ECG Clinical PGD FAQs - Weight Management v3.0

(Updated to include Wegovy 7.2 mg escalation pathway)

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1. Can I continue prescribing weight loss medication to an existing patient after switching to the ECG weight management PGD?

Yes, provided the patient is **eligible for treatment** under ECG's PGD.

You must:

- Clearly **document the switch** in the patient's notes, including:
  - which PGD was used previously (provider, version, and date)
  - the date the switch was made
  - confirmation that the patient meets ECG's inclusion/exclusion criteria

Please note that if the patient now falls outside ECG criteria that were eligible under the previous PGD, you may continue supplying treatment only **until the old PGD expires.**

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2. Can patients switch providers during treatment?

Yes, but you must carry out a **full consultation** (via video-call or in person). This ensures professional accountability and confirms that the patient meets ECG's inclusion/exclusion criteria, which may differ from their previous provider's.

You must:

- Verify the patient's starting BMI - acceptable evidence includes a dated photo, health records, or confirmation from previous provider
- Verify the patient's current dose using a dispensing label or screenshot of the last supply dated within the last eight weeks
- Document starting BMI and dose, including the method of verification
- Make an **independent clinical decision** based on your current PGD - you must not rely on another provider's clinical judgement

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3. Can patients switch between Mounjaro and Wegovy?

Yes. However, if more than 12 weeks have passed since the patient's last dose of the original medication, they must meet the **BMI eligibility criteria** for initiation of therapy. This is considered a new treatment episode. If their last dose was within the last 12 weeks, this does not apply, provided they met the criteria at the start of their initial treatment and this is clearly documented.

As the two drugs have a similar half-life and require weekly dosing, **a 7-day interval** is required between the last dose of the old drug and the first dose of the new.

Dose escalation when switching therapies

Best practice to restart titration from the lowest dose of the new drug.

Mounjaro's additional GIP mechanism reduces the gastrointestinal side effects typically caused by GLP-1 drugs. This means that patients switching **from Mounjaro to Wegovy** are at high risk of nausea/vomiting if they begin at a high dose.

Re-titration rarely causes a significant stall in weight loss progress, and restarting at the lowest dose may help **prolong treatment effectiveness**, supporting better long-term weight loss outcomes.

Some providers may choose to use **dose conversion** instead. This is usually tolerated and may only result in a short period of increased nausea. However, if this approach is taken, the decision must be based on **individual clinical judgment** and clearly documented in the patient's notes. Dose conversion guidance is provided below.

Switching from Wegovy to Mounjaro – Recommended Starting Doses

Last Tolerated Wegovy Dose	Mounjaro Starting Dose
0.25 mg	2.5 mg
0.5 mg	5 mg
1 mg	7.5 mg
1.7 mg	10 mg
2.4 mg	12.5 mg
7.2 mg	15 mg

Switching from Mounjaro to Wegovy - Recommended Starting Doses

Last Tolerated Mounjaro Dose	Wegovy Starting Dose
2.5 mg	0.25 mg
5 mg	0.5 mg
7.5 mg	0.5 mg
10 mg	1 mg
12.5 mg	1 mg
15 mg	1.7 mg

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4. How long can patients continue weight loss treatment?

There is **no maximum duration**. Discontinuation often leads to weight regain within a few months, so long-term use is generally recommended if the patient remains clinically well. Most patients' weight loss will plateau well before reaching underweight ranges.

- **If BMI <22.5 kg/m^2:** Consider reducing to the lowest effective maintenance dose.
- **If BMI <20 kg/m^2:** Treatment should be stopped, as risks may outweigh benefits.

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5. Can patients escalate from 2.4 mg to 7.2 mg Wegovy under the PGD?

Yes. The updated PGD allows eligible patients to escalate their dose to 7.2 mg once weekly. This dose was administered as three consecutive injections of 2.4 mg during the same weekly dosing session.

Escalation must only occur after a full clinical assessment, confirming suitability.

The 2.4 dose must have been used for at least four consecutive weeks, with good tolerance and no ongoing adverse effects.

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6. Which patients are eligible (and not eligible) to increase to 7.2 mg Wegovy?

