Episode 6 - Obesity Medicine (Medication Management)

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Sponsor: The Ohio Chapter of The American College of Physicians

Episode Summary:
In this second episode of the two-part series on obesity medicine, Chris Chiu discusses medication management with Dr. Allison Rhodes and Dr. Sara Li. The experts explore various medication options for obesity treatment, including traditional medications like metformin and phentermine, combination therapies, and newer GLP-1 agonists. They discuss medication selection criteria, insurance considerations, side effects, contraindications, and practical implementation in primary care settings.

Key Takeaways:

1. Medication Selection Framework:
    - Consider insurance coverage first
    - Evaluate contraindications
    - Assess comorbid conditions
    - Match medications to patient symptoms and needs
2. First-Line Options:
    - Metformin: Often used off-label, expect 3-4% weight loss
    - Phentermine: Effective stimulant with good safety profile
    - Consider weight-neutral alternatives for existing medications
3. Weight-Positive Medications to Review:
    - Beta blockers (except carvedilol)
    - Certain antidepressants
    - Gabapentin and pregabalin
    - Antihistamines
    - Some contraceptives
4. GLP-1 Agonists:
    - Highly effective but expensive

- Insurance coverage often determines access
- Requires careful titration and monitoring
- Notable side effects include GI issues
- Contraindicated in MEN2 and medullary thyroid cancer

5. Practical Implementation Tips:
    - Utilize clinical pharmacist support when available
    - Schedule dedicated weight management visits
    - Plan for regular follow-up during titration
    - Address side effects proactively
    - Consider team-based approach
6. Monitoring Requirements:
    - Ohio law requires 90-day follow-up for phentermine
    - 5% weight loss required at 90 days to continue therapy
    - Regular monitoring of side effects and efficacy
    - Adjust treatment plan based on response
7. Future Considerations:
    - More peptide combinations coming
    - New monoclonal antibodies in development
    - Need for improved insurance coverage
    - Importance of individualizing treatment

Transcript:
This transcript has been edited for clarity

[00:00:00] **Christopher:** Welcome to Everyday Medicine, a podcast from the Division of General Internal Medicine at The Ohio State University. This podcast is focused on primary care and aims to provide current information to medical professionals from experts in Ohio. We're also graciously sponsored by collaboration with The Ohio Chapter of The American College of Physicians.

[00:00:18] This is the second episode in a two part series on obesity medicine. The first episode focused on evaluation and management, as well as counseling of patients with obesity. This episode, we'll dive deeper into medications for obesity management.

[00:00:34] We're back to another episode of our Everyday Medicine podcast. I have two wonderful guests here. I have recently listened to both of them do separate discussions and presentations on obesity medicine.

[00:00:46] And so I thought it would be great to bring them both on for people to hear about some great pearls about how to manage patients with obesity and talk about lots of new things out there and people are talking about this and social media and pop culture. And so I think being able to give providers tools to be able to manage these patients and their questions would be great. So I have Dr. Allison Rhodes and I have Dr. Sara Li. Do guys want to say hi?

[00:01:11] **Allison:** Hi Chris, this is Allison and I just want to say thank you so much for inviting us to speak today. I know anecdotally all of us practicing clinical medicine recognize that over the years it feels like more and more of our patients are struggling with their health as it relates to having excess adiposity.

[00:01:26] **Christopher:** Thank you, Allison. It's great having you here and to clarify. Allison is a dual boarded physician in both internal medicine and obesity medicine. She practices here at The Ohio State University within the Division of General Internal medicine.

[00:01:39] **Sara:** My name's Sara, and I work here as a primary care doctor at the Ohio State University in the General Internal Medicine Clinic. I'm about five to six years into my primary care practice.

[00:01:50] **Christopher:** Oh, fantastic. Both of you have good, background in primary care, so I'm really excited to talk to you today to hopefully help me as the primary care physician and help my colleagues to figure this out.

[00:02:01] All right, we've started talking about medicines, and I know this is a big area. Sara, let's start with you. If someone comes up to you and they're in that motivated state. What, are medications that you start reaching for first line?

