From:	SAMANTHA K PABICH
To:	ETF SMB Board Feedback
Cc:	tricia.sieg@etf.wisc.gov
Subject:	Feedback on anti-obesity medications from the Wisconsin Obesity Society
Date:	Tuesday, July 2, 2024 12:04:25 AM
Attachments:	ETF Summer 2024.pdf

Dear ETF Board Members,

Please see this letter from the Wisconsin Obesity Society with information for your consideration regarding anti-obesity medications.

Warm regards,
Sam Pabich, MD, MPH

To: Employee Trust Fund Board

From: Wisconsin Obesity Society

Date: July 1, 2024

To our partners in promoting the health of the people of Wisconsin,

We are Obesity Medicine specialists who advocate for cost-effective care of obesity, a chronic disease that directly leads to dozens of other comorbid conditions, in hopes of preventing long-term morbidity and mortality, containing medical costs, and improving the quality of patients' lives.

We have been supportive of ETF's addition of anti-obesity therapies, and have advocated for taking reasonable steps to add coverage for AOMs in a tiered fashion, so that more affordable therapies are offered to most people, and newer, more effective, and more costly therapies are (initially) offered to those who have late-stage disease or cannot take the other medications. We have been disappointed that this strategy was not considered in past cost-benefit analysis.

We have also become aware of additional concerns that stemmed from the previous analysis, and write today to address these:

- It was reported in a Blue Cross Blue Shield study[1] that only 70% of patients continued a GLP1 agonist medication past the first 4-6 weeks. While this may be the case, in many instances, the patient has not chosen to discontinue the medication, but had not been able to fill it due to cost restriction, insurance change, or product availability. That study assessed patients on weight management GLP1 medications between 2014-2023. For the duration of 2014-2022, Saxenda was the only GLP1 agonist for weight management on the market, and therefore the results are almost certainly skewed toward a typical patient experience with Saxenda (which is both less effective and less tolerated than its newer counterparts). Below, we present the discontinuation rates reported in the landmark clinical trials for the

[1] Gleason, Patrick P., Benjamin Y. Urick, Landon Z. Marshall, Nicholas Friedlander, Yang Qiu, and R. Scott Leslie. "Real-world persistence and adherence to glucagon-like peptide-1 receptor agonists among obese commercially insured adults without diabetes." *Journal of Managed Care & Specialty Pharmacy* (2024): 1-8.

medications, and also, from our personal experience, estimates of patient-driven discontinuation from surveyed WOS clinicians:

Name of Medication	Discontinuation reported in applicable clinical trials:	Estimated patient-driven discontinuation rate within 6 months	Additional reasons for discontinuation
Phentermine	44% for Qsymia (CONQUER)	10-30%	Many clinicians prescribe phentermine and topiramate separately to reduce cost. Some clinicians discontinue Phentermine after 90 days as this becomes "off-label" per the FDA.
Topiramate		20-40%	
Naltrexone-Bupropion	49% (COR1)	50-90%	
Liraglutide	29% (SCALE)	20-30%	
Semaglutide	7% (STEP1)	10-15%	Often stopped due to inability to obtain medication (insurance, cost, availability).
Tirzepatide	7% (SURMOUNT 4)	5-15%	Often stopped due to inability to obtain medication (insurance, cost, availability)
Orlistat		50-100%	

- Utilization management: concerns have been raised that "casual users" who are seeking to use medications for cosmetic benefits will cause a large increase in cost to the state, but will not yield benefits to patients' health, and will not result in return on investment through medial events prevented. A very reasonable step to address this concern would be first to make medications available only to those who have medical comorbidities.

The Wisconsin Obesity Society does support the idea that all obesity has the potential to cause harm in time. Therefore our top recommendation would be to allow coverage of anti-obesity medications to all patients with obesity.

However, if budgetary constraints require triage decisions, we recommend prioritizing coverage for some of our most afflicted patients: covering some would be preferred to covering none. With this strategy, we would recommend re-evaluation of coverage expansion at a given time point with

the hope that eventually all patients with obesity will have access to these medications in an early, preventive manner. The cost of these medications will likely decrease in time as more new medications and generics enter the market, increasing competition.

- Real World Logistics: To effectively institute medication coverage based on comorbidity, clinician education and transparency are imperative. This might be accomplished with information on a web page.

  An reasonable menu of treatment options might include:

Available to All:
-Generic combinations of Phentermine/Topiramate (approximating Qsymia)
-Generic combinations of Naltrexone/Bupropion (approximating Contrave)
-consider option for generic Liraglutide
-Consider option for brand-name Qsymia (Phentermine-Topiramate)

Available to Some: Would suggest that ETF choose either Semaglutide (Wegovy) or Tirzepatide (Zepbound) based on negotiated cost. Liraglutide (Saxenda) is considerably less effective, and therefore a less efficient choice.

Criteria for Use:
-Coronary Artery Disease based on history of MI, revascularization or CABG)
-History of Ischemic stroke
-Peripheral artery disease based on ABI<0.84 or history of amputation
-F3/F4 Liver Fibrosis based on Hepatic Elastography or biopsy
-Obesity Hypoventilation Syndrome based on daytime hypercapnia during wakefulness.
-Obstructive Sleep Apnea

Option for case consideration:
-If treating clinician believes the patient is likely to die from obesity-related comorbidity in the next 5 years.

Medications should be discontinued if patient does not lose at least 5% of their weight after 6 months of taking the maximum tolerated dose of medication.

Thank you for your consideration of this information. We would appreciate an opportunity to answer any questions you might have, or provide you with more information on our real-world experiences with these medications. If possible, we would request a hybrid in-person/virtual meeting with the ETF board in the next 30 days, in preparation for your August board meeting.

Best Regards,

The Wisconsin Obesity Society

This letter was approved by a quorum at meeting on June 27, 2024

https://www.wisconsinobesitysociety.org/

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July 9, 2024

Dr. Samantha Pabich
skpabich@medicine.wisc.edu

Dear Dr. Pabich,

Good to you hear from you again and thank you for sending the memo from the Wisconsin Obesity Society.

At the August 14, 2024, Group Insurance Board (Board) meeting the Board will hear an informational presentation with the current working title of, "Weight-Loss Drugs Analysis and Coverage Considerations." The Board will not vote on anything regarding weight-loss drug coverage at the August 2024 meeting.

The Board will receive the Wisconsin Obesity Society's July 1st letter in the packet of Board Correspondence each Board member receives before the August 14, 2024, meeting.

Again, thank you for your email. Please continue to share any information about weight-loss drugs you think the Board and/or I would benefit from knowing. I was very interested in reading your comments to Navitus about adding Wegovy coverage for the prevention of MACE in patients with cardiovascular disease and obesity but not pertaining to treatment of the obesity without cardiovascular disease.

Sincerely,

Tricia Sieg
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