VA/DOD Clinical Practice Guidelines

THE MANAGEMENT OF ADULT OVERWEIGHT AND OBESITY

Provider Summary

Version 4.0 | 2025

VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF ADULT OVERWEIGHT AND OBESITY

Department of Veterans Affairs
Department of Defense

Provider Summary

QUALIFYING STATEMENTS

The Department of Veterans Affairs (VA) and the Department of Defense (DOD) guidelines are based on the best information available at the time of publication. The guidelines are designed to provide information and assist decision-making. They are not intended to define a standard of care and should not be construed as such. Neither should they be interpreted as prescribing an exclusive course of management.

This clinical practice guideline (CPG) is based on a systematic review of both clinical and epidemiological evidence published through January 2025. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of recommendations.

Variations in practice will inevitably and appropriately occur when providers consider the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Therefore, every health care professional using these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any clinical situation with a patient-centered approach.

These guidelines are not intended to represent VA or DOD policies. Further, the inclusion of recommendations for specific testing, therapeutic interventions, or both within these guidelines does not guarantee coverage of civilian sector care.

Version 4.0 – 2025

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Introduction

The Department of Veterans Affairs (VA) and Department of Defense (DOD) Evidence-Based Practice Work Group (EBPWG) was established and first chartered in 2004. Its mission is to advise the "…Health Executive Council on the use of clinical and epidemiological evidence to improve the health of the population across the Veterans Health Administration and Military Health System," by facilitating the development of clinical practice guidelines (CPGs) for the VA and DOD populations.(4) The development and update of VA/DOD CPGs is funded by VA Evidence Based Practice, Office of Quality and Patient Safety. The system-wide goal of evidence-based CPGs is to improve patient health and well-being.

In 2020, the VA and DOD updated the 2014 CPG for the Management of Adult Overweight and Obesity (2020 OBE CPG), based on evidence reviewed from February 1, 2013 to April 8, 2019. Since the release of the 2020 OBE CPG, the evidence base has expanded. Consequently, an update was recommended in 2024. This updated CPG uses the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach, reflecting a rigorous application of the methodology.(5) Therefore, the strength of some recommendations may have been modified based on the confidence in the quality of the supporting evidence (see Evidence Quality and Recommendation Strength in the full CPG).

The updated 2025 VA/DOD CPG for the Management of Overweight and Obesity in Adults includes objective, evidence-based information on managing overweight and obesity. Successful implementation of this CPG will assist providers in:

- Assessing the patient's condition and, in collaboration with the patient, determining the most appropriate therapeutic plan;
- Optimizing each patient's functional independence, health outcomes, and quality of life.
- Minimizing preventable complications and morbidity; and
- Emphasizing the use of patient-centered care.

Key Elements of Weight Management

The key elements of weight loss and weight management that are addressed by this guideline include:

1. Obesity is a chronic disease that requires lifelong management.
2. Shared decision-making, a process that includes assessment and re-assessment of patient values, motivation, and interest in weight management options, is fundamental to weight management.
3. Reviewing medications carefully and eliminating obesogenic agents used to treat other illnesses is important. Consider first using agents that are weight-neutral or promote weight loss when treating a patient with overweight or obesity for any medical concern.
4. A comprehensive lifestyle intervention (CLI), defined as the combination of three critical components (i.e., behavioral, dietary, and physical activity) that aim to produce a negative energy balance, is central to successful and sustained weight loss and maintenance.