[00:02:13] **Sara:** Yeah, that's a great question. And then I think a lot depends on the insurance, unfortunately. But I will say for that initial intake visit, I'm like Allison. I try to offer them something, even if based on the insurance. I'll say that I'm saying insurance because a lot of them require it. Require patient to fail lifestyle management for three to six months, depending on the insurance plan. So if I feel like this patient actually needs to try lifestyle longer, but that initial visit, I like to offer them something. I'm usually offering trial of metformin. As a off label for, sometimes I might even check for insulin resistance, but even if the patient doesn't have insulin resistance, I will offer a low dose metformin to kickstart the things a little bit.

[00:02:57] And I'm also going to review their medication list in detail for any way positive medications. And if I see them, I will probably make some suggestion or contact their specialist to see if I can make some swap that initial visit.

[00:03:11] **Christopher:** Questions. One, after you start metformin, do you recheck for glycemic control just because you started it? Two, how high do you titrate? Do you go up to like the two grams a day that we do for diabetics? Three, how much weight is expected to be lost once getting someone to two grams?

[00:03:26] **Sara:** Yeah, I think the data show the metformin patients lose about three to 4%.

[00:03:31] And I think everyone's different. I try noto get to the max dose immediately. I try to have my patients stay out of 500, twice a day dose. Mainly because the data from metformin is that the longer you're able to take it, the more weight they're gonna lose. So my goal is for the patient to remain on the metformin, and I don't want them to give up develop side effect and give up on the metformin. So unless the patient is motivated and that's, to go up and really want to try. We'll probably stay at the 500 milligram twice a day until the next follow up visit.

[00:04:04] **Christopher:** And you're saying about weight positive medications, are there any that have surprised you that were uh, weight positive medications that most people didn't realize?

[00:04:13] **Sara:** I will say the most common ones in primary care are beta blockers. Most beta blockers... metoprolol, atenolol, propranolol, they're all weight positive. The only weight neutral beta blocker is carvedilol. So I'm often emailing cardiologists if I can make that swap. In terms of the antidepressant, the weight neutral ones are like Sertraline, Fluoxetine. Bupropion is slightly weight negative, but Paroxetine is the most weight positive. So if I see someone on Paroxetine, I might be actively trying to switch them into

a slightly better one, at least. Gabapentin and pregabalin is also the biggest culprit, I think, in primary care.

[00:04:55] So those are a really big deal. And some of the oral contraceptive is, it really depends on the patient. The worst one is definitely Depo-Provera injection. But I tend to believe my patient, if someone says I started oral contraceptive and after that I gained this much weight, then I say for this patient, that might be the reason for weight gain. Additionally, most anti psychotic medications are weight positive. Some of the worst ones are olanzapine, seroquel.

[00:05:21] **Allison:** Dr. Li, 100 percent agree with you. One of the things that I think is interesting that often doesn't end up on the medication list are the benadryl at night to help with sleep, or the NyQuil PM, and antihistamines are weight promoting medications. And so I talk to patients about, really optimizing their seasonal allergy regimen. If they don't need to take oral Zyrtec every single day and they could get away with just intranasal Flonase, that's better, but a lot of times patients are taking antihistamines at night for sleep and they don't even, realize that could be causing weight gain. And then that also tips me off that there's probably something else going on with their sleep or their stress that we need to get into.

[00:05:55] When a patient comes in and I'm considering prescribing anti obesity medications, I have a four step process that I go through in my head. And unfortunately, the first part of this process is really dictated by the lay of the land with insurance these days. But my first question I ask myself is, what does my patient's insurance cover?

[00:06:12] And I think really getting a sense of which plans cover GLP 1 agonists for weight loss, just so you know which plans those are, and then sadly assuming that most of the other ones are probably not, currently. The second thing I ask myself is what contraindications does my patient have to specific medications?

[00:06:28] And that's one of the things I'm doing in my pre visit chart review. I'm looking, have they ever had a kidney stone before? That would be a contraindication to topiramate. I'm looking to see if they've had a history of bulimia. That would be a contraindication to bupropion and Then the third step I use is looking at their comorbid condition.

[00:06:46] So is there a particular condition that I can help them have some benefit with in addition to helping them with weight loss? Do they have a more low mood, low energy depression? Do they have a history of nicotine use that would make them a good candidate for bupropion? Do they have PCOS? Do they have lipedema? Do they have any degree of insulin resistance? I'll prescribe metformin for anyone with an A1c of 5. 2 and above if they have excess adiposity and if they have a history of migraines, thinking about topiramate. And then the last step that I'm trying to get out with my patients to really try and customize the medication to them, and this happens when I'm interviewing the patient and in my intake form. Finding out what their symptoms are that are really bothersome.

