MILLIMAN WHITE PAPER

Observational study of FlyteHealth's comprehensive obesity care program with the State of Connecticut: Year one insights

Commissioned by FlyteHealth

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Executive summary

In 2023, the State of Connecticut (SoCT) partnered with FlyteHealth to launch a pilot of FlyteHealth's Comprehensive Obesity Care (COC) program. The stated intent of the program was to address rising costs associated with anti-obesity medications (AOMs). The SoCT's employee health plan has experienced a 50% year-over-year rise in spending on glucagon-like-peptide-1 agonists (GLP-1s) used to treat obesity beginning in 2020.[1] Beginning July 1, 2023, the state required enrollees to participate in FlyteHealth's program to access coverage of these medications for treatment of all FDA approved indications. This approach aimed to ensure that GLP-1 prescriptions were coupled with comprehensive lifestyle and clinical support to maximize effectiveness and long-term success. According to FlyteHealth, their COC program provides patients with an individualized approach, directing patients to obesity treatment, which may include AOM therapy, that best matches their health profile.

Milliman was engaged by FlyteHealth to independently analyze the FlyteHealth COC program's initial observations on cost avoidance for the SoCT employee health plan. The study was performed with permission of SoCT. The timeframe of this study was insufficient to assess the total cost of care offsets; therefore, this analysis was limited to the program's impact on pharmaceutical product utilization. Other limitations to the study, which are important considerations for any of this report's users, are discussed below. It is important to note that Milliman is not endorsing FlyteHealth or its COC program.

In the context of this study with the limitations discussed below, the FlyteHealth COC program demonstrated the following:

- Approximately $430,000 to $1.2 million (1% to 3% of the total SoCT AOM pharmacy spend in the study period) was avoided based on the rejected claims and by switching eligible program participants to lower net cost therapies appropriate for each member.
- Eighty-six percent of participants who were naïve GLP-1 users from July 1, 2023 to December 31, 2023 were adherent to their GLP-1 medication. Participant adherence for GLP-1s was calculated using the proportion of days covered (PDC) calculation.[2] The PDC was defined as the number of days covered by a GLP-1 prescription divided by the number of days during the measurement period. A member was deemed adherent if their PDC rate was at least 80%.[3]
- Of the 329 naïve GLP-1 participants who enrolled within the first six months of the program, their persistence rate varied between 63% and 90% based on enrollment month in FlyteHealth. Persistence was measured by assessing if a member had a gap in therapy greater than 60 days and included all GLP-1 products, regardless of diagnosis. Naïve GLP-1 participants were defined as not having a GLP-1 prescription in the baseline claims data prior to FlyteHealth program enrollment.

This white paper presents the analytical framework Milliman used to prepare the observations about the FlyteHealth COC program, which are discussed in this report.

[1] The State of Connecticut. (2024, June 13). *Comptroller Sean Scanlon announces continued partnership with Intellihealth*. https://osc.ct.gov/articles/comptroller-sean-scanlon-announces-continued-partnership-with-intellihealth/.
[2] Pharmacy Quality Alliance. (2022, April 19). *PQA adherence measures*. https://www.pqaalliance.org/adherence-measures.
[3] *Understanding adherence measure calculations*. (2021, January 15). Pharmacy Quality Solutions. https://www.pharmacyquality.com/2021/01/15/understanding-adherence-measure-calculations/.

Background on obesity

Obesity is a complex chronic disease affecting over 40% of U.S. adults.[4] It is associated with over 200 health conditions, including metabolic disorders, heart disease, cancer, respiratory issues, musculoskeletal issues, and mental disorders.[5] In addition to health consequences, obesity places a substantial economic burden on individuals and the broader healthcare system. The annual medical costs related to obesity in the U.S. have been estimated at almost $173 billion, with annual productivity losses adding up to $6.4 billion in additional costs.[6] Recognizing the multifaceted and systemic nature of obesity can help inform more effective prevention and treatment strategies, benefitting policymakers, healthcare providers, and patients alike. Historically, the method used to determine whether a person has obesity was to calculate their body mass index (BMI), an estimate of body fat percentage based on a person's height and weight. In 2025, the Lancet proposed to update the clinical guidelines to not solely rely on BMI to diagnose obesity.[7]

Background on lifestyle management programs

Several lifestyle and weight management programs aimed at managing weight loss are available on the market. These programs typically focus on a combination of dietary changes, physical activity, and behavioral therapy to promote sustainable weight loss and improve overall health.

Commercial weight loss programs typically offer structured plans that include meal planning, support groups, and health coaching with an emphasis on portion control, balanced nutrition, and regular physical activity.[8,9]

Online and app-based programs have emerged as digital solutions, which provide tools for tracking food intake, physical activity, and weight progress. They often include educational content, personalized coaching, and community support to help users make healthy lifestyle choices.[10]

More recently, some of these programs have expanded to include AOMs, including GLP-1s.[11]

Background on GLP-1s

Recent advances in AOMs, particularly GLP-1s, have significantly improved the efficacy of pharmacotherapy for weight loss. However, these developments also raise questions about treatment cost, coverage, patient adherence, and how best to integrate medications into comprehensive care programs.

AOMs are broadly categorized into GLP-1s and non-GLP-1 medications, each with distinct mechanisms, effectiveness, and safety profiles.

- **GLP-1s:** Originally developed to treat type 2 diabetes, these products have emerged as effective weight loss therapies due to their ability to help regulate appetite and glucose. Clinical trials have shown GLP-1s can help people achieve average weight reductions on the order of 5% to 15%–sometimes up to 30%–of baseline weight over 6 to 12 months of therapy in obese patients.[12] This represents a markedly greater efficacy than older weight loss drugs but also is commonly accompanied by gastrointestinal side effects during initial dose escalation, such as nausea, vomiting and diarrhea. Other less common side effects include gallstones, pancreatitis, and hypoglycemia.[13]. Since their approval, the weight loss versions of GLP-1s have received expanded indications, with more in the pipeline.[14] In 2024, Wegovy® (semaglutide) received an expanded indication for the reduction of cardiovascular risk in obese or overweight patients.[15] Zepbound® (tirzepatide), a newer agent in the class, has a dual mechanism of action that targets the

[4] CDC. (September 9, 2024). *Obesity and severe obesity prevalence in adults: United States, August 2021–August 2023*. https://www.cdc.gov/nchs/products/databriefs/db508.htm.
[5] *Obesity*. (2025). American Medical Association. Retrieved April 24, 2025 from https://www.ama-assn.org/topics/obesity.
[6] CDC. (July 15, 2022). *Consequences of obesity*. https://www.cdc.gov/obesity/basics/consequences.html.
[7] Rubino, F. et al. (2025). Definition and Diagnostic Criteria of Clinical Obesity. *The Lancet Diabetes & Endocrinology*, *13*(3), 221–262.
[8] WeightWatchers. (2025). Retrieved April 24, 2025 from https://www.weightwatchers.com/us/.
[9] Jenny Craig. (2025). How it works. Retrieved April 24, 2025 from https://www.jennycraig.com/how-it-works.
[10] Livongo. (2025). Retrieved on April 24, 2025 from https://www.livongo.com.
[11] Fierce Healthcare. (December 12, 2024). *Ro teams up with Eli Lilly to offer single-dose vials of weight loss drug Zepbound*. https://www.fiercehealthcare.com/providers/ro-teams-eli-lilly-offer-single-dose-vials-weight-loss-drug-zepbound.
[12] Rao, M., Shaughnessy, A., & Sokol R. (2024). Prescribing GLP-1 agonists for weight loss: Wrestling with our philosophical angst. *American Family Physician*. *110*(4), 340–341.
[13] https://www.gov.uk/drug-safety-update/glp-1-receptor-agonists-reminder-of-the-potential-side-effects-and-to-be-aware-of-the-potential-for-misuse
[14] BioSpace (December 23, 2024). *7 indications for GLP-1s beyond weight loss*. https://www.biospace.com/drug-development/7-indications-for-glp-1s-beyond-weight-loss.
[15] FDA. (March 8, 2024). *FDA approves first treatment to reduce risk of serious heart problems specifically in adults with obesity or overweight*. https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-reduce-risk-serious-heart-problems-specifically-adults-obesity-or.

