ABSTRACT · OBESITYWEEK 2026

Clinical Eligibility and Coverage Gaps for GLP-1–Based Receptor Agonists in Patients with Obesity

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ABSTRACT

Background

The FDA has approved GLP-1–based receptor agonists (GLP-1–based RAs) for weight management. Treatment guidelines recommend these medications as first-line therapies in adults with obesity or overweight who have or are at high-risk for obesity related complications (ORCs). This study characterizes coverage patterns and prior authorization (PA) outcomes for a U.S. national cohort of commercially insured adults seeking on-label GLP-1–based RAs for weight management.

Methods

This retrospective observational study used de-identified clinical and insurance data from a telehealth platform. Adults aged 18–63 who met clinical criteria (BMI ≥27.0 and <30.0 kg/m² with ≥1 ORC or BMI ≥30.0 kg/m²) and completed medication-specific verification of benefits (VOB) for GLP-1–based RAs from January 1 to September 30, 2025 were included. VOB results were categorized as coverage without PA, coverage with PA, plan exclusion, or indeterminate. PAs were submitted when VOB indicated possible coverage, with outcomes observed through October 30, 2025. Results were summarized by medication, payer/pharmacy benefit manager (PBM), region, demographics, and clinical characteristics.

Results

Among 225,000 randomly selected patients, 35.7% had coverage with PA for semaglutide and 31.1% had coverage with PA for tirzepatide; coverage without PA was uncommon (3.7% and 2.8%, respectively, Fig. 1). Around a quarter (27.0%) of VOBs for each medication were indeterminate. Among 69,462 patients with treatment-initiation PA submissions, 53.2% were approved, 35.7% denied, and 11.2% unknown. Leading denial reasons were plan exclusions or coverage limitations (51.1%), unmet clinical eligibility criteria (24.7%; e.g., BMI, diagnosis, or comorbidity criteria), and unmet therapy requirements (12.7%; e.g., prior medication trial or other therapy-related criteria). Patients with BMI 27.0–29.9 kg/m² and ≥1 ORC had the highest overall denial rates among BMI groups (38.7%), with 41.7% of those attributed to clinical eligibility criteria not being met. Plan exclusions/coverage limitations were most common among those with BMI ≥40.0 kg/m² (56.7%). Across VOB and PA outcomes, there was greater variation by payer/PBM and region than by patient demographics or measured clinical characteristics.

Conclusions

Among clinically eligible, commercially insured adults seeking GLP-1–based RAs through telehealth, access was constrained by plan exclusions and PA requirements. Coverage without PA was rare, and more than one-third of initial PAs were denied. Findings indicate a potential incongruity between treatment-eligible patients and real-world access. This highlights a gap in understanding coverage and authorization processes when supporting clinically eligible patients seeking standard-of-care obesity treatment. Future studies are needed to better understand benefit-design and policy strategies to reduce barriers to standard-of-care obesity treatment.

POSTER

Clinical Eligibility and Coverage Gaps for GLP-1-Based Receptor Agonists in Patients with Obesity

Background

Obesity affects more than 100 million (40.3%) U.S. adults[1] and is associated with increased risk of numerous obesity-related complications (ORCs).[2–4] The FDA has approved GLP-1-based receptor agonists (GLP-1-based RAs) for weight management. Treatment guidelines recommend these medications as first-line therapies in adults with obesity or overweight who have or are at high risk for ORCs.[5] However, access to these therapies is often limited by insurance coverage policies, including prior authorization (PA) requirements.[6,7]

Despite increasing demand, limited real-world evidence exists characterizing insurance coverage patterns, PA outcomes, and reasons for coverage denials among patients seeking GLP-1-based RAs for weight management. This study characterizes coverage patterns and PA outcomes, including denial reasons, for a U.S. national cohort of commercially insured adults seeking on-label GLP-1-based RAs for weight management.

Methods

This retrospective observational study used de-identified clinical and insurance data from Ro, a nationwide telehealth platform, including patient-reported intake data, laboratory data (when available), and insurance verification and authorization records. Commercially insured adults aged 18–63 who were determined to be clinically eligible for treatment (BMI ≥27.0 and <30.0 kg/m^2 with ≥1 ORC or BMI ≥30.0 kg/m^2), had no evidence of type 2 diabetes, and completed medication-specific verification of benefits (VOB) for GLP-1-based RAs (semaglutide and tirzepatide) from January 1 to September 30, 2025 were included. VOB results were categorized as coverage without PA, coverage with PA, plan exclusion, or indeterminate.

Initial PAs were submitted when VOB indicated possible coverage or required additional review, with outcomes observed through October 30, 2025 and categorized as approved, denied, or unknown. Denial reasons were grouped into predefined categories based on structured insurance authorization records. Results were summarized by medication, payer/pharmacy benefit manager (PBM), region, demographics, and clinical characteristics.

Authors

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Affiliations

Authors Smith, Broffman, Chai, Manalac, Iscowitz, Strait, DiGilio, and Given are current employees of Roman Health Ventures, the telehealth platform that supplied data for this study. Kyle is the founder of ConscienHealth and a paid advisor to Roman Health Ventures. Tchang is an associate professor of clinical medicine at Weill Cornell Medicine and a paid advisor to Roman Health Ventures. Wang and Orroth are employees of Amgen, the sponsors of this study.