[00:07:30] When are they having cravings? Are they having more cravings or more hunger? What is really bothering them in terms of their hunger and satiety patterns? And then using the medications and their mechanism of action and their timing of administration to really optimize that for my patients.

[00:07:45] For example, a lot of patients actually have a condition called night eating syndrome, which is not well identified, you know, especially on a 24 hour recall. If you say from the time you wake up to the time you go to bed, they're not going to tell you about the candy wrappers they wake up in bed with the next morning. But understanding that, then you can start to make changes in medications to help with those lifestyle changes.

[00:08:06] **Christopher:** Just to sort of recap, you're saying that, looking at the patient, maybe other comorbid issues where you may find some benefit for these other medications. And so you listed topiramate, you listed bupropion, and you listed metformin. What else is on this list of other medications that one might consider?

[00:08:25] **Allison:** When I think about anti obesity medications I can group them into three categories in two different frameworks. So the first framework is the more mechanism of action, scientific framework. So I think about medicines that fall under a neuromodulatory category.

[00:08:39] I think about medications that fall under a digestion modulatory category. And then lastly, hormone modulators. Under the neuromodulatory category, that would be phentermine, topiramate, bupropion, naltrexone, and lisdexamphetamine. Combined together, phentermine and topiramate are a brand name medicine for weight loss called Qsymia. And combined together, bupropion and naltrexone are a brand name medicine called Contrave for weight loss. And the other name for lisdexamphetamine is Vyvanse. In terms of digestion modulators, those would be oralistat and plenity, and oralistat is over the counter. I will say though, because of the very prominent side effects.... I actually use that as a treatment for constipation associated with GLP-1 agonist therapy, but I never use it as a primary weight loss modality.

[00:09:28] My joke with my patients is I really want them to like me and come back and see me, and if I recommend oralistat at a first visit, that might not happen. Plenity is actually considered a medical device. It's a super absorbent gel capsule that is obtained with a prescription but is tends to not be covered by insurance.

[00:09:44] And then the hormone modulatory category that's where we get into metformin and then our GLP- 1 and now our latest GLP1/GIP receptor agonist Zepbound. But the other medications there would be Saxenda and Wagovy.

[00:09:57] **Christopher:** I feel that the monotherapies are, at least even if they pay out of pocket because a lot of times insurance does not pay for these indication for obesity. Most people don't seem to be using any of these combination medications. Do you find this true?

[00:10:12] **Allison:** I do. In my practice, I can't tell you the last time I prescribed Qsymia or Contrave. And the reason why is because I don't want the headache of having to deal with the prior authorization with insurance, and I can mimic the doses by combining each of the individual components.

[00:10:26] The other thing that I think is nice from a scientific method perspective is if you start a patient on one of the two components, if they have a side effect to that one component, then you'll be able to stop that individual agent as opposed to having to stop the combined medication and not necessarily knowing to which medication the patient had a side effect to.

[00:10:44] And one of the things that I think is actually again, low hanging fruit. When you're in the primary care practice, know these medications that can help your patients that are always going to be covered by their insurance. So topiramate, bupropion, naltrexone, metformin, again, oralist at over the counter and leverage those to help your patients, have them start losing weight and work towards those lifestyle changes. And that way they're not losing hope if they don't have GLP one agonist coverage at this time.

[00:11:09] **Christopher:** Sara, do you ever use any of these combination or do you often do monotherapy or even try to mimic these combination medications?

[00:11:18] **Sara:** Yeah, so in terms of the naltrexone bupropion, I don't use that combination a lot. I will say trying to recreate that combination with individual components is a little difficult just because the naltrexone doesn't come in that low of a dose. So you have to make a quarter tab of a tiny tablet, which is very difficult.

[00:11:36] But I don't generally prescribe a lot of naltrexone/ bupropion because the weight loss is modest. And I have a lot of patients that don't tolerate it, mainly because of the naltrexone, they just don't feel right on it. The one group of patients that I have found useful, and the data I think suggests this, is that patients with strong food craving or near like addiction to food type of a phenotype of patients, they seem to derive more benefit from naltrexone/ bupropion.