GLP-1 and glucose-dependent insulinotropic polypeptide (GIP) receptors for weight loss. In December of 2024, Zepbound became the first medication indicated for the treatment of moderate to severe obstructive sleep apnea in adults with obesity.[16,17] A triple-hormone-receptor agonist, retatrutide, is currently in phase 3 clinical trials with data expected to be released in 2025.[18] Appendix A provides a complete listing of the products and their indications.

- **Non-GLP-1 AOMs:** Prior to GLP-1s expanding into the weight loss indication, other medications have historically been used to treat obesity, with generally lower average efficacy (often 3% to 8% weight reduction).[19] These include agents like phentermine (an appetite suppressant and controlled substance approved for short-term use), combination therapies such as phentermine/topiramate and bupropion/naltrexone, and gastrointestinal fat absorption inhibitors like orlistat. Non-GLP-1 drugs are taken orally, and many are available as low-cost generics. These medications may be appropriate for patients who cannot tolerate GLP-1s[20].

The increasing number and variety of weight loss medications available underscores the importance of assessing each patient's case to determine which, if any, medication therapy is most appropriate. Factors to consider should include the patient's health status (e.g., BMI and additional measures of body fat and organ or tissue disease), limitations to daily living, current medications, family history, access to treatment, medication cost and route of administration, and side effect profiles of the drugs. The recently updated obesity diagnostic criteria from the Lancet Diabetes and Endocrinology Commission discuss the importance of a comprehensive assessment of the patient and not relying on BMI as a single metric to determine the appropriate treatment plan for an individual.[21]

Commercial weight loss coverage and utilization management

The increasing popularity of GLP-1 medications for treating obesity is prompting insurers and other payers to reassess their coverage policies. Historically, weight loss medications were often excluded from commercial coverage, being seen as nonessential or lifestyle related treatments. As obesity is increasingly recognized as a medical condition and new weight loss therapies prove more effective, many commercial insurers are rethinking their approach to covering these treatments. A 2024 industry trend report revealed that 43% of commercial health plans now include weight loss medications in their coverage, with another 28% contemplating this change soon.[22] Despite this, coverage is not widespread as over half of large employers worry about the long-term financial impact of these drugs[23]. Several large payers and health plans have recently discontinued coverage for GLP-1s for weight loss, citing concerns over growing cost, poor adherence, and nontargeted utilization in less severe patients.[24] Plans are concerned they may not realize the long term return of their investment on these therapies if their member population is subject to high turnover or plan migration.[25] Plans that do provide coverage often apply utilization management (UM) strategies to control costs and usage.

Payers are using various methods to manage the rising demand for GLP-1 drugs. Applying UM is crucial to ensuring appropriate utilization when these products are covered. Common UM strategies include:

- **Prior authorization:** Ensuring clinical criteria such as BMI and comorbidities are met and lifestyle intervention attempts are documented before approving coverage.
- **Step therapy:** Mandating that patients try non-GLP-1 drugs, less expensive treatments, or lifestyle management programs before receiving coverage approval.
- **Quantity limits:** Limiting the amounts of medication a patient can receive at one time to prevent stockpiling.
- **Periodic reassessment of effectiveness:** Discontinuing the medication if a patient does not achieve a specified weight loss goal (e.g., 5% after three to six months of therapy).

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[16] Eli Lilly. (December 20, 2024). *FDA approves Zepbound® (tirzepatide) as the first and only prescription medicine for moderate-to-severe obstructive sleep apnea in adults with obesity*. https://investor.lilly.com/news-releases/news-release-details/fda-approves-zepboundr-tirzepatide-first-and-only-prescription.
[17] BioSpace (December 23, 2024). *7 Indications for GLP-1s Beyond Weight Loss*. https://www.biospace.com/drug-development/7-indications-for-glp-1s-beyond-weight-loss.
[18] Constantino, A.K. (February 6, 2025). Eli Lilly to release late-stage data on next-generation weight loss drug retatrutide in 2025, earlier than expected. *NBC Philadelphia*. https://www.nbcphiladelphia.com/news/business/money-report/eli-lilly-to-release-late-stage-data-on-next-generation-weight-loss-drug-retatrutide-in-2025-earlier-than-expected/4101436/.
[19] Munoz-Mantilla, D. (January 26, 2024). *Top weight loss medications*. Obesity Medicine Association. https://obesitymedicine.org/blog/weight-loss-medications/.
[20] https://diabetesjournals.org/spectrum/article-abstract/37/4/296/157428/First-Generation-Anti-Obesity-Medications?redirectedFrom=fulltext
[21] Rubino, F. et al. (2025). Definition and diagnostic criteria of clinical obesity. *The Lancet Diabetes & Endocrinology*, *13*(3), 221–262.
[22] Managed Markets Insight & Technology (January 18, 2024). *Commercial payers wrestle with managing weight loss drug coverage*. https://www.mmitnetwork.com/aishealth/spotlight-on-market-access/commercial-payers-wrestle-with-managing-weight-loss-drug-coverage.
[23] https://www.shrm.org/topics-tools/news/benefits-compensation/employer-coverage-of-glp-1-drugs-jumps#:~:text=Employer%20Considerations&text=Of%20the%20organizations%20that%20currently,%25)%20are%20other%20top%20factors.
[24] Klein, H.E. (2024). Rising costs lead insurers to drop weight loss drug coverage, further increasing patient burden. *The American Journal of Managed Care*, *30*(Spec No. 10), SP781–SP782.
[25] https://employersolutions.vanderbilthealth.com/employer-insights-blog/glp-1-drugs-weight-loss-drive-pharmacy-benefit-spend-employers#:~:text=Companies%20in%20industries%20with%20high,term%20clinical%20or%20financial%20benefit.

- **Concurrent lifestyle program management:** Requiring participation in a clinical care lifestyle program alongside weight loss medication therapy.
- **Prescriber restrictions:** Limiting prescribing to healthcare professionals within a designated specialty, certification, training, or center of excellence (e.g., obesity specialists).

These strategies aim to ensure appropriate use of medications and focus treatment on patients who most need the therapy.

Cost avoidance opportunities

While the new AOMs can be transformative, many plan sponsors have expressed concerns around the cost of medication waste due to suboptimal adherence and persistence. According to an analysis of adults in the U.S. with type 2 diabetes who utilized GLP-1s, just over half of adults were adherent to the medication after 12 months with 47.7% having discontinued therapy by 12 months.[26] Another study conducted by two pharmacy benefit managers (PBMs) on commercially insured individuals with obesity or prediabetes who newly initiated treatment with a GLP-1, 32% of members were persistent at one year and 27% were adherent to therapy in the year following.[27] Nonpersistence and nonadherence directly translate to waste from a plan perspective. Studies have shown that when patients discontinue these drugs, they typically gain back a significant portion of the weight that they lost while on the drug within one year.[28,29] A Milliman white paper on GLP-1s indicated for chronic weight management illustrates a potential 26% of wasted spend when patients do not sustain therapy for at least 12 months.[30] Additionally, some patients may cycle on and off therapy, incurring treatment initiation costs from clinician visits and restarting side effect management each time.