5. Negative energy balance should be achieved through decreased caloric intake and increased physical activity. There is more than one successful strategy to achieve these goals.
6. Dietary supplements or nutraceuticals do not contribute to clinically meaningful weight loss or weight management.
7. Pharmacotherapy and/or bariatric procedures may be considered in conjunction with comprehensive lifestyle interventions. Both require long-term follow-up.
8. There are several FDA-approved medications with an indication for weight loss. In addition to efficacy and safety, it is important to individualize treatment, taking into consideration the potential for side effects and patient tolerability as well as patient preferences, to optimize long-term adherence to pharmacotherapy. Providers and patients must both be aware that weight regain often results after discontinuation, so that long-term use of pharmacotherapy for maintenance of weight loss is often needed.
9. Bariatric procedures are effective for weight loss. Type 2 diabetes mellitus especially improves with bariatric procedures. Patient individualization is required.
10. A multifaceted approach that combines comprehensive lifestyle intervention, pharmacologic, and surgical options as simultaneous effective treatment strategies can enhance weight loss and maintenance.

Recommendations

The evidence-based clinical practice recommendations listed in the table below were developed using a systematic approach considering four domains as per the GRADE approach (see Summary of Guideline Development Methodology). These domains include confidence in the quality of the evidence, balance of desirable and undesirable outcomes (i.e., benefits and harms), patient values and preferences, and other implications (e.g., resource use, equity, acceptability).

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Measures of Adiposity		1.	There is insufficient evidence to recommend either for or against a particular measure of adiposity to manage clinical outcomes in patients with overweight or obesity.	Neither for nor against	Reviewed, New-added
Management of Overweight and Obesity	*Lifestyle Interventions (LI)*	2.	We recommend offering an in-person group or individual comprehensive lifestyle intervention that always includes behavioral, dietary, and physical activity components for patients with overweight or obesity.	Strong for	Not Reviewed, Not-changed
		3.	We suggest offering a comprehensive lifestyle intervention for weight maintenance to patients who have completed a comprehensive lifestyle intervention for weight loss.	Weak for	Not Reviewed, Not-changed
		4.	We suggest offering an individual or group telephone-delivered comprehensive lifestyle intervention for weight loss, either as an alternative to or in conjunction with an in-person intervention.	Weak for	Not Reviewed, Not-changed
		5.	There is insufficient evidence to recommend either for or against a specific number of sessions, or a specific technology (except for telephone, see Recommendation 4), as the primary mode of delivery of a comprehensive lifestyle intervention.	Neither for nor against	Reviewed New-replaced
	Dietary Component of a CLI	6.	We recommend offering patients a dietary approach that contributes to a negative energy balance to achieve weight loss as the dietary component of a comprehensive lifestyle intervention.	Strong for	Reviewed, Not-changed
		7.	For weight loss and weight maintenance, there is insufficient evidence to recommend either for or against a particular dietary approach and/or strategy over another.	Neither for not against	Reviewed, New-replaced
	Physical Activity Component of a CLI	8.	We suggest physical activity of any type for weight management and other health outcomes, and as the physical activity component of a comprehensive lifestyle intervention.	Weak for	Reviewed, New-replaced
		9.	To optimize health outcomes, we suggest moderate to vigorous intensity aerobic exercise combined with resistance training.	Weak for	Reviewed, New-replaced