[00:12:02] So for those patients, I have tried. I have gotten feedback that it really does help decrease their craving and they're no longer tied to their food or thinking about the food all the time. In terms of the phentermine/ topiramate, I used to use that combination quite a bit and I utilize the manufacturer coupon that will get the patients down to about 100 per month and some of my patients are willing to pay for that and for those patients I have try them. That being said, the dosage titration of Qsymia is pretty complicated. There's a loading dose of 3. 75 milligrams for two weeks, followed by 7. 5 for the maintenance. And then there's, it's a very cumbersome and then the Ohio law used to be even more cumbersome regarding Qsymia.

[00:12:50] So I have stepped away from using the combination as much and doing more just a straight phentermine. And then using that first. And if you need it, adding topiramate later.

[00:13:01] **Christopher:** Can you both talk a little bit about phentermine use? Because this was, I feel, before the new GLP- 1s, this seemed to have the best studies in terms of actual weight loss.

[00:13:12] I think I've gone to multiple talks from Obesity Medicine Specialist Dr.Fatima Cody Stanford. . She's been on like, I think the Today Show and I've seen her at either SGIM or ACP. And I think one of the things that she often talks about is phentermine. Until recently here in Ohio, Phentermine has been really difficult because after three months you have to stop. But now that the laws have changed, I feel that this seems to be something that people might be considering more often. I think one thing that some of my older colleagues remember is like the "Fen-Phen craze" and phentermine being one of the "Fens". Can either of you talk about the safety and efficacy of phentermine and whether it's easy to actually use in a primary care setting.

[00:13:51] **Sara:** So in terms of the "Fen-Fhen craze", I, my understanding is, the dosage that we're using now is much, much lower. Is it even different formulation?

[00:13:59] **Allison:** Yeah, the second "fen" was fenfluramine, and fenfluramine was the part of that compound

[00:14:04] that, caused the cardiac side effects that we're so worried about. So Phentermine, as a monotherapy, has not shown to cause, cardiac side effects other than the known possible elevation of blood pressure or a patient that's at risk for arrhythmia, redeveloping that arrhythmia or having it be more uncontrolled.

[00:14:21] **Sara:** Yeah, but for a lot of primary care colleagues, I just want to say phentermine is very easy to use and patient device benefit and then they tolerate pretty well.

[00:14:31] So the phentermine comes in three different dosage. So it has eight milligram, 15 milligram. 37. 5 milligram. The most of the side effect are so the stimulants, so dry mouth, headache, difficulty with sleeping, increased heart rate. The blood pressure could be elevated, but I do want to point out that there are actually some studies shows that because phentermine is a pretty effective weight loss medication, that in the study actually patient the blood pressure decreased because of the weight loss.

[00:15:00] So medications like bupropion has far more risk of elevated blood pressure than phentermine. So when I, if I have someone with the uncontrolled hypertension, I'm much more concerned about bupropion rather than phentermine. And you do want to make sure the patient doesn't have any kind of arrhythmia or cardiovascular disease.

[00:15:16] So those patients probably don't benefit from phentermine. Another thing about phentermine that I love is that right now we have a lot of ADHD medication shortage, and phentermine being a stimulant, I'm able to get like a dual benefit for some of my patients that have a maybe an undiagnosed ADHD and feels difficulty concentrating, or even diagnosed ADHD and difficulty getting ADHD medications.

[00:15:39] I'm able to get a dual benefit of concentration and weight. Here in Ohio, the new law, the got changed in February of 2023 is that once you start phentermine or phentermine/topiramate, they don't specify which type of medications within the first 90 days, a physician has to see the patient. And then it could be tele- visit, but it has to be a physician that sees the patient. And the physician has to make sure the patient is tolerating the medication, check the OARRS, and make sure the patient doesn't have any sign of abusing any other drugs. And the patient must be losing 5 percent of their body weight within the first 90 days for the physician to continue that prescription.

[00:16:21] **Christopher:** Now is this only physicians or can my APP colleagues also see the patient?

[00:16:25] **Sara:** I have to re- read the law about the APP, but my pharmacist contacted the board and it was told the pharmacist cannot see the patient, it has to be physician.

[00:16:34] **Christopher:** Especially, with the collaborative practices that we have here at OSU.