- **Medication Persistence:** This refers to how long a patient remains on their medication. Nonpersistence is typically calculated as a gap in treatment of 45 to 60 days.[31,32] Real-world data indicates that the attrition rate for GLP-1s is higher than what was seen in clinical trials.[33] Reasons for discontinuation include the inability to tolerate side effects, losing motivation after not seeing expected results, and insurance or cost sharing hurdles .[34] Nonpersistence has implications for the payer and the patient. If a patient stops the medication after a few months, they may regain the lost weight, meaning the money invested for those months of drug access provided little lasting value.[35] Therefore, improving GLP-1 persistence is crucial to realizing long-term health benefits for the patient and subsequently offsetting long-term medical costs for the plan. In a recent 2024 study conducted by a large payer looking at GLP-1s used for weight loss only, approximately 30% of naïve GLP-1 users discontinued therapy within the first month. Additionally, only approximately 42% remained on their medication longer than 12 weeks.[36]
- **Medication Adherence:** Adherence refers to the degree to which a patient correctly takes their medication as prescribed by their provider. Participant adherence for GLP-1s is typically calculated using the prescription fills and PDC calculation.[37] According to industry standards, a member is deemed adherent if their PDC was at least 80%.[38] Suboptimal adherence can stem from patients skipping doses due to side effects, attempting to "stretch" expensive medication, or not having a routine with injectable therapy. Low adherence can reduce the drug's effectiveness (e.g., not reaching the therapeutic dose or losing momentum in weight loss), again potentially leading to less overall success despite the cost incurred.

[26] Weiss, T. et al. (2020). Real-world adherence and discontinuation of glucagon-like peptide-1 receptor agonists therapy in type 2 diabetes mellitus patients in the United States. *Patient Preference and Adherence*, 2337–2345.
[27] Year-Two Real-World Analysis of Glucagon-Like Peptide-1 Agonist (GLP-1) Obesity Treatment Adherence and Persistency. (2024). https://www.primetherapeutics.com/documents/d/primetherapeutics/prime-mrx-glp-1-year-two-study-abstract-final-7-10.
[28] Wilding, P.H. (2022). Weight regain and cardiometabolic effects after withdrawal of semaglutide: The STEP 1 trial extension. *Diabetes, Obesity and Metabolism*, *24*(8), 1553–1564.
[29] Schoenfeld, P. (February 20, 2024). *Continued treatment with Tirzepatide is necessary to maintain weight loss*. Evidence-Based GI. https://gi.org/journals-publications/ebgi/schoenfeld2_feb2024/.
[30] See GLP-1 agonists in Medicaid: Utilization, growth and management at https://www.milliman.com/en/insight/glp-1-agonists-medicaid-utilization-growth-management.
[31] Svensson, A.-M. et al. (2020). Treatment persistence in patients with type 2 diabetes treated with glucagon-like peptide-1 agonists in clinical practice in Sweden. *Diabetes, Obesity & Metabolism*, 23*(3)*, 720–729.
[32] Choe, J.H. & Xuan, S. (2024) Medication Persistence and its impact on type 2 diabetes. *The American Journal of Managed Care*, *30*(4), e124–e134.
[33] Starr, M. (July 25, 2024) *Report: GLP-1 adherence rates lower than expected*. Pharmacy Practice News. https://www.pharmacypracticenews.com/Operations-and-Management/Article/07-24/Report-GLP-1-Adherence-Rates-Lower-Than-Expected/74208.
[34] Rodriguez, P.J. et al. (2025). Discontinuation and reinitiation of dual-labeled GLP-1 receptor agonists among US adults with overweight or obesity. *JAMA Network Open*, 8*(1)*, e2457349.
[35] Abdullah bin Ahmed, I. (2024). A comprehensive review on weight gain following discontinuation of glucagon-like peptide-1 receptor agonists for obesity. *Journal of Obesity*, 2024, 8056440.
[36] Blue Health Intelligence. (2024, May). *Real-world trends in GLP-1 treatment persistence and prescribing for weight management*. https://www.bcbs.com/dA/46383dfc2d/fileAsset/BHI_Issue_Brief_GLP1_Trends.pdf.
[37] Pharmacy Quality Alliance. (2022, April 19). *PQA adherence measures*. https://www.pqaalliance.org/adherence-measures.
[38] *Understanding adherence measure calculations*. (2021, January 15). Pharmacy Quality Solutions. https://www.pharmacyquality.com/2021/01/15/understanding-adherence-measure-calculations/.

In 2019, the Centers for Disease Control and Prevention (CDC) reported that the annual medical expenses for obese adults were $1,861 higher than adults with a healthy weight.[39] Additional studies have shown decreases in medical care experiences associated with weight loss in patients with chronic conditions.[40] Patients using GLP-1s who experience weight loss and other health benefits, like improvements in cardiovascular risk factors, might see a decrease in healthcare costs over time; however, more research on long-term cost offsets is needed. GLP-1 medications have increased efficacy in obesity treatment while presenting challenges around ensuring proper use. This has highlighted the importance of payers evaluating their coverage policies and understanding patient adherence to determine how best to integrate medications into comprehensive care programs. It is critical for payers to measure and monitor the performance, effectiveness, and cost of these therapies along with the overall healthcare costs for these members and the plan to better understand the plan's return on investment and health outcomes.

FlyteHealth case study

BACKGROUND AND OVERVIEW

With the increasing popularity of pharmacotherapy use for obesity management, payers are looking to comprehensively engage patients to participate in a multimodal approach that includes lifestyle modifications and pharmacotherapy. Comprehensive lifestyle interventions generally include a reduced calorie diet, increased physical activity, and behavior therapy that may result in long-term benefits for patients.[41] Accessible resources and programs may be needed for patients to utilize specific evidence-based diet and exercise programs endorsed by the medical community and industry for these medications.

According to information provided by FlyteHealth, their COC program delivers a comprehensive suite of clinical care provided as structured, tech-enabled, patient specific care pathways. Participants receive personalized care from a multidisciplinary team, including obesity specialist physicians, nurse practitioners, and dietitians. The tailored plan focuses on nutritional counseling, encouraging physical activity, behavior modification support, and medication management while actively managing comorbid conditions of hypertension, hyperlipidemia, and prediabetes for complete cardiometabolic care. The FlyteHealth tech platform and the FlyteHealth app track participants' weight, diet, blood pressure, and progress. It also requires virtual face to face appointments with the Flyte providers to manage clinical care. FlyteHealth reports that patients in their program lose an average of 16% of their body weight.[42]

SoCT background

The SoCT self-insured employee health plan serves employees, dependents, and retirees, with more than 200,000 members under coverage. On July 1, 2023, the Office of the State Comptroller initiated a pilot with FlyteHealth to administer Flyte's virtual care obesity program to the state employee plan[43]. In conjunction with implementing the FlyteHealth program, the state also moved to require any state health plan members seeking a GLP-1 prescription for obesity to enroll in the FlyteHealth program. This meant if a doctor prescribed a GLP-1 for obesity, the prescription would only be authorized under the insurance plan if the patient were enrolled in the FlyteHealth program. Existing GLP-1 users were given an exception to continue this medication without mandatory enrollment into the pilot. During the time of the study, members could also voluntarily enroll in Flyte for weight management even without a GLP-1, though the impetus was largely on current medication users.

