Q&A from ADCES Industry Supported Symposium

Can tirzepatide be used as monotherapy?
Yes.

Can tirzepatide be used in adolescents?
Tirzepatide is approved for adults with T2D as an adjunct to diet and exercise. It is not known if tirzepatide is safe and effective for use in children under 18 years of age.

For how long does weight loss last? Does it reach a plateau?
In the SURPASS-2 and -3 trials, tirzepatide sustained the weight loss trajectory (kg and % weight loss) over 40 and 52 weeks better than did comparators. Weight loss at the highest dose of tirzepatide (15 mg) plateaued around 52 weeks.

What is the incidence of hypoglycemic events with tirzepatide?
Based on the mechanism of action of tirzepatide, the risk of clinically significant hypoglycemia is very low. There was a very low incidence of hypoglycemia in the SURPASS trials. The risk for hypoglycemia may be higher when tirzepatide is taken with another medicine that can cause low blood glucose levels, such as a sulfonylurea or insulin.

Is tirzepatide only for people with diabetes?
Tirzepatide is currently approved for adults with T2D as an adjunct to diet and exercise.

How can I explain to my patients how tirzepatide works?
Tirzepatide increases the effect of two hormones that result in slowed gastric emptying. Patients feel full faster and thus eat less.

Will tirzepatide be marketed as a weight loss medication for obesity in patients who do not have diabetes?
Tirzepatide is being evaluated in ongoing clinical trials of T2D (SURPASS), obesity with and without diabetes (SURMOUNT), nonalcoholic steatohepatitis (SYNERGY), and heart failure (SUMMIT).

How do you think about weight regain with removing tirzepatide and lifelong treatment with tirzepatide?
This has not been assessed in clinical trials, and so it is not currently known.

How is tirzepatide different from GLP-1RAs?
Tirzepatide is a single molecule that activates the body's receptors for glucose-dependent insulinotropic polypeptide (GIP) and glucagon-like peptide-1 (GLP-1). It is the first FDA-approved unimolecular dual agonist for T2D.

I have a patient who is a nondiabetic who has asked me if there is a study that she can participate in to get tirzepatide?
Tirzepatide is being evaluated in ongoing clinical trials of T2D (SURPASS), obesity with and without diabetes (SURMOUNT), nonalcoholic steatohepatitis (SYNERGY), and heart failure (SUMMIT). Patients and clinicians can search https://clinicaltrials.gov/ for studies of tirzepatide that are recruiting participants.

If a patient is already taking semaglutide or dulaglutide at a high dose, what dose would you recommend starting tirzepatide at? The lowest dose (2.5mg) or at 5mg?
The FDA-approved starting dose is 2.5 mg. The dosage can be increased in 2.5-mg increments every 4 weeks.

How do you talk about social determinants of health (SDOH) without offending someone?
Some patients are very sensitive about discussing SDOH and their personal circumstances. Begin by building rapport with the patient and asking permission.

(Cont'd)

There are different ways to bring it up, but you always have to be sensitive to patients' needs and respect their boundaries.

Once you have the patients' permission, you might ask: Do you have problems affording food or medication? Have you missed appointments because of lack of transportation? It is very important to empathize and show respect regarding an individual's circumstance.

How should I talk with my patients about changing their medication?

Collaboration between the provider and patient is key, and shared decision making is a helpful tool. A thorough assessment of why a medication change is being considered should be conducted, including the implications of making a change. Discussions should include the risks and benefits of the current medication compared with those of the medication the patient wants to change to, side effects, cost, etc.

Some PCPs won't prescribe novel therapies. How can we overcome their inertia?

This is an issue that can't necessarily be resolved in just one conversation but can be approached in two ways: With anything new, there must be an ample amount of education with opportunities for questions and answers. The goal is to allow the provider to become familiar, and even comfortable, with the new therapy. Secondly, we need have respectful conversations to get to the root of why the provider is opposed to the new therapy. You may not see what the provider sees when he or she is caring for patients, and there could be a barrier that with more dialog, education, and resources could be reasonably overcome.

Sometimes new medications are not discussed because of a lack of staffing to do a prior authorization (PA). Is this considered an unconscious bias?

Yes, and a lack of education. With rapid changes in healthcare and the payor system, it is impossible for us to know the coverage for each individual patient. If a PA is needed, knowing how to go through the process efficiently will save time. Your local pharmacist is a great resource to help with the process and assist with navigating any barriers that may arise.

When prescribing medications for weight loss, are providers/pharmacists discussing that these medications are meant to be taken long term? I've had so many patients who think they will get off medication once their weight loss goal is achieved.

Chronic diseases (eg, hypertension, diabetes, obesity) are lifelong journeys that require lifestyle changes. The patient needs to understand that the interventions that brought them to their desired goal will normally have to be continued to maintain the goal. In some cases, patients have been able to discontinue medications, but that may not be possible for every patient. Successful cessation of therapy usually comes after the patient has maintained the desired outcome for some time and the provider feels the patient will maintain lifestyle modifications. The best way to ensure the appropriate route is taken for the patient is keeping the lines of communication open and practicing shared decision making.

The FDA has approved medications for both short-term (≤12 weeks) and long-term (>12 weeks) weight management as adjuncts to diet, exercise, and behavioral therapy. Providers should be knowledgeable about the therapy and balance the potential benefits of successful weight loss against the potential risks of the medication for each patient. Weight gain after discontinuing tirzepatide and lifelong treatment with tirzepatide have not been assessed in clinical trials.

Would gastroparesis or gallbladder disease be contraindications for GLP-1RAs?

GLP-1RA trials and post marketing studies have reported acute gall bladder disease such as cholelithiasis or cholecystitis. In the event cholelithiasis is suspected, patients should have appropriate clinical follow-up and diagnostic studies.