[00:16:37] **Allison:** I do believe that the APPs can see the patient because they're practicing under a physician's supervision. My only two cents on the phentermine is yeah, it's very safe. It tends to be very effective. I think because it was our really our only weight loss medication that we could use historically for a long time until we started using other medications off- label. I think a number of patients have tried phentermine before in the past and because it is a stimulant, you can develop tolerance to the medication.

[00:17:06] So I think it's important if a patient has taken phentermine multiple times before in the past to just educate them that the greater number of times that they've taken it, the more likely they will have developed tolerance. So it just may not work for them. The other thing that I like about Phentermine, which Dr. Li highlighted with the different doses, is, you can prescribe it once a day, you can prescribe it twice a day, and that way it is similar to the stimulant therapy for ADHD. And so there's a lot of customization that you can do with phentermine. The last thing I will say, though, is, making sure that your patients that are on phentermine are either talking about their nutrition with you or a registered dietitian, I think is very important because the last thing you want to do is have a patient take phentermine, not eat all day, binge at night, that's not going to set them up for success in the long term. And so just making sure that they're establishing regular routine eating habits that are going to allow them to preserve their metabolism while they're on this medication is of utmost importance.

[00:18:03] **Christopher:** So you were discussing that at 90 days with Phentermine, they should have at least a 5 percent weight loss. Otherwise they fail therapy and they need to stop is that correct?

[00:18:11] **Sara:** Yeah, according to the Ohio Medical Board, if they do not lose 5 percent of body weight at 90 days, you have to stop the medication.

[00:18:17] **Christopher:** Now, there is something, I feel there's something similar to many of these weight loss medications, at least when I remember looking under how they're prescribed, like whether it's, some of the combination medications, I don't know if it has to do with how they were also tested, but then I often see 5 percent weight loss at 90 days or something similar to that.

[00:18:35] And then if that fails, then that means they fail therapy and then you stop. Is that true? Or did I just make that up in my head?

[00:18:41] **Allison:** I think 5 to 10 percent body weight loss is what's expected when patients are making lifestyle changes on their own. And so if they're not even achieving 5 percent with the addition of pharmacotherapy, then I think that's probably where that number is coming from.

[00:18:53] **Christopher:** With those close follow ups with the initial medication, if you're not making at least that goal, then maybe you should rethink what the plan should be.

[00:19:00] We're onto the last portion cause I think that is the biggest thing that people have been hearing about. Every lay person knows about it because they've seen it on Instagram. The GLP1 agonists and maybe some of the newer medications that have GLP1/GIP.

[00:19:14] They also have triple therapy with GLP1/GIP plus glucagon, which I don't really understand. Maybe let's start with from the primary care setting, because we see a lot of GLP1 because we've been doing it for years for diabetes.

[00:19:26] Often when I have the patient in that scenario where they come up to me saying, I want to be on medications for weight loss, they often say, I want to be placed on ozempic because I think it'll help my weight loss. What is your response and what are your thoughts about that.

[00:19:38] **Sara:** That's the response I get too. And I actually got a lot of portal message requesting specifically for Ozempic or Wegovy but this is where, we talked about in the beginning, I will dedicate 100 percent of these kind of patients to a dedicated weight management visit.

[00:19:52] So I try not to be like the last question that you tackle on the primary care visit. We'll schedule a visit, we'll do from the front to end, and I make no suggestion until I have address all the pillars and then at the end, I will say, okay, we have talked about everything we've talked about nutrition exercise and now moving towards the medication and then you know how Allison talked about how to choose medicine.

[00:20:14] And if I feel that based on the history, there's no contraindication. This is one of the most effective medication that we have. Then I will agree with you. I think this medication is the right one for you. We have to deal with insurance issues. But I'm willing to give this medicine a try and start, but I try not to only jump on the semaglutide or GLP 1 and really do a comprehensive weight management visit.

[00:20:38] **Christopher:** Allison, so Ozempic is semiglutide. Wegovy is semiglutide. What's the difference?

[00:20:45] **Allison:** The difference has to do with the, pharmaceutical industry and, rebranding. I can't tell you when, Ozempic or semiglutide really became a hit, in terms of the like social media. All my friends, family members are texting me, have you heard of this drug? And I'm like, yes, I've been practicing obesity medicine for a number of years now.