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Management of Overweight and Obesity (continued)	Weight Bias and Stigma	10.	We suggest offering cognitive behavioral interventions to individuals experiencing internalized weight bias and stigma.	Weak for	Reviewed, New-added
	Metabolic/Bariatric Procedures – Short-term	11.	For temporary weight loss, we suggest intragastric balloons, in conjunction with a comprehensive lifestyle intervention, in patients with a body mass index ≥30 kg/m^2, adherent to FDA guidelines*(read narrative).	Weak for	Reviewed, Amended
	Metabolic/Bariatric Procedures – Long-Term	12.	We suggest metabolic and bariatric surgery, in conjunction with a comprehensive lifestyle intervention, for durable weight loss in patients with a body mass index ≥30 kg/m² with type 2 diabetes mellitus or with a body mass index ≥35 kg/m².	Weak for	Reviewed, Amended
		13.	We suggest endoscopic sleeve gastroplasty (ESG) for weight loss, in conjunction with a comprehensive lifestyle intervention, in patients with a body mass index ≥30 kg/m².	Weak for	Reviewed, New-added
	Pharmacotherapy – Initiation and Discontinuing/Tapering	14.	There is insufficient evidence to recommend either for or against delaying the start of pharmacotherapy, in relationship to CLI, to improve outcomes in patients with overweight or obesity.	Neither for nor against	Reviewed, New-added
		15.	We suggest against discontinuing obesity medications, taking into account patient characteristics and preferences, as it results in weight regain.	Weak against	Reviewed, New-added
		16.	There is insufficient evidence to recommend either for or against reduction of the dose or frequency of pharmacotherapy to maintain achieved weight loss and avoid weight regain.	Neither for not against	Reviewed, New-added
	Pharmacotherapy – Medication	17.	We recommend semaglutide or tirzepatide for both weight loss and to maintain weight loss, in conjunction with a comprehensive lifestyle intervention, in patients with a body mass index ≥27 kg/m^2 who also have an obesity-associated condition; and those who have a body mass index ≥30 kg/m^2.	Strong for	Reviewed, New-added
		18.	We suggest phentermine/topiramate extended release(ER) or liraglutide for both weight loss and to maintain weight loss, in conjunction with a comprehensive lifestyle intervention, in patients with a body mass index ≥27 kg/m^2 who also have an obesity-associated condition; and, those who have a body mass index ≥30 kg/m2.	Weak for	Reviewed, Amended

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Management of Overweight and Obesity (continued)	Pharmacotherapy – Medication	19.	We suggest naltrexone/bupropion extended release (ER) for weight loss, in conjunction with a comprehensive lifestyle intervention, in patients with a body mass index ≥27 kg/m^2 who also have an obesity-associated condition; and those who have a body mass index ≥30 kg/m^2.	Weak for	Reviewed, Amended
		20.	We suggest the use of glucagon-like peptide type 1 agonist-containing agents, in conjunction with CLI, for the treatment of patients with overweight and obesity, with either co-occurring prediabetes or type 2 diabetes mellitus.	Weak for	Reviewed, New-Added
		21.	There is insufficient evidence to recommend either for or against orlistat, metformin, sodium glucose co-transporter type 2 inhibitors, or pramlintide for weight loss.	Neither for nor against	Reviewed, Amended
		22.	There is insufficient evidence to recommend either for or against phentermine monotherapy, benzphetamine, diethylpropion, or phendimetrazine for weight maintenance.	Neither for nor against	Reviewed, Amended
	Dietary Supplements and Nutraceuticals	23.	We suggest against using dietary supplements or nutraceuticals for clinically meaningful weight management.	Weak against	Not reviewed, Amended

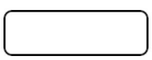
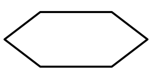
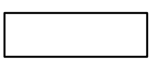
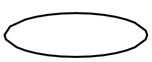
[a] For additional information, please refer to Determining Recommendation Strength and Direction
[b] For additional information, please refer to Recommendation Categorization