The program was offered to all active state employees, their adult dependents, and retirees who met clinical criteria for obesity treatment. Eligibility criteria for FlyteHealth aligned with standard AOM guidelines[44,45] at the time of this pilot program: BMI≥30 or BMI≥27 with at least one weight related comorbidity (e.g., type 2 diabetes, hypertension, and sleep apnea).

[39] CDC. (2024, May 14). *Adult obesity facts*. https://www.cdc.gov/obesity/adult-obesity-facts/.
[40] Thorpe, K. et al. (2021). Weight loss-associated decreases in medical care expenditures for commercially insured patients with chronic conditions. *Journal of Occupational and Environmental Medicine*, *63*(10), 847–851.
[41] CDC. (2024, October 29). *Obesity strategies: What can be done*. https://www.cdc.gov/obesity/php/about/obesity-strategies-what-can-be-done.html.
[42] Castenada, G. (2025, January 20). *HLTH: Transforming obesity management with FlyteHealth's personalized approach*. HLTH. https://community.hlth.com/insights/podcasts/hlth-transforming-obesity-management-with-flytehealth-s-personalized-approach-2025-01-20.
[43] The State of Connecticut. (2024, June 13). *Comptroller Sean Scanlon announces continued partnership with Intellihealth*. https://osc.ct.gov/articles/comptroller-sean-scanlon-announces-continued-partnership-with-intellihealth/.
[44] CDC. (2024, March 19). *Adult BMI categories*. https://www.cdc.gov/bmi/adult-calculator/bmi-categories.html.
[45] Novo Nordisk. (2021, June 4). *Novo Nordisk receives FDA approval for Wegovy® to treat adults with obesity based on unprecedented efficacy for a prescription medicine in clinical trials*. https://www.novonordisk-us.com/media/news-archive/news-details.html?id=62113.

Case study structure and methodology

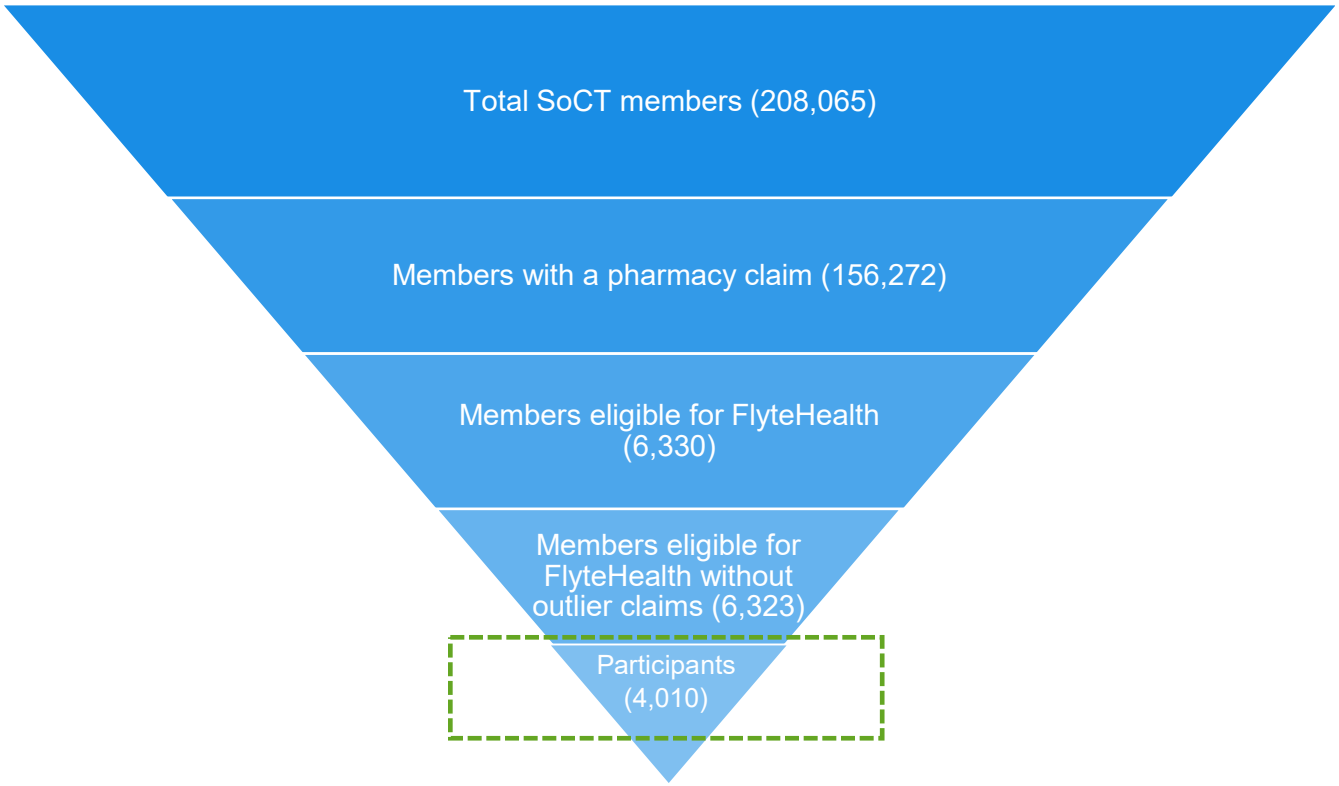
DATA SOURCES AND STUDY OVERVIEW

The SoCT prescription drug claims data were provided directly to Milliman by the SoCT PBM for claims incurred from July 1, 2022 and paid through June 30, 2024. The SoCT pharmacy benefit plan utilizes point of sale rebates and all costs analyzed are therefore net of rebates and member cost share. The SoCT pilot period was defined as July 1, 2023 to June 30, 2024. To be included in the observational study, members had to have a prescription drug claim during the program pilot period and within the 12 months prior. Of the total SoCT plan population that met this criterion, 6,330 members were eligible to participate in the FlyteHealth program based on the BMI and eligibility information obtained and provided by FlyteHealth as described above. The analysis showed 63% of eligible SoCT members participated in the FlyteHealth pilot program at some point. Of the participant population, 117 were diabetic and 557 were retirees. Seven members had a single prescription drug claim exceeding $500,000; these members were deemed outliers and excluded from this analysis.

The cost analyses are based on the claims amount paid by SoCT to their PBM after member cost sharing and assumes net of rebates as SoCT has point of sale rebates in place for their plan. At the time of this study, there were no co-pays for GLP-1 medications.

Figure 1 shows the funnel from the total SoCT population to the FlyteHealth participant population.