[00:21:05] Thank you. I have heard of Ozempic. But now I get the text. Have you heard of this medicine called Zepbound? I'm like, yes, I have heard of that. But In terms of the differences there are different pen, mechanisms, in terms of administration. So Ozempic there's a dial up mechanism. Wegovy is a single use injection pen. that, that is another difference. But I do, counsel my patients that the biggest difference is really, is your insurance going to cover it or not? And I think if there's anything that primary care providers can do to lessen portal messages and lessen headaches, initially when I first started in practice in obesity medicine, I was able to send Ozympic in under a diagnosis of insulin resistance or like impaired glucose tolerance, kind of hand wavy, like the patient's not diabetic, but they have blood sugar issues.

[00:21:48] But really in the past two years that has just not been the case. Insurance companies are really cracking down on covering these medications just because they're so expensive. You know, when I approach a GLP 1 agonist, I think the first thing I ask my patients to do if I don't already know for sure that their insurance covers a GLP 1 is I have them call their insurance and ask them and I tell them specifically ask them if your insurance covers Saxenda or Wegovy for weight loss and the reason I include Saxenda is because Saxenda was actually the first injectable GLP 1 agonist for weight loss So if an insurance formulary has not yet been updated you know, to include Wegovy, and I think most formularies probably haven't included ZepBound yet because that just, came, out in terms of approval for management of obesity. I have them call about Saxenda because that will typically be on the formulary. And generally, if Saxenda or Wegovy are covered, then you know that, ZepBound, when it's available, will also be covered because it's considered in that same tier. In terms of who should be placed on a GLP 1 agonist? I think one of the great things about these medications is you really mostly just have to worry about contraindications because they're going to pretty much help anybody lose weight. I think again the things to really counsel your patients on are why are you using this medication? What's the purpose? What's the long term plan? The data have shown that patients who stop these medications gain the weight back. And so I think, the way Dr. Li approaches her visits, where she's talking all about the lifestyle stuff first, and then, we'll talk more about GLP1 agonist therapy, is so important because patients have to realize that this is a tool to help them achieve their healthiest weight and their healthiest level of adiposity, but should not be the primary mechanism through which they achieve that. Just because again, let's say they changed jobs. Let's say they change insurance and they don't have coverage for GLP one in a couple months. What are they going to do then?

[00:23:34] So I think just making sure patients are aware of that lay of the land is very important. And then, just like with phentermine, GLP 1 agonists provide incredible appetite suppression for patients. And, it's unlike phentermine with daily dosing where it wears off by the end of the day and you can have some return of appetite.

[00:23:50] GLP 1 agonists, their duration of action is almost up to that seven day mark. They're dosed weekly, except for Saxenda. And so making sure your patients understand that again, this is not a tool to not eat. This is a tool to be able to have more time before you, make your food related decisions. And then also to be able to really understand your hunger and satiety cues and not just to totally suppress them.

[00:24:14] **Christopher:** So what are some other contraindications and side effects? I've recently seen some periop literature where they found like food still like in the system, even though the patient's been been fasting because of their GLP one and they had higher risk for aspiration. I don't know if they actually had aspiration events like those. I don't know clinically. But, can you talk a little bit about that?

[00:24:35] **Allison:** Sure, So whenever I'm prescribing a GLP 1 agonist, I talk to my patients about the path of food from mouth to anus. and I explain to them that GLP 1 is going to affect their, pretty much their entire experience. So I start with the northernmost anatomy and I say, okay. What this hormone is doing is it's causing increased satiety. If you are more satiated, it's almost like your stomach is already full. And if your stomach's already full, that can cause you to have reflux. So you may have a burning sensation in your throat. You may have, more foul breath in the morning when you wake up. So you're really needing to be aware of the fact that you are going to have those symptoms with much smaller portions when you're eating and just make sure you're understanding your new hormone regulation that your body has. And so that I think, when we're seeing these upper endoscopy reports for patients have retained food contents that is due to that you'll be one effect on the stomach. The other thing that I explained to them is, once food moves from the stomach down into the small intestine and then into the colon, I described GLP 1 slows down, motility in the gastrointestinal tract.