Algorithm

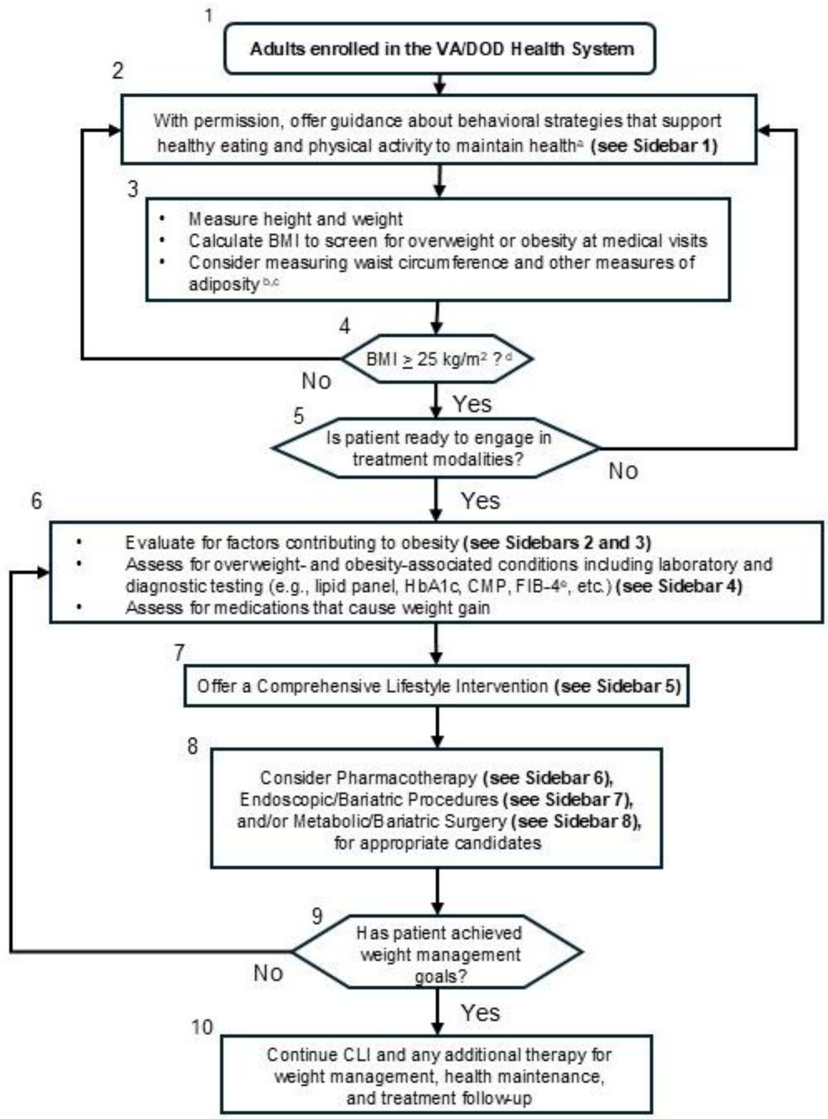
This CPG includes algorithms designed to facilitate understanding of the clinical pathways and decision-making processes used in managing patients with overweight or obesity. The use of the algorithm format as a way to represent patient management was chosen based on the understanding that such a format may promote more efficient diagnostic and therapeutic decision making; it also has the potential to change patterns of resource use. Although the Work Group recognizes that not all clinical practices are linear, the simplified linear approach depicted through the algorithm and its format allows the provider to assess the critical information needed at the major decision points in the clinical process. It includes:

1. An ordered sequence of steps of care
2. Recommended observations and examinations
3. Decisions to be considered
4. Actions to be taken

For each VA/DOD CPG, there is a corresponding clinical algorithm that is depicted by a step-by-step decision tree. Standardized symbols are used to display each step in the algorithm, and arrows connect the numbered boxes, indicating the order in which the steps should be followed.(6) Sidebars provide more detailed information to assist in defining and interpreting elements in the boxes.

Shape	Description
	Rounded rectangles represent a clinical state or condition
	Hexagons represent a decision point in the guideline, formulated as a question that can be answered “Yes” or “No”
	Rectangles represent an action in the process of care
	Ovals represent a link to another section within the guideline

Algorithm Module



[a] See, for example, *2020-2025 Dietary Guidelines for Americans, 9th edition,* available at: [Dietary Guidelines for Americans] and *Physical Guidelines for Americans, 2nd Edition*, available at: [Physical Activity Guidelines for Americans | odphp.health.gov]

[b] Waist circumference: ≥102 cm (40 in) for men and ≥88 cm (35 in) for women, for those of Asian descent: ≥90 cm (35.4 in) for men and ≥80 cm (31.5 in) for women or waist-to-hip ratio (WHR) >0.90 for men and >0.80 for women, or waist-to-height ratio (WtHR)(7) ≥ 0.50 for all

[c] The waist circumference measurement should be made with a tape measure placed around the bare abdomen just above the iliac crest. The tape should be snug, but should not compress the skin, and the measurement should be obtained while the patient is standing at the end of normal exhalation(8)

[d] For patients of Asian descent: is BMI ≥23 kg/m2?;(9) for patients >65 years old: consider individualized assessment(10)

[e] The Fibrosis-4 (FIB-4) index(11) is a non-invasive scoring system used to estimate liver fibrosis based on several laboratory tests.