FIGURE 1: SOCT POPULATION BREAKDOWN FOR CASE STUDY



This study looked at the following three measures in the FlyteHealth COC program:

- Cost avoidance
- Adherence
- Persistence

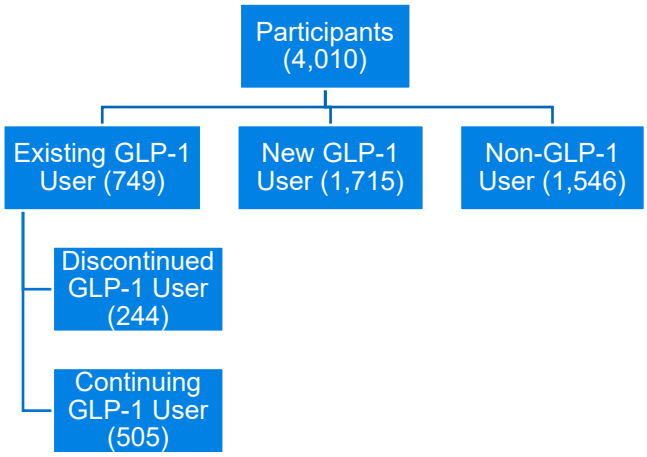
COST IMPACT AND AVOIDANCE METHODOLOGY

To assess cost avoidance when UM or program participation requirements were in place, this analysis looked at rejected claims for the medication of interest. In this case, rejected GLP-1s were identified for participants within two months of their FlyteHealth program enrollment. The actual costs of the medications the participants were prescribed under FlyteHealth were compared to the actual cost of the medication from the rejected claims to determine the cost avoidance in the absence of the program intervention. This analysis also compared existing GLP-1 cost to the actual cost of medications the participants were prescribed under FlyteHealth.

The cost avoidance analysis classified participants into three cohorts based on their GLP-1 usage history, as shown in Figure 2.

- **Existing GLP-1 User:** The participant had a GLP-1 prescription within the enrollment month or three months prior. Once in the program, they could be classified as either a discontinued GLP-1 user or continuing GLP-1 user.
- **New GLP-1 User:** The participant's first GLP-1 prescription appeared any time after their enrollment month.
- **Non-GLP User:** The participant received a non-GLP-1 AOM while in the program.

FIGURE 2: BREAKOUT OF PARTICIPANT CLASSIFICATION BASED ON MEDICATION USE



COST AVOIDANCE RESULTS

The analysis estimates approximately $430,000 to $1.2 million (1% to 3% of the total SoCT AOM pharmacy spend in the study period) was avoided based on the members' rejected claims and from switching members to lower net cost therapies. Reported costs are net of rebates and member cost sharing and are based on the claim amounts paid by the SoCT to the PBM. Cost avoidance achieved across three participant cohorts was split into three buckets (see also Figure 3):

1. Discontinued GLP-1 User: Discontinuation of GLP-1 therapy for existing GLP-1 users
2. New GLP-1 User: Rejected GLP-1 claim compared to FlyteHealth prescribed GLP-1
3. Non-GLP-1 User: Rejected GLP-1 claim compared to FlyteHealth prescribed non-GLP AOM alternatives

DISCONTINUED GLP-1 USER: DISCONTINUATION OF GLP-1 THERAPY FOR EXISTING GLP-1 USERS

A member was defined as an existing GLP-1 user who discontinued use if there was a GLP-1 prescription prescribed by a non-Flyte provider within the member's enrollment month or three months prior and no GLP-1 prescription after the enrollment month. The analysis showed that 33% of existing GLP-1 users discontinued therapy. The discontinued GLP-1 cost avoidance was calculated as the cost difference between the actual non-GLP-1 AOM drug spend after program enrollment and the assumed GLP-1 spend in the absence of therapy discontinuation. The actual non-GLP-1 AOM drug spend was based on the non-GLP-1 AOM claim spend, or no AOM spend, in the prescription claims data after enrollment, assuming current net costs and member sharing. The assumed GLP-1

spend was based on the 30-day equivalent cost per GLP-1 script from the prescription claims in the study period. A range of costs avoided was developed by assuming a range of therapy drop-off rates between 58%[46] and 0%.

The estimated cost avoidance from discontinuation of therapy for existing GLP-1 users ranged between $70,000 and $170,000 (0.2% to 0.4% of the SoCT's total AOM pharmacy spend in the study period) based on 244 participants with an average length of program participation of 1.7 months.

NEW GLP-1 USER: REJECTED GLP-1 CLAIM COMPARED TO FLYTEHEALTH PRESCRIBED GLP-1

The analysis found that 10% of new GLP-1 users had a rejected GLP-1 claim within two months of enrollment that was more expensive than the net cost of the GLP-1 drug prescribed in the program. This cohort of participants was identified as having a rejected GLP-1 claim within two months of their enrollment month that was different from the GLP-1 therapy they received during the FlyteHealth program. The cost difference was calculated between the assumed GLP-1 spend for the rejected GLP-1 claim and the actual GLP-1 costs for the new GLP-1 users after enrollment. A member was defined as a new GLP-1 user if their first GLP-1 script started after their enrollment month.

The assumed GLP-1 spend for the rejected GLP-1 was based on the 30-day equivalent cost per GLP-1 script based on the prescription claims in the study period. The actual GLP-1 spend was based on the GLP-1 spend in prescription claims data for new GLP-1 users after enrollment. A range of costs avoided was developed by assuming a range of therapy drop-off rates between 58%[47] and 0%.

The cost avoidance was estimated to range between $270,000 and $760,000 (0.6% to 1.8% of the total SoCT AOM pharmacy spend in the study period). Cost avoidance was calculated from FlyteHealth prescribing lower net cost GLP-1s on average compared to the identified rejected claims based on 167 participants with an average length of program participation of 6.2 months.

NON-GLP-1 USER: REJECTED GLP-1 CLAIM COMPARED TO FLYTEHEALTH PRESCRIBED NON-GLP AOM ALTERNATIVES

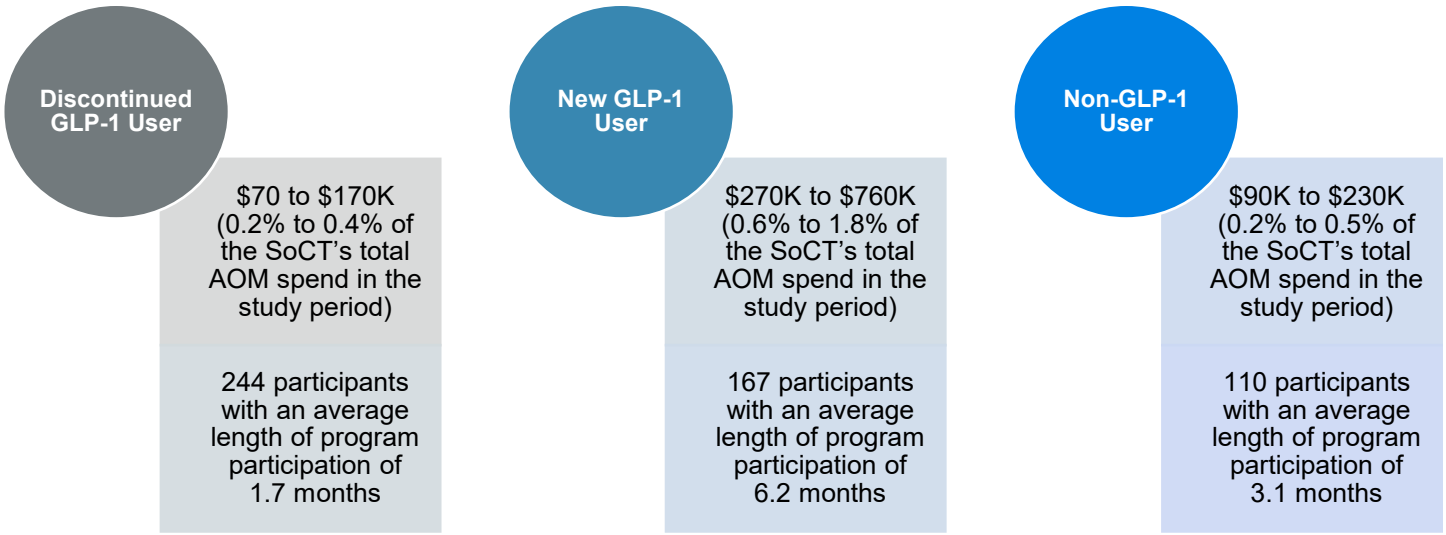
The analysis found that 7% of non-GLP-1 users had a rejected GLP-1 claim within two months of enrollment and received a non-GLP-1 AOM in the program. A member was defined as a non-GLP-1 user if they did not have a GLP-1 prescription during their program enrollment. The cost difference was calculated between the assumed GLP-1 spend for the rejected GLP-1 claim and the actual non-GLP-1 AOM costs for participants identified as non-GLP-1 users.