[00:25:37] And I hearkened back to my, first year of medical school anatomy professor who said the colon is a luxury item. Its only job is to reabsorb water. So I explained to my patients. All right, if food is going through your colon much more slowly, and your colon's whole job is to reabsorb water, that is going to make you constipated, and I think that's the biggest side effect that I see in patients, that they are constipated, they're not having bowel movements for three or four days, that makes reflux worse because the whole system's backed up, and so, I counsel my patients extensively when they first start these medications, and, I think Dr Li and I both have said multiple times how important close follow up is with these patients, but before I increase any dose, I am asking my patients.

[00:26:17] Do you have any reflux? Are you having increased belching? How often are you having a bowel movement? I pull out the Bristol stool scale. I have them describe their stool to me, and the reason why is because for them to have a successful experience on these medications, it's very important to make sure that their bowels are moving regularly.

[00:26:32] My top go to's for bowel management, I love a psyllium husk capsule that also helps increase their fiber intake, which is great. I try to stay away from Metamucil because it does have sucralose in it. and so even though it's orange and powdered and tastes good, that non nutritive sweetener, has had lots of negative health outcomes associated with it.

[00:26:49] And then I really like magnesium supplementation at night. And the reason why is because our food supply is pretty magnesium deplete because our soil is lacking the magnesium that it used to have. And then magnesium is also been shown not only to help with bowel motility, but also some relaxation and promoting sleep. So again, attacking all four pillars at once. And in terms of other severe side effects to pay attention to... patients can develop cholecystitis, pancreatitis, and the big contraindication is anybody with a history of medullary thyroid cancer, or MEN2 syndrome. I get a lot of questions, what about papillary thyroid cancer?

[00:27:26] There's no contraindication if a patient has a history of papillary thyroid cancer, again, you really just want to make sure you're aware of, family history of MEN2 syndrome and if that's an issue for your patient identify it. I recently actually had a situation where a primary care doctor reached out to me, and her patient developed cholecystitis on a GLP 1. The patient was going to go in for surgery, and she said, what do I do with the GLP 1?

[00:27:47] When these things happen for cholecystitis, I always recommend, stop the GLP 1 until the patient's able to have surgery and then see how they do post op, but then it can be safely restarted in the weeks following post op depending on how their recovery goes, but pancreatitis is definitely a hard stop for the GLP 1s.

[00:28:04] **Sara:** One additional thing to consider is that if the patient is a childbearing age woman the GOP one would need to be stopped two months in advance before trying to conceive. So that makes it a difficult choice if someone's actively trying to conceive in the near future. I also I think, read or heard anesthesia guideline that they want pre op patients these medicines to be held at least two weeks in advance.

[00:28:28] **Christopher:** Going back to the pancreatitis... so it's definitely a no go. I always wonder about this because our diabetic patients are at higher risk for pancreatitis. And so they often have pancreatitis and I always wonder if we just got their sugars under control, would they have pancreatitis? It sounds like we're in that same area with our patients with just obesity medication management.

[00:28:49] Sara from a practical standpoint, how do you initiate GLP 1, Wegovy in clinic? Is it difficult? Is it hard? What are some of the barriers you run into? What are things that help you with this titration? Because Wegovy, you increase the dose every month for like, five or six months, which is a lot of work. How do you work with it in a primary care schedule?

[00:29:08] **Sara:** Yeah, so this is where I rely on my team because I don't think I can do my job by myself. So here at OSU I'm blessed to have a really wonderful clinical pharmacist team that do collaborative management. Because of my interest in obesity medicine and also my pharmacist on my site is also interested in obesity medicine. So, she and I created this workflow where you know Once the physician does an intake visit and identify maybe a couple potential medications. So, I will place a referral to the clinical pharmacist team and I might say, you know This patient's a good candidate for semaglutide, if not covered, alternative might be phentermine or something like that.

[00:29:46] And then we've actually came to a workflow where we ask the physician not to order the medicine on that initial intake visit. And then once the patient set up an appointment with the clinical pharmacist, then clinical pharmacist actually does her own review of contraindications and make sure there's no medication interaction issues. Then during that visit, the clinical pharmacist does all the education. So we do a lot of upfront educations with how to store medication, how to inject medications, what side effects to watch out for. We do a preemptive counseling on constipation being the most prominent side effect and starting strategies to try to combat that. And the clinical pharmacist will order the medications. That way, we're able to order the correct medication, right amount of dosage, and then if the patient has the insurance plan that can do prior auth on that same day, then the pharmacist is completing prior authorization on that same day.