Abbreviations: BMI: body mass index; CLI: comprehensive lifestyle intervention; CMP: comprehensive metabolic panel; DOD: Department of Defense; VA: Department of Veterans Affairs; WHR: waist-to-hip ratio; WtHR: waist-to-height ratio

Sidebar 1: Principles and Core Strategies of Motivational Interviewing and Behavioral Counseling
• Respect autonomy and resist directing • Understand the patient's motivations • Listen with empathy • Empower the patient by building confidence • Ask **O**pen-ended questions to evoke change talk and provide **A**ffirmations, **R**eflections, and **S**ummaries (OARS) • Use the 5 A's: Ask, Assess, Advise, Agree, Assist[a]

[a] See information for Behavioral Counseling Interventions, available at: Behavioral Counseling Interventions: An Evidence-based Approach | United States Preventive Services Taskforce

Sidebar 2: Select Medications and their Potential Effects on Weight[a]
Providers will need to individualize recommendations to their patient

Medication Classes	Medications with Potential for Weight GAIN	Medications that are Weight Neutral or have Potential for Weight LOSS
Antipsychotics[d]	• Chlorpromazine • Clozapine • Iloperidone • Olanzapine • Paliperidone • Quetiapine • Risperidone • Thioridazine	Consider an antipsychotic with minimal to no effect on weight gain if possible. NOTE: No antipsychotic medication is associated with weight loss. • Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Fluphenazine • Haloperidol • Loxapine • Lumateperone • Lurasidone • Molindone • Perphenazine • Pimavanserin • Xanomeline-trospium • Ziprasidone
Antidepressants[e]	• Mirtazapine • Some selective serotonin reuptake inhibitors (SSRI) (e.g., paroxetine, sertraline, citalopram[b], and escitalopram[b]) • MAOIs (e.g., phenelzine) • Tricyclic anti-depressants (e.g., amitriptyline, clomipramine, doxepin, imipramine, nortriptyline, protriptyline[b])	Consider an antidepressant with minimal to no effect on weight gain if possible. • Bupropion (associated with weight loss) • Some SSRIs (e.g., fluoxetine) • SNRIs (e.g., desvenlafaxine, venlafaxine, duloxetine) • Trazodone, Nefazodone • Vortioxetine

Sidebar 2: Select Medications and their Potential Effects on Weight[a] Providers will need to individualize recommendations to their patient		
Medication Classes	**Medications with Potential for Weight GAIN**	**Medications that are Weight Neutral or have Potential for Weight LOSS**
Antiseizure drugs or mood stabilizing agents	• Divalproex • Gabapentin • Lithium • Perampanel • Pregabalin • Valproic acid • Vigabatrin	Associated with weight loss: • Topiramate • Zonisamide • Cannabidiol • Stiripentol Associated with minimal weight loss, conflicting or no evidence for weight gain or loss: • Brivaracetam, levetiracetam • Carbamazepine, Eslicarbazepine, Oxcarbazepine • Cenobamate • Clobazam • Ethosuximide • Felbamate • Lacosamide • Lamotrigine • Phenobarbital • Phenytoin • Primidone • Rufinamide • Tiagabine NOTE: Prioritize seizure control
Antihyperglycemic agents	• Insulin[c] • Sulfonylureas (e.g., chlorpropamide, glimepiride, glipizide, glyburide) • Meglitinides (e.g., nateglinide, repaglinide) • Thiazolidinediones (e.g., pioglitazone, rosiglitazone)	Associated with weight loss: • GLP-1/GIP tirzepatide • GLP-1 containing agonists (e.g., semaglutide, liraglutide, exenatide, dulaglutide, lixisenatide) • SGLT2 inhibitors (e.g., empagliflozin, canagliflozin, dapagliflozin, ertugliflozin) • Metformin • Alpha-glucosidase inhibitors (e.g., acarbose, miglitol) • Pramlintide Weight neutral: • Dipeptidyl-peptidase-4 inhibitors (e.g., alogliptin, linagliptin, saxagliptin, sitagliptin)