Actual non-GLP-1 AOM spend was based on the non-GLP-1 AOM spend in claims data for non-GLP-1 users after enrollment. This included the scenario of no AOM use during the program. A range of costs avoided was developed by assuming a range of therapy drop-off rates between 58%[48] and 0%.

The amount of cost avoidance was estimated to range between $90,000 and $230,000 (0.2% to 0.5% of the total SoCT AOM pharmacy spend in the study period) and calculated from FlyteHealth prescribing non-GLP-1 AOM alternatives for participants who had a rejected claim. This population comprised 110 participants with an average length of program participation of 3.1 months.

[46] Blue Health Intelligence. (2024, May). *Real-world trends in GLP-1 treatment persistence and prescribing for weight management.* https://www.bcbs.com/dA/46383dfc2d/fileAsset/BHI_Issue_Brief_GLP1_Trends.pdf.
[47] Ibid.
[48] Ibid.

FIGURE 3: COST AVOIDANCE RESULTS



ADHERENCE AND PERSISTENCE OBSERVATIONS

The analysis looked at two common measures of prescription drug program outcomes: adherence and persistence.

Participant adherence for GLP-1s was calculated using the PDC method.[49] The PDC was defined as the number of days covered by a GLP-1 prescription divided by the number of days during the measurement period. A member was deemed adherent if their PDC rate was at least 80%.[50] Because the titration period for GLP-1s often involves using starter doses that could distort PDC if not accounted for, the calculation was adjusted by measuring days of therapy rather than prescription count. Only naïve users who enrolled within the first six months of the program were assessed for adherence to allow for a long enough window after therapy initiation to evaluate their behaviors in the program. Naïve GLP-1 participants were defined as not having a GLP-1 prescription within the baseline claims data prior to program enrollment. Of the 329 naïve GLP-1 participants in the program's first six months, 86% were adherent, with an average PDC of 90%.

> Eighty-six percent of participants who were naïve GLP-1 users from July 1, 2023 to December 31, 2023 were adherent to their GLP-1 medication.

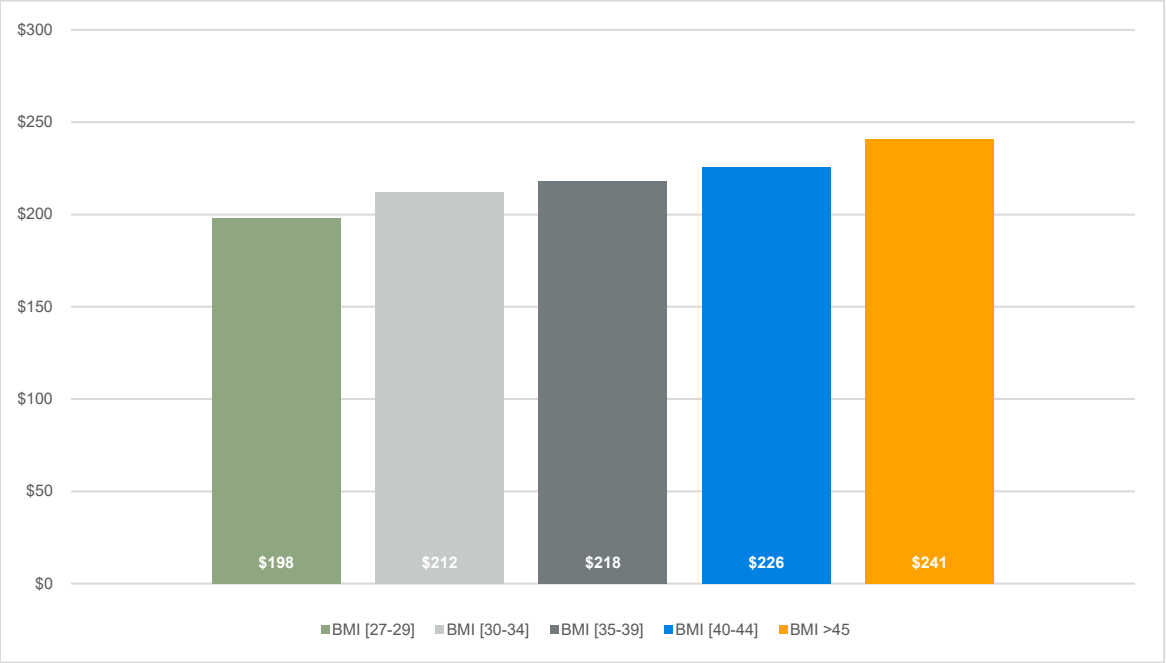
Participant persistence was measured by assessing if a member had a gap in therapy greater than 60 days and included all GLP-1 products, regardless of diagnosis. Time on therapy may inversely impact a member's persistence; therefore, persistence was only calculated for members who started GLP-1s within the first six months of the FlyteHealth pilot program. Of the 329 naïve GLP-1 participants who enrolled within the first six months of the program, the persistence rate varied between 63% and 90% based on enrollment month in FlyteHealth.

AOM USAGE PATTERNS

Participants were segmented into cohorts based on their BMI. Reported BMIs were provided by FlyteHealth for the participants. The per-member per-month (PMPM) GLP-1 spend was calculated for each participant's BMI cohort, as illustrated in Figure 4. The participants in the highest BMI brackets (e.g., BMI≥45) exhibited the greatest GLP-1 costs when the pilot program was in place as the FlyteHealth program targeted the most severe BMI cohorts with GLP-1 medications.

[49] Pharmacy Quality Alliance. (2022, April 19). *PQA adherence measures*. https://www.pqaalliance.org/adherence-measures.
[50] *Understanding adherence measure calculations*. (2021, January 15). Pharmacy Quality Solutions. https://www.pharmacyquality.com/2021/01/15/understanding-adherence-measure-calculations/.

FIGURE 4: PARTICIPANT GLP-1 SPEND PMPM BY BMI



Discussion and limitations

The SoCT COC pilot provides a valuable case study in managing obesity care within a health plan environment. The SoCT's pilot is among the first large public sector implementation of a care management program for obesity. Within the first nine to ten months, approximately 4,000 state health plan members enrolled in FlyteHealth for weight management. Of those who participated, the average BMI according to FlyteHealth was 36, indicating the program was reaching members with severe obesity. The pilot initially targeted members who were already seeking medication and were therefore inherently a self-selected, motivated group, which may also have contributed to higher adherence and persistence rates.