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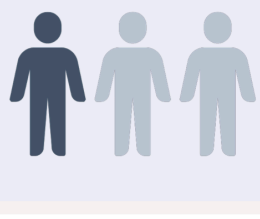
Key Findings

Out of a sample of 225,000 clinically eligible, commercially insured adults seeking GLP-1 RA treatment for overweight or obesity:

Only 3%
Had coverage that did not require a prior authorization



1 out of 3
Prior authorizations were denied



Only 1 out of 5
Had access through insurance



Results

Sample characteristics are depicted in Figure 1. Among 225,000 randomly selected patients, 35.7% had coverage with PA for semaglutide and 31.1% had coverage with PA for tirzepatide; coverage without PA was uncommon (3.7% and 2.8%, respectively, Figure 2). Around a quarter (27.0%) of VOBs for each medication were indeterminate.

Among 69,462 patients with treatment-initiation PA submissions, 53.2% were approved, 35.7% denied, and 11.2% unknown. Leading denial reasons were plan exclusions or coverage limitations (51.1%), unmet clinical eligibility criteria (24.7%; e.g., BMI, diagnosis, or comorbidity criteria), and unmet therapy requirements (12.7%; e.g., prior medication trial/step therapy). Patients with BMI 27.0–29.9 kg/m^2 and ≥1 ORC had the highest overall denial rates among BMI groups (38.7%), with 41.7% of those attributed to clinical eligibility criteria not being met. Plan exclusions/coverage limitations were most common among those with BMI ≥40.0 kg/m^2 (56.7%), suggesting the highest need patients have the worst access.

Across VOB (Figure 3) and PA outcomes, there was greater variation by payer/PBM and region than by patient demographics or measured clinical characteristics.

Figure 2: Coverage and PA Outcomes

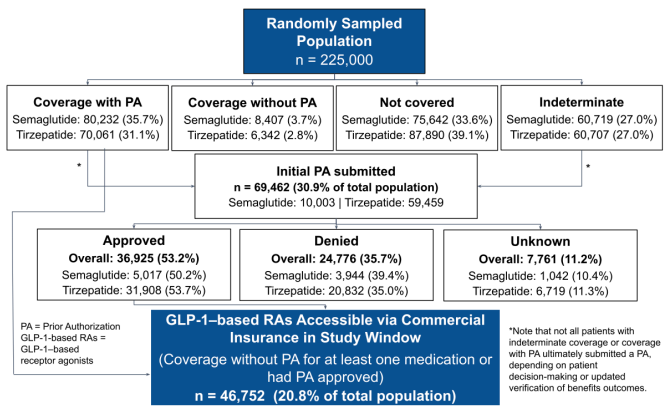


Figure 1. Patient Characteristics

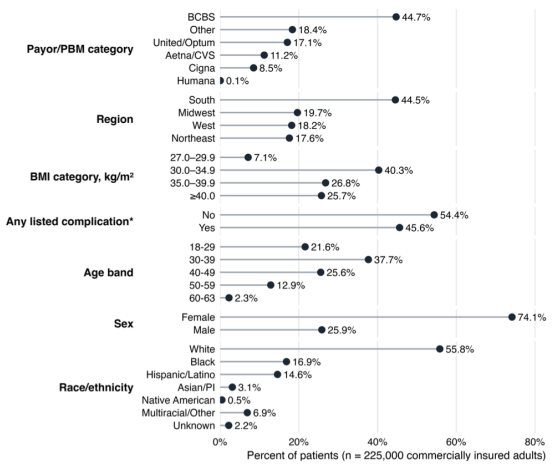
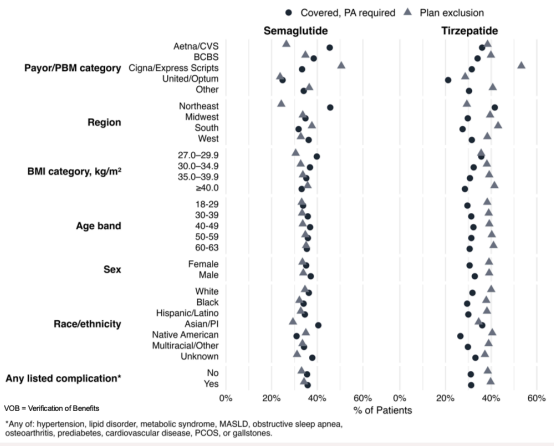


Figure 3: VOB Outcomes by Medication and Characteristic



VOB = Verification of Benefits

*Any of: hypertension, lipid disorder, metabolic syndrome, MASLD, obstructive sleep apnea, osteoarthritis, prediabetes, cardiovascular disease, PCOS, or gallstones.

Conclusions

Findings show incongruity between treatment-eligible patients and real-world access. Few patients have established commercial coverage and among those that do, PAs are frequently denied. Notably, high-risk patients with BMI ≥40 were most likely to have plan exclusions / coverage limitations, suggesting that patients with enhanced burden of disease do not experience improved access but are instead likelier to have worse or no access.

Future studies are needed to better understand benefit-design to leverage policy strategies in order to reduce barriers to standard-of-care obesity treatment.

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