Sidebar 2: Select Medications and their Potential Effects on Weight[a] Providers will need to individualize recommendations to their patient		
Medication Classes	**Medications with Potential for Weight GAIN**	**Medications that are Weight Neutral or have Potential for Weight LOSS**
Beta-blockers	• Metoprolol • Atenolol • Propranolol Less weight gain than above: • Carvedilol[b] • Nebivolol[b]	Consider calcium channel blockers, angiotensin receptor blockers, angiotensin-converting enzyme inhibitors, and thiazide or loop diuretics, as indicated. NOTE: Other alternative classes of antihypertensive medications may be an option depending on the indication (e.g., angina, heart failure, HTN, migraine).
Alpha-blockers	• Terazosin • Doxazosin • Prazosin	• Alfuzosin • Tamsulosin
Glucocorticoids	• Systemic Steroids (e.g., Prednisone, Dexamethasone, Methylprednisolone, Hydrocortisone)	Consider weight-neutral steroid-sparing alternatives based on indication. Some examples include: • Biologics/disease-modifying antirheumatic drugs • Nontraditional therapies • NSAIDs
Hormonal agents	Oral or Depot Progestin-only therapy (e.g., medroxyprogesterone, megestrol acetate)[f] Less weight gain than above: Combination contraceptives (e.g., oral, patch)[f]	Consider alternative methods based on indication (e.g., contraception; menopause). Some examples include: • Copper intrauterine device • Barrier Method
Antihistamines(12,13)	• H1 antihistamines (e.g., hydroxyzine, diphenhydramine, fexofenadine), cetirizine, and desloratadine	Depending on symptoms, consider alternatives such as: ipratropium nasal spray, decongestants, inhalers, and/or nonpharmacologic measures (e.g., nasal irrigation)
Antiretrovirals	• Protease Inhibitors (e.g., atazanavir, darunavir) • Integrase Inhibitors (e.g., bictegravir, dolutegravir, raltegravir)	Other ARVs are typically weight-neutral. Prioritize viremia control.

[a] The information provided in the table is not to be considered all-inclusive and is a compilation of information from the medical literature (systematic reviews, meta-analyses, subgroup analysis of clinical trials, cohort studies, reviews), some of which may have included differing comparators with variable results based on length of follow-up, baseline weight, patient comorbidities, etc.; medical and pharmacy resources; and select product information (adverse events, post-marketing and case reports).

[b] Weight gain and weight loss have been reported. *should there be more description of initial vs. long-term effects on weight* for beta blockers: Bakris GL, Fonseca V, Katholi RE, et al. Metabolic Effects of Carvedilol vs Metoprolol in Patients With Type 2 Diabetes Mellitus and Hypertension: A Randomized Controlled Trial. JAMA. 2004;292(18):2227–2236. doi:10.1001/jama.292.18.2227(14)