Nonadherence contributes to medication waste as prescriptions are filled but not used optimally. Medication discontinuation can lead to weight regain, undermining long-term outcomes and wasting health plan spend. The SoCT pilot attempts to address nonadherence by providing ongoing coaching, dose management, and multidisciplinary support through FlyteHealth. Early indications from the program show participants in the COC program who were naïve GLP-1 users enrolled between July 1, 2023 and December 1, 2023 had an adherence rate of 86%, with an average PDC of 90%. There were no co-pays for GLP-1 prescriptions during the pilot period, which also may have contributed to higher adherence and persistence rates.

An analysis was developed to quantify the costs the program avoided by comparing the GLP-1 therapy of incoming participants to the AOM therapy prescribed by FlyteHealth. In some cases, the SoCT avoided medication costs as FlyteHealth discontinued participants' GLP-1 therapies in favor of non-GLP-1 AOM treatment upon program enrollment when FlyteHealth's obesity specialist deemed the change appropriate. Additionally, the analysis quantified costs avoided by comparing the rejected GLP-1 therapy incoming participants attempted to fill within two months of enrollment to the therapy prescribed by FlyteHealth after enrollment. In other cases, the SoCT avoided costs as FlyteHealth prescribed lower net cost AOM therapies, including GLP-1s, than the rejected therapy.

Obesity is a chronic condition that requires long-term management. Over time, the portion of patients who remain adherent to AOM therapy and lose weight may begin to experience improved health outcomes, potentially reducing medical and pharmacy benefit costs as certain services are reduced or avoided. However, more research is needed to fully understand the long-term effects of GLP-1s on insulin usage, healthcare utilization, and therapeutic outcomes for related comorbid conditions. Though weight loss medications fall under the pharmacy benefit, their use could have implications for medical costs. Covering GLP-1 medications may increase overall pharmacy spend, which was the case for SoCT. However, a hypothesis, which was outside the scope of this analysis, is that successful weight loss will reduce medical spend in the future through fewer hospitalizations, surgeries, or treatments for obesity related conditions. In that hypothesis, dollars are being invested in the pharmacy side to save larger dollars on the medical side later. This is analogous to plan sponsor coverage and spending on preventive medication with proven clinical results, such as statins, when they were first introduced to prevent heart attacks. The challenge for plan sponsors is timing and population segmentation as the pharmacy costs are immediate and visible while medical cost savings are delayed and sometimes diffuse. A robust evaluation should look at total cost of care, including medical and pharmacy, over a three- to five-year horizon.

The results of the Milliman analysis of the FlyteHealth COC program should be interpreted with the following limitations in mind. First, the requirement for members to enroll in the program to receive GLP-1 therapy may also have self-selected for those truly motivated to lose weight as casual or less motivated individuals might not have gone through the enrollment process; thus, focusing the study on those most likely to benefit created a possible a selection bias. Second, the observation window of 12 months was short to assess the COC program. The data currently cover at most 12 months of observations. Many potential benefits (e.g., reduction in cardiovascular events and long-term cost savings) may not materialize within this time. Therefore, our analysis can speak about short-term utilization but any extrapolation to long-term outcomes cannot be made. Additionally, this case study did not have a parallel randomized control group for comparison, which means there could be other confounding factors. Without randomization, one should be cautious in attributing causality for every observation solely to the program. The generalizability of the study is also limited in that the population in this program consists of state employees/affiliates in the SoCT, which may not be representative of all populations. Furthermore, our evaluation does not compare Flyte to alternative vendors in this space because that was outside the scope of this analysis. Lastly, this study was limited to pharmacy claims only and did not consider medical costs or confounding conditions. In the future, a more rigorous study with a longer-term follow-up that includes medical and pharmacy data can be performed to strengthen the evidence base. Future case studies could also consider the impact of an avoided waste calculation[51] for participants. This could be done by comparing the

[51] See Payer strategies for GLP-1 medications for weight loss at https://www.milliman.com/-/media/milliman/pdfs/2023-articles/8-28-23_glp-1s-for-weight-loss_20230824.ashx.

actual wasted GLP-1 spend due to nonadherence to an assumed wasted GLP-1 spend in the absence of the FlyteHealth program intervention. Ideally, the assumed wasted GLP-1 spend could be developed using a randomized control group.

Conclusion

The FlyteHealth COC program is explicitly designed to individualize therapy to FDA eligible patients by utilizing a patent-pending algorithm for personalization to provide intensive coaching and medical, team-based care. Covering GLP-1 medications may increase overall pharmacy spend, which was the case for SoCT. However, the hypothesis, which was outside the scope of this analysis, is that successful weight loss will reduce medical spend in the future through fewer hospitalizations, surgeries, or treatments for obesity related conditions.

In the context of this study with the limitations discussed above, the following was observed from the FlyteHealth COC program:

- Approximately $430,000 to $1.2 million in costs (1% to 3% of the total SoCT AOM pharmacy spend in the study period) was avoided based on the rejected claims and from switching members to lower net cost therapies appropriate for each member.
- Eighty-six percent of participants who were naïve GLP-1 users from July 1, 2023 to December 31, 2023 were adherent to their GLP-1 medication.
- Of the 329 naïve GLP-1 participants who enrolled within the first six months of the program, their persistence rate varied from 63% to 90% based on enrollment month in FlyteHealth.

As data continues to emerge, a more rigorous study should be performed to include a randomized control group, medical data to look at total cost of care impacts, and longer observational timeframes.

Caveats and limitations

The material in this paper represents the opinion of the authors and is not representative of Milliman's view. As such, Milliman is not advocating for, or endorsing, any specific views contained in this paper related to GLP-1 medications.

This report was commissioned by FlyteHealth to discuss initial observations on FlyteHealth's COC program with the SoCT's insured members. Milliman independently conducted the pharmacy claims analysis. This information may not be appropriate, and should not be used, for other purposes. This information may not be shared with any third parties without Milliman's prior written consent. Even if we allow distribution, this material is not meant to benefit or be relied upon by any third parties. Any third-party recipient of this paper that desires professional guidance should not rely upon Milliman's work product but should engage qualified professionals for advice appropriate to its specific needs.

The results of this analysis are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without thoroughly understanding those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate initial observations on FlyteHealth's COC program with the SoCT. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice.

The models rely on data and information as input. We relied on information provided by FlyteHealth, the SoCT, and the PBM and accepted it without audit, though we reviewed it for reasonability. To the extent that the data and information provided were not accurate, or were not complete, the values provided in this report may likewise be inaccurate or incomplete. The models, including all input, calculations, and output, may not be appropriate for any other purpose. Actual results will certainly vary for specific stakeholders due to differences such as variations in demographics, trends, discount arrangements, formulary, utilization patterns, and rebate arrangements.

Differences between the experience will depend on the extent to which future experience conforms to the assumptions made in the calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. The observed results of this study may not be applicable for all insured populations given such differences as variability in population health, demographics, and industry. Population specific characteristics should be considered in the translatability of this study's results to other populations.

During the pilot, it is possible that other changes in the healthcare landscape influenced the outcomes. For example, the case study did not explicitly adjust for drug shortage impacts. In addition, the tail end of the COVID-19 pandemic era has affected weight and health behaviors; if people were already trending to weight loss postpandemic or returning to routine care around the same time as the program, these changes could coincidentally have boosted outcomes. We assumed any such effects were minor relative to the program's impact, but they were hard to fully disentangle.

Briana Botros and Kim Ren are actuaries for Milliman and members of the American Academy of Actuaries, and they meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices. This report outlines the review and opinions of the authors and not necessarily those of Milliman. Milliman does not endorse any program, public policy, or advocacy position on matters discussed in this report.