The dose can be increased to 7.2 mg **only if ALL** of the following are met:

- **Clinical justification**: Weight loss has stalled or significantly slowed, or the patient's current weight loss trajectory indicates they are unlikely to lose 5% of their initial weight within 12 weeks on the 2.4 mg weekly dose.
- The patient has completed at least 4 consecutive weeks at 2.4 mg with good tolerance (required by SPC)
- The patient reports no ongoing moderate or severe gastrointestinal symptoms at the 2.4 mg dose.
- The patient has no dysaesthesia (abnormal/unpleasant nerve sensations) at the 2.4 mg dose. (A significantly increased incidence of dysaesthesia was observed in patients taking 7.2 mg compared with 2.4 mg in STEP UP Trials)
- The patient is willing and able to safely administer three consecutive injections on the same day each week, using a new needle for each injection, and spacing injections ≥5 cm apart.

DO NOT escalate the dose to 7.2 mg if ANY of the following are present:

- Any unresolved GI adverse effects at 2.4 mg (e.g., nausea, vomiting, diarrhoea, constipation).
  (7.2 mg increases GI adverse event frequency)
- Any sensory symptoms at 2.4 mg, including burning, tingling, skin pain or hypersensitivity.
  (Dysaesthesia is dose-dependent and significantly higher at 7.2 mg)

- Any recent illness causing dehydration or reduced fluid intake.
- The patient is awaiting a procedure requiring general anaesthesia or deep sedation within the next 4 weeks.
  (Higher doses increase delayed gastric emptying → aspiration risk)

If the patient develops significant GI symptoms, dysaesthesia or dehydration at 7.2 mg:

- Immediately de-escalate back to 2.4 mg
- DO NOT attempt re-escalation until symptoms have fully resolved

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7. Can patients take 4.8 mg (two injections) as a "stepping stone" to the 7.2 mg dose?

No. The SPC does not provide any flexibility for this approach, so using a 4.8 mg dose as a stepping stone would be considered off-license, and is therefore not permissible under the PGD.

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8. PGD Exclusions - Patients with obesity caused by an endocrinological disorder.

This PGD exclusion is based on **regulatory requirements**. In patients with underlying endocrinological conditions, **weight loss during treatment may be reduced**. As a result, these patients may be **less likely to achieve the 5% weight loss threshold** required for continued use of weight loss medications*. With the greater efficacy of Mounjaro and Wegovy compared to older medications, this is often **not a significant clinical issue**. However, it may still impact the **speed and extent of weight loss**.

This exclusion specifically refers to cases where the **primary cause** of weight gain is the **endocrinological condition**. In some cases, even when patients have conditions such as polycystic ovarian syndrome (PCOS) or Cushing's syndrome, these factors may only contribute to weight gain rather than cause it.

To determine whether the exclusion applies, consider the following questions:

1. **Did the condition *cause* the weight gain? -** If the patient was already overweight before diagnosis, it's likely that the condition is not the primary cause, and the exclusion may not apply.
2. **Is the condition still causing weight gain? -** If the patient's weight has stabilised and they are no longer gaining weight, GLP-1 treatment may still be effective.

3. **Does the patient achieve the required weight loss within the time frame*? -** If the patient loses at least 5% of their starting weight within the relevant time frame, they are considered a responder and can continue treatment, regardless of underlying conditions.

**Mounjaro and Wegovy have a 6-month window in which patients must achieve ≥5% weight reduction. For Saxenda and Mysimba, the window is 12 weeks at the therapeutic dose (usually 16 weeks after initiating treatment, including the dose escalation period). The window for Orlistat is 12 weeks.*

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9. My patient has a history of gallstones, cholecystitis, or cholecystectomy – can I prescribe a GLP-1?

Under the PGD, the following apply:

- **Current gallstones or cholecystitis:** Excluded.
- **Cholecystectomy:** Not excluded, provided surgery was >3 months ago and no GI symptoms persist.
- **History of cholecystitis with no current gallstones:** Not excluded.

While GLP-1 medications are not contraindicated in these patients, there is a **higher risk of gallstone formation or recurrence**. Therefore, patients should be **advised to maintain good hydration**, especially during periods of rapid weight loss, to help reduce this risk.

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10. My patient takes metformin. Can I initiate GLP-1 treatment?

Yes. GLP-1 receptor agonists can be safely used with metformin, provided the patient meets other PGD criteria. No additional blood glucose monitoring is required unless the patient is also on insulin or sulfonylureas.