[c]High basal insulin (≥ 0.5units/kg) can cause sub-clinical hypoglycemia that can increase appetite
[d] See Table D-3: Antipsychotic Adverse Event Profiles in the April 2023 VA/DOD Clinical Practice Guideline for Management of First-Episode Psychosis and Schizophrenia. Available at: https://www.healthquality.va.gov/guidelines/MH/scz/
[e] See Table J-2: Antidepressant Adverse Event Profiles in the February 2022 VA/DOD Clinical Practice Guideline for the Management of Major Depressive Disorder. Available at: https://www.healthquality.va.gov/guidelines/MH/mdd/
[f] Lopez LM, Ramesh S, Chen M, et al. Progestin-only contraceptives: effects on weight. Cochrane Database Syst Rev. 2016(8):CD008815.(15); Gallo MF, Lopez LM, Grimes DA, Carayon F, Schulz KF, Helmerhorst FM. Combination contraceptives: effects on weight. Cochrane Database Syst Rev. 2014(1):CD003987.(16)

Abbreviations: ARB: angiotensin receptor blocker; ARV: antiretroviral; GLP-1: glucagon-like peptide-1 receptor; HTN: hypertension; MAOI: monoamine oxidase inhibitor; NSAID: nonsteroidal anti-inflammatory drug; SGLT2: sodium-glucose cotransporter 2

Sidebar 3: Assessment of Factors Associated with Obesity

- Assess for presence of obesogenic medications (see Sidebar 2 on pharmacotherapy)
- Assess for factors associated with overweight or obesity if physical exam and personal family history warrant, including but not limited to: depression, eating disorders or disordered eating, food insecurity and nutritional insufficiency, menopause, endocrine disorders (e.g., hypothyroidism, acromegaly, hypogonadism, hypercortisolism), neurologic conditions (e.g., hypothalamic obesity, traumatic brain injury, brain tumor, cranial irradiation, spinal cord injury), sleep apnea

Sidebar 4: Common Overweight- & Obesity-Associated Conditions By System[a]

- Endocrine conditions (e.g., Prediabetes and Diabetes Mellitus, Metabolic Syndrome[b])
- Cardiovascular conditions (e.g., ASCVD, HTN, Dyslipidemia, Atrial Fibrillation, CHF, Stroke)
- Gastrointestinal conditions (e.g., MASLD, GERD)
- Musculoskeletal (e.g., OA/degenerative joint disease)
- Mental health conditions (e.g., depression, PTSD, anxiety, disordered eating)
- Respiratory conditions (e.g., OSA, asthma, hypoventilation syndrome)
- Genitourinary conditions (e.g., PCOS, female infertility, male hypogonadism, stress incontinence)
- Renal (e.g., microalbuminuria, CKD)
- Cancer(1-3)
- Neurological (e.g., IIH)

[a] This list of conditions is not a comprehensive list of overweight and obesity associated conditions.
[b] See National Cholesterol Education Program definition of metabolic syndrome, available at: https://www.nhlbi.nih.gov/files/docs/guidelines/atglance.pdf
Abbreviations: ASCVD: atherosclerotic cardiovascular disease; CHF: congestive heart failure; CKD: chronic kidney disease; GERD: gastroesophageal reflux disease; HTN: hypertension; IIH: idiopathic intracranial hypertension; MASLD: metabolic dysfunction-associated steatotic liver disease; OA: osteoarthritis; OSA: obstructive sleep apnea; PCOS: polycystic ovarian syndrome; PTSD: post-traumatic stress disorder

Sidebar 5: Comprehensive Lifestyle Intervention
• Defined as an intervention that combines behavioral, nutritional, and physical activity components together (see Recommendation 2, Recommendation 6, Recommendation 8, Recommendation 9, and Appendix O of the OBE CPG) • The intervention can be delivered in an individual or group setting, in person, by telephone, or through synchronous video (see Recommendation 2, Recommendation 4, Recommendation 5, and Appendix O of the OBE CPG) • Though there is insufficient evidence to recommend a specific number of sessions of comprehensive lifestyle intervention, most CLIs offer at least 12 intervention sessions in the first 12 months of intervention (see Recommendation 2)

Abbreviations: CLI: comprehensive lifestyle intervention

Sidebar 6: Assessment for Pharmacotherapy
The thresholds listed below are for the initiation of therapy. These medications may be continued for maintenance of BMI target goals. Consider for long-term pharmacotherapy (see Appendix J of the OBE CPG): • Patients with a BMI ≥30 kg/m^2 • Patients with a BMI ≥27 kg/m^2 and an obesity-related comorbidity (see Table J-1 of the OBE CPG) • Individualize choice of medication to patient-specific comorbidities, dosing, administration, and potential for side effects NOTE: Patients with BMI≥25-27 kg/m2 with additional adiposity measures require special considerations. See Recommendations for further information.