The analysis as described herein is designed to evaluate pharmaceutical outcomes only. The results do not include findings from patient reported outcomes, electronic health record data, clinical outcomes, or costs related to medical care received. Medical data was not available for this analysis. To the extent participants in the FlyteHealth program have higher acuity, they may experience higher trends from stricter disease management in the program. The results of this analysis are on an observational basis; differences in results could be due to factors outside the intervention of the program. None of the claims amounts included in this study have been adjusted for any confounding factors or were they risk adjusted. The findings will be limited in generalizability to insured populations similar to the participants studied.

Methodology and key assumptions

Many assumptions were needed for this analysis.

- **Participants:** These were defined as members who had a FlyteHealth app account created between July 1, 2023 and June 30, 2024 with at least one activity logged into their FlyteHealth app.
- **Claims data, medication pricing, and rebates:** The analysis was performed on the SoCT prescription claims data for claims incurred from July 1, 2022 and paid through June 30, 2024. All medication cost analyses were done net of rebates and member cost sharing and are based on the claim amounts paid by the SoCT to the PBM. At the time of this study, there were no co-pays for GLP-1 medications. Going forward, this is subject to change at the SoCT's discretion. Our study assumes consistent enrollment in the prescription benefit, which may influence the adherence and persistence findings. The PBM data were obtained by Milliman directly from the PBM.
- **Inclusion criteria:** Members must have had a pharmacy claim in the pilot period and a claim within the 12 months prior. (July 1, 2022 to June 30, 2023 and July 1, 2023 to June 30, 2024) to be included in the case study. We excluded outliers from this study, defined as members with a single claim greater than $500,000. Participants may have had a diabetes diagnosis and/or obesity, among other comorbidities.
- **Program cost accounting:** The vendor fees the SoCT paid to FlyteHealth were excluded from this analysis. Any additional internal administrative costs (e.g., the state's effort to administer the program) were assumed to be minimal and not quantified. We assumed no incentives were paid to members (the program itself is the incentive via medication access).
- **External factors:** We assumed no major policy changes (like sudden Medicare coverage or new competing drugs on the market) during the analysis window that would drastically alter utilization beyond the program's influence. The introduction of another new obesity drug (e.g., a high dose oral agent) could change patterns, but none was widely available in 2023 aside from those in the same class. We did note the FDA's expanded indication of Wegovy for certain heart risk reduction in 2024;[52] however, that likely did not affect the case study results.

[52] FDA. (March 8, 2024). *FDA approves first treatment to reduce risk of serious heart problems specifically in adults with obesity or overweight.* https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-reduce-risk-serious-heart-problems-specifically-adults-obesity-or.

Appendix A: Summary of GLP-1s by approval date and indication

Drug product name	Date approved	Product indication
Type 2 diabetes		
Byetta®* (exenatide)[53]	April 28, 2005	As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus (T2DM)
Victoza®* (liraglutide)[54]	January 25, 2010	▪ As an adjunct to diet and exercise to improve glycemic control in adults and patients aged ten years and older with T2DM ▪ To reduce the risk of major adverse cardiovascular events in adults with T2DM and established cardiovascular disease
Trulicity® (dulaglutide)[55]	September 18, 2014	▪ As an adjunct to diet and exercise to improve glycemic control in adults and pediatric patients ten years and older with T2DM ▪ To reduce the risk of major adverse cardiovascular events in adults with T2DM who have established cardiovascular disease or multiple cardiovascular risk factors
Bydureon Bcise® (exenatide ER)[56] *(Bydureon Suspension® and Bydureon Pen have been discontinued)*	October 20, 2017	As an adjunct to diet and exercise to improve glycemic control in T2DM in adults and patients aged ten years and older
Ozempic® (semaglutide)[57]	December 5, 2017	▪ As an adjunct to diet and exercise to improve glycemic control in adults with T2DM: ▪ To reduce the risk of major adverse cardiovascular events in adults with T2DM and established cardiovascular disease ▪ To reduce the risk of sustained eGFR decline, end-stage kidney disease, and cardiovascular death in adults with T2DM and chronic kidney disease
Rybelsus® (semaglutide)[58]	September 20, 2019	As an adjunct to diet and exercise to improve glycemic control in adults with T2DM
Mounjaro™ (tirzepatide)*[59]	May 13, 2022	As an adjunct to diet and exercise to improve glycemic control in adults with T2DM
Chronic weight management		
Saxenda® (liraglutide)[60]	December 23, 2014	As an adjunct to a reduced calorie diet and increased physical activity for chronic weight management in: ▪ Adult patients with an initial body mass index (BMI) of: – 30 kg/m^2 or greater (obese) or – 27 kg/m^2 or greater (overweight) in the presence of at least one weight related comorbid condition (e.g., hypertension, T2DM, or dyslipidemia) ▪ Pediatric patients aged 12 years and older with: – body weight above 60 kg and – an initial BMI corresponding to 30 kg/m^2 or greater for adults (obese) by international cut-offs (Cole Criteria)
Wegovy® (semaglutide)[61]	June 4, 2021	In combination with a reduced calorie diet and increased physical activity: ▪ to reduce the risk of major adverse cardiovascular events (cardiovascular death, nonfatal myocardial infarction, or

[53] See Highlights of prescribing information at https://den8dhaj6zs0e.cloudfront.net/50fd68b9-106b-4550-b5d0-12b045f8b184/ce8afab9-2b45-436d-957c-a73978d09e93/ce8afab9-2b45-436d-957c-a73978d09e93_viewable_rendition__v.pdf.
[54] See Highlights of prescribing information at https://www.novo-pi.com/victoza.pdf.
[55] See Highlights of prescribing information at https://uspl.lilly.com/trulicity/trulicity.html#pi.
[56] See Highlights of prescribing information at https://den8dhaj6zs0e.cloudfront.net/50fd68b9-106b-4550-b5d0-12b045f8b184/df5ddbd6-546b-43da-b794-56f711189aba/df5ddbd6-546b-43da-b794-56f711189aba_viewable_rendition__v.pdf.
[57] See Highlights of prescribing information at https://www.novo-pi.com/ozempic.pdf.
[58] See Highlights of prescribing information at https://www.novo-pi.com/rybelsus.pdf.
[59] See Highlights of prescribing information at https://uspl.lilly.com/mounjaro/mounjaro.html#pi.
[60] See Highlights of prescribing information at https://www.novo-pi.com/saxenda.pdf.
[61] See Highlights of prescribing information at https://www.novo-pi.com/wegovy.pdf.

Drug product name	Date approved	Product indication
		nonfatal stroke) in adults with established cardiovascular disease and either obesity or overweight ▪ to reduce excess body weight and maintain weight reduction long term in: – adults and pediatric patients aged 12 years and older with obesity – adults with overweight in the presence of at least one weight related comorbid condition
Zepbound® (tirzepatide)**[62]	November 8, 2023	In combination with a reduced calorie diet and increased physical activity: ▪ to reduce excess body weight and maintain weight reduction long term in adults with obesity or with overweight in the presence of at least one weight related comorbid condition ▪ to treat moderate to severe obstructive sleep apnea in adults with obesity

**Available generically*
***Tirzepatide is a dual glucose-dependent insulinotropic polypeptide (GIP) receptor and glucagon-like peptide-1 (GLP-1) receptor agonist.*

[62] See Highlights of prescribing information at https://pi.lilly.com/us/zepbound-uspi.pdf.