Always inform the GP (with consent) to support continuity of care. Ensure GI symptoms from metformin have stabilised before starting, as overlapping side effects may reduce adherence.

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11. Why does the PGD exclude patients over 75?

This decision has been made by ECG's independent medical advisory team, in line with patient safety priorities and substantial clinical evidence, which indicates that the risk of severe adverse events is significantly increased in elderly and/or frail patients.

- **Malnutrition and dehydration** are both more likely and more problematic in older adults. Serious complications arising from dehydration, such as **kidney failure, gall bladder problems, pancreatitis and cardiac problems**, are much more common in the elderly when using these medications. Even the common GI side effects seen with these medications are often much more severe in older people and can become debilitating.
- Additionally, while patients lose fat rapidly, **they also often lose a significant amount of lean mass (muscle and bone density)**. This is relatively easy for a younger person to recover from, but studies show that recovery is slower and more difficult after the age of 70-75, particularly for women.
- Muscle wastage increases the risk of **falls**, and loss of bone density increases the risk of **serious fractures**. Recovery is often slow, and long-term disability is more likely, leading to reduced quality of life. In clinical practice, we have seen patients in their early 70s become quite frail whilst on medication, resulting in the decision to discontinue treatment.

There is a lot of variation in the general health/frailty of one 75-year-old compared with another, and we understand the frustration that a fixed threshold can cause. However, PGDs must set the threshold somewhere. As community pharmacies are unable to provide the degree of patient monitoring needed to ensure safety in this patient group, our PGD errs on the side of caution.

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12. Why are patients with hepatic impairment excluded?

Patients with hepatic impairment are excluded due to the **challenges of accurately assessing and classifying liver function** in community pharmacy and private clinic settings. Even when medical records are available, it is often difficult to determine whether liver impairment is **mild, moderate, or severe** unless a consultant has clearly documented this.

In addition, some weight loss medications can occasionally cause **elevations in liver enzymes**. While this is usually not a concern in patients with normal liver function, patients with existing hepatic impairment require **additional monitoring**.

For safety reasons, patients with liver impairment should be managed under the supervision of their **GP or specialist consultant**, where appropriate monitoring and dose adjustments can be made if necessary.

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13. My patient has a history of bariatric or bowel surgery. Can I prescribe GLP-1 treatment?

Yes, if surgery was >3 months ago and there are no ongoing GI symptoms. However, dose escalation should be approached cautiously:

- Delay escalation until GI side effects such as nausea, bloating and diarrhoea have resolved
- Consider maintaining a lower dose if weight loss is ongoing
- Maximum dose escalation is not always necessary. Patients can remain on any tolerated dose provided they achieve ≥5% weight loss within 6 months.

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14. Why does the PGD exclude patients with type 1 diabetes and patients with type 2 diabetes taking insulin and/or sulfonylureas?

GLP-1s are not contraindicated but carry safety risks when used in conjunction with insulin and/or sulfonylureas. Due to an increased risk of hypoglycaemia, safe use requires close monitoring and dose adjustment by a specialist team. Therefore, treatment under this PGD is neither safe nor appropriate.

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15. How do I know whether a patient's renal impairment is severe?

Severe renal impairment is defined as an **estimated glomerular filtration rate (eGFR) of less than 30 mL/min/1.73m^2**. If your patient's most recent eGFR result is close to this threshold and is more than 3 months old, a **repeat test should be arranged before initiating treatment** to ensure it is safe to proceed.

If treatment is started, **advise the patient on maintaining adequate hydration**, especially in those with chronic kidney disease (CKD), as they are at higher risk of **acute kidney injury** and other complications related to dehydration.

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16. Can I supply extra medication for holidays or stock-up?

Monthly monitoring is required, with a maximum 4-week supply per consultation. Stockpiling (e.g. due to price changes) is not permitted.

To cover patient holidays, you may bring forward the patient's next appointment by a few days so they can collect their next month's supply before travel. This must be clearly documented in the notes.

17. Under a PGD, can supply be made by someone other than the healthcare professional who carried out the consultation?

No. The same healthcare professional must:

- Assess the patient's suitability
- Make the decision to supply
- Personally supply/administer the medicine

These steps cannot be divided between different healthcare professionals for the same episode of care.