patients. The ICB will notify practices when prescribing can be extended to *Cohort 2*.

OR

3. **Transition of care for young people** from Complications of Excess Weight (CEW) services – any BMI

Patients requiring urgent weight loss for a time sensitive intervention for a life-threatening condition (e.g. surgery, cancer therapy) who do not meet any of the above criteria who have a BMI ≥ 35 will need to have an Individual Funding Request (IFR) approval.

There may also be some other rare situations where urgent weight loss is needed (e.g. Idiopathic intracranial hypertension resistant or intolerant of medical intervention with impending visual compromise or on transplant waiting list). An IFR will need to be completed for these.

Where there is suspicion of, or confirmed, rare monogenic or hypothalamic **cause of obesity, patients should be referred to Consultant Endocrinology services**. If the consultant feels the patient would benefit from the multi-disciplinary team (MDT) support of a specialist weight management service they would then refer the patient to the specialist weight management service, using an IFR if they do not meet any of the above criteria (any BMI).

*As tirzepatide becomes widely available through primary care not all patients meeting the NHS England eligibility cohorts will require specialist referral. Consider referral to specialist weight management services for the **people who meet NHS England cohort criteria and have**:

• **Complex neuropsychological needs** that are interfering with the individual's ability to engage with primary care services, e.g. severe and enduring mental illness, learning disabilities, special educational needs and disabilities

• **Additional complex medical, psychological and social care needs** requiring specialist input and support. Such referral shall be at clinician discretion.

• Patients **on NHS prescribed weight loss medical therapies who despite maximum tolerated doses, have ongoing weight-related complications** and would benefit from evaluation for alternative weight loss intervention.

**Exclusion criteria for specialist weight management services**

- People who do not satisfy the prerequisite and referral criteria
- People who are pregnant or breastfeeding
- Uncontrolled Health Conditions: Including uncontrolled hypertension, heart conditions, or any medical condition preventing increased activity levels
- Severe Mental Health Conditions: Patients with severe, unstable mental health conditions beyond primary care expertise, active eating disorders (e.g. binge eating disorder), recent suicide attempts (within the past year), or mental health concerns that would prevent engagement in a behavioural change program

- Post-Bariatric Surgery: Patients must be at least two years post-bariatric surgery before referral.
- Conditions for Referral Once Stable:
  - Substance Use: Patients in recovery from alcohol or drug use should have received support and maintained recovery for at least three months.
  - Other Conditions: Conditions such as hypothyroidism and Cushing's syndrome must be stabilized before patients can be considered for referral.

Note: These referral inclusion / exclusion criteria do not apply to the maternity or paediatric weight loss support currently provided by the Barnsley specialist weight management service.

Where a patient does not meet these criteria, but a referrer and / or provider believes that there is clinical exceptionality as to why the patient should receive to Tier 3 Weight Management Services referrers and / or providers may submit an Individual Funding Request in accordance with the relevant SYICB policy.

Requests can be e-mailed to: syicb-sheffield.sybifr@nhs.net

## Appendix 6 Dose reduction once weight loss goals are achieved

If the weight loss goal has been achieved before the 24-month treatment period ends reduce the dose to a 5mg maintenance dose. A gradual dose reduction is preferable. If weight regain is detected, the patient should be reassessed, and consideration given to up titrating the dose and strengthening diet and physical activity support as needed. Tirzepatide prescribing at this dose may continue until the end of the 24-month treatment period or be stopped in line with stopping criteria.

Patients should continue to receive monthly weight monitoring and structured behavioural support to equip them with strategies to maintain their weight loss long-term. Page 11 and Appendix 3 provides more details on continuing Tirzepatide/GLP1-RA in patients with diabetes.

## Appendix 7 Obstructive sleep apnoea/hypopnoea syndrome

Obese or overweight patients, or those with type 2 diabetes or cardiovascular disease are at increased risk of developing obstructive sleep apnoea/hypopnoea syndrome (OSAHS). Consider the possibility of undiagnosed OSAHS in patients requesting support for weight loss and review in line with NICE NG202[27]. Clinicians may also direct patients to the DVLA regulations for OSAHS[28].

Referrals to the sleep apnoea service for the following should be marked as urgent:

- Professional drivers, e.g. bus or train, HGV drivers, taxi or van/ delivery drivers or drivers who drive long distances as part of their job.
- Patients with safety critical occupations, e.g. pilot, train driver, crane operator, heavy machinery driver, forklift operator, industrial power tool operator e.g. lathe, bench saw.
- Patients awaiting surgery where any delay in receiving a diagnosis could be detrimental, e.g. cancer surgery.

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