[00:30:42] And I have found that to be tremendously helpful because it used to be that I would place the order, the patients within a couple of days would send me saying, oh, the prior auth got denied. And I have this back and forth dreadful portal messaging encounter. But after the medicine is started, then the clinical pharmacist will have a monthly tele visit with the patient.

[00:31:03] So that during that visit, they're reviewing side effect tolerance, reviewing education again. And then if the patient is tolerating it, then they're prescribing the next dose up. And this is where the having a pharmacist who knows ins and outs of the insurance kind of a plan and how this medicine is really helpful.

[00:31:21] Because at OSU, the OSU health plan does cover semaglutide for weight loss. So I don't have to jump a lot of hoops to get those started, but there's also a lot of rules within the OSU health plan. So some of the rules are the transition dosage. The OSU health plan will only approve basically two refills. The initial one and one more refill. They don't like patient to linger on a lower dosage. My pharmacist is so knowledgeable about that, so she could be like, we need to resubmit a prior auth for this reasons, and I don't think as a primary care, I could keep track of all these healthcare insurance plan and their requirements.

[00:32:00] **Christopher:** Gotcha. All right. Last question and I appreciate so much of the time that you guys have spent with me. So what does the future of obesity medications look like? It sounds like we have these combination medications that are added on to GLP 1s. What do we have that are, like literally almost here going to be maybe covered by insurance? And what does the future look like?

[00:32:22] **Allison:** I will say I think the categories of maybe almost here and then covered by insurance definitely might not be the same thing, but I think we're going to continue to see more combinations of these peptide combinations. So, the receptor agonists related to gut hormones. I know that there's work being done in terms of like monoclonal antibodies. There's like a muscle receptor binder that's coming out. So, I think it will be interesting in the next like 5 to 10 years really to see. see, I think we're going to have an explosion of medical therapies and really the push is just going to be to advocate for our patients to have coverage for these medications. Right now the, the insurance landscape is really, these medicines are so expensive for them to cover and for them to cover them and have patients maybe not have the successful weight loss and maybe not have the reduction in medical comorbidities that are also costing these insurance companies. So, I think there needs to be some changes, not only with the insurance landscape, but also the pharmaceutical industry to really help make these medications more affordable for our entire system. But I'm excited. I'm glad that Dr Li and I are both passionate about this field of medicine, and hopefully we'll have a long road ahead of us helping our patients.

[00:33:33] **Christopher:** Thank you so much for spending time with me today. Any closing thoughts before we sign off?

[00:33:38] **Sara:** No, I just want to say this is a really exciting time to be interested in obesity medicine and I'm really looking forward to the future.

[00:33:45] **Allison:** As you're working with your patients? I think acknowledging frustration and reframing The things that they may feel like they're not being successful at as a learning and growth opportunities is really key. So if a patient comes in and they haven't lost a single pound, that is just a learning opportunity. It is just a learning opportunity to know what didn't work and try again. And I think being your patient's cheerleader, always encouraging every single step that they take, is really going to be able to help them learn to do that reframing on their own, which will guarantee their long term success.

[00:34:15] **Sara:** Just want to add to that because that's a really great thought. There's so much study coming out in obesity medicine about different phenotypes of obesity. Not every patient's going to respond to, every medicine just because semaglutide is great. Not every patient's going to respond to it. So just because one doesn't work, don't give up. Try a different one. Try different things. Don't give up.

[00:34:33] **Christopher:** Thank you guys so much. I appreciate this so much. I learned so much and I think the listeners will enjoy this as well. Thank you guys.

[00:34:40] **Sara:** Thank you. Yeah.

[00:34:41] **Allison:** Thank

[00:34:42] **Sara:** you,

[00:34:42] **Allison:** Thank

[00:34:42] **Sara:** Chris..

[00:34:42] **Allison:** Thank you.

[00:34:43] **Christopher:** So that's the end of our two part series on obesity medicine. Thank you again for listening to another episode of Everyday Medicine, a podcast from OSU's Division of General Internal Medicine. Please consider subscribing to our feed on your favorite podcasting platform so you don't miss out. You can also get our show notes and transcripts soon from our Division webpage at http://medicine.osu.edu/GIM. I have a great day. Bye.