The Management of Obesity for Appropriate Individuals: Sample Questions and Answers

Recently, there has been significant interest from the healthcare community regarding anti-obesity medications (AOMs). In an effort to provide you with the information you need to answer any questions you encounter, we have created these sample Q&As. The topics covered include

- What is the return on investment (ROI) for AOMs?
- What role does the prior authorization (PA) process play in AOM prescriptions?
- What is the typical duration for an employee/member to be on AOM therapy?
- What does formulary coverage for AOMs look like today?
- What is important when you look at modeling by the pharmacy benefit manager (PBM)?
- Is it worth it for employers with higher turnover to offer their employees AOMs?

Q1. What is my ROI?

Providing a precise ROI when adding AOM coverage is challenging because it can be very difficult to calculate the associated direct medical and indirect cost offsets over time. If you want to have this modeling performed for your organization, please contact a Novo Nordisk Account Manager. The fastest growing obesity categories are Class II and III obesity.[1,2] These patients may often suffer from multiple comorbid conditions and costly healthcare. These patients represent a potential opportunity for an impactful ROI. However, it is still important to remember that healthcare providers should be focusing on treating appropriate patients with all classes of obesity, since obesity is a chronic and progressive disease.[3,4] However, tools and resources exist to demonstrate potential benefits in a real-world setting. Please contact your Novo Nordisk Account Manager for further details.

Q2. How should a weight-loss strategy and a medical weight-management strategy differ?

It's important to reverse the nationwide trend of increased obesity among individuals and embrace what works. In order to begin to reverse the trend, a comprehensive strategy and plan of action to manage excess weight is required. By providing coverage of AOMs and wellness strategies, medical and Rx coverage policy criteria often combine typical weight-loss approaches with more comprehensive medical solutions. It is important to have both a weight-loss engagement model to address prevention and mitigation of migrating patients and a medical-strategy policy to support those individuals for whom diet and exercise have not been effective. Providing coverage of AOMs as part of an integrated platform of behavioral modification, nutrition counseling, and overall well-being can give members with obesity the assistance they need.

Q3. How does the PA process control for inappropriate or excessive AOM prescriptions?

PA criteria assure appropriate prescription refills and quantity limits are satisfied and provide a safeguard to align with label indications and to ensure that prescriptions are given to appropriate adult patients with an initial body mass index (BMI) of 30 kg/m^2 or greater (obesity) or 27 kg/m^2 or greater (overweight) in the presence of at least 1 weight-related comorbid condition (eg, hypertension, type 2 diabetes mellitus, or dyslipidemia).

Q4. What is the true mix (market basket) of AOMs that are used in the market and how does that affect the blended cost for the category?

It's important to consider the mix of AOMs and available generic AOMs to determine blended cost, cost savings, and impact on per member per month (PMPM) costs.

Q5. My organization offers behavior modification solutions for people with obesity but our employees are not using this benefit. What can we do?

Studies show that wellness programs alone are often insufficient to help employees with obesity, and employees may be aware of these findings.[5] However, existing behavior modification program utilization may be encouraged because AOMs should be used in conjunction with or as an adjunct to a reduced-calorie diet and increased physical activity. Providing coverage for AOMs, in addition to wellness programs, can give employees/members with obesity who require medical weight management the assistance they need.

Q6. What percentage of my employees/members should I expect to use AOMs?

It's difficult to model the projected total use of AOMs in an employee/member population because, at present, data indicates they are prescribed to only a small proportion of the eligible population. For instance, one study showed that AOMs are prescribed to only 3% of the eligible population.[6,7] Plus, about 20% of AOMs prescribed are branded, based on latest AOMs utilization (IQVIA) data. Since 20% of AOM utilization is branded, and given 3% prevalence of use, only 0.6% of a population is expected to be using branded AOMs.[6,8]

Q7. How long is an employee/member expected to be on AOM therapy?

As with many types of treatments, the length of time an employee/member will require medication varies, depending on many factors such as the type of medication and the physician-patient selected approach.

Q8. What does the average PMPM spend for branded AOMs look like (low to high)?

The average PMPM spend for AOMs is approximately $0.85 to $1.08, depending on the utilization management that is employed. The average PMPM spend for diabetes drugs is $12.22.[8] This number for branded AOMs is driven by patients who are prescribed AOMs and the small number of physicians who prescribe AOMs.[6]

Q9. What does formulary coverage for AOMs look like today?

As of now, AOMs are covered by top payers as a result of full formulary review—clinical, safety, and economic analyses.[8] A recent analysis presented at the 2022 Professional Society for Health Economics and Outcomes Research (ISPOR) showed that AOMs provide more relative value than other covered formulary classes (migraine, etc). Despite this, many AOMs are not covered by top payers.

Q10. Is it worth it for employers with higher turnover to offer their employees AOMs?

In today's job market, employers are finding it increasingly difficult to draw in the best possible employees. Employers can consider whether providing coverage for AOMs may help make them stand out in the eyes of prospective employees. In addition, it is hard to predict which employees will remain at a company and which ones will leave; therefore, providing access to coverage for AOMs continues to make sense to employers considering the high degree of indirect costs associated with obesity.

References: 1. Centers for Disease Control and Prevention. National Center for Health Statistics. *Health, United States, 2019* [supplement]. Accessed July 5, 2022. https://www.cdc.gov/nchs/data/hus/2019/026-508.pdf **2.** Centers for Disease Control and Prevention. National Center for Health Statistics. Prevalence of obesity and severe obesity among adults: United States, 2017–2018. NCHS Data Brief No. 360. Published February 2020. Accessed July 5, 2022. https://www.cdc.gov/nchs/products/databriefs/db360.htm **3.** Bray GA, Kim KK, Wilding JPH; World Obesity Federation. Obesity: a chronic relapsing progressive disease process. A position statement of the World Obesity Federation. *Obes Rev*. 2017;18(7):715-723. **4.** Mechanick JI, Garber AJ, Handelsman Y, Garvey WT. American Association of Clinical Endocrinologists' position statement on obesity and obesity medicine. *Endocr Pract*. 2012;18(5):642-648. **5.** Jinnett K, Kyle T, Parry T, Stevenin B, Ramasamy A; ACTION Steering Group. Insights into the role of employers supporting obesity management in people with obesity: results of the national ACTION study. *Popul Health Manag.* 2019;22(4):308-314. **6.** Saxon DR, Iwamoto SJ, Mettenbrink CJ, et al. Antiobesity medication use in 2.2 million adults across eight large health care organizations: 2009-2015. *Obesity*. 2019;27(12):1975-1981. **7.** Elangovan A, Shah, Smith ZL. Pharmacotherapy for obesity-trends using a population level national database. *Obes Surg*. 2021;31:1105-1112. 8. Data on file. Novo Nordisk Inc.; Plainsboro, NJ. **8.** Evernorth. Accessed August 26, 2022. www.evernorth.com/drug-trend-report/trend-by-plan-type