Abbreviations: BMI: body mass index; kg: kilograms; m: meters
*Use Asian population cutoffs per Table 7 above

Sidebar 7: Assessment for Endoscopic and/or Bariatric Therapies
Consider for endoscopic and/or bariatric therapies (see Recommendation 11, Recommendation 13, and Appendix K of the OBE CPG): • For intragastric balloons, patients with a BMI of 30-40 kg/m^2 • For endoscopic sleeve gastrectomy, patients with a BMI of 30-50 kg/m^2

Abbreviations: BMI: body mass index; kg: kilograms; m: meters

Sidebar 8: Assessment for Metabolic and/or Bariatric Surgery
Consider for metabolic/bariatric surgery (see Recommendation 12 and Appendix K of the OBE CPG): • Patients with a BMI ≥30 kg/m^2 and T2DM • Patients with a BMI ≥35 kg/m^2

Abbreviations: BMI: body mass index; kg: kilograms; m: meters; T2DM: type 2 diabetes mellitus

Scope of the CPG

Regardless of setting, any patient in the VA and DOD healthcare system should ideally have access to the interventions that are recommended in this guideline after taking into consideration the patient's specific circumstances.

Guideline recommendations are intended to support the delivery of evidence-based, patient-centered healthcare, which occurs at the intersection of best available evidence, patient preference, and practitioner expertise and experience. Effective, open communication between healthcare professionals and the patient is essential and should be supported by evidence-based information tailored to the patient's needs. Use of an empathetic and non-judgmental approach facilitates discussions sensitive to sex, culture, ethnicity, and other considerations. The information that patients are given about treatment and care should be culturally appropriate and available to people with limited literacy skills. Treatment information should also be accessible to people with additional needs, such as physical, sensory, or learning disabilities. Family and caregiver involvement should be considered, if appropriate.

This CPG is designed to assist providers in managing or co-managing patients with overweight or obesity. Moreover, the patient population of interest for this CPG is adult with overweight or obesity who are eligible for care in the VA and DOD healthcare delivery systems including those who are in the community receiving care from community-based clinicians. It includes Veterans as well as deployed and non-deployed active duty Service, Guard, and Reserve Members and their adult dependents.

Classification of Overweight and Obesity

For adults, having a BMI of 25 – 29.9 kg/m^2 is considered overweight, while a BMI of 30 kg/m^2 or higher is considered obese. The category of "obese" is further divided into subcategories of Class 1 obesity (BMI 30.0 – 34.9 kg/m^2), Class 2 obesity (BMI 35.0 – 39.9 kg/m^2), and Class 3 obesity (BMI ≥40 kg/m^2).(17) For individuals of Asian descent, the World Health Organization suggests a lower threshold for overweight (BMI >23.0 kg/m^2) and obesity (BMI >25 kg/m^2).

An online BMI calculator is available at the CDC website.

Methods

The 2025 VA/DOD Obesity CPG is an update to the 2020 VA/DOD Obesity CPG. The methodology used in developing the 2025 VA/DOD Obesity CPG follows the *Guideline for Guidelines*, an internal document of the VA and DOD EBPWG.(18) The *Guideline for Guidelines* can be downloaded from http://www.healthquality.va.gov/policy/index.asp. The guideline development process for the 2025 VA/DOD Obesity CPG update consisted of the following steps: formulating and prioritizing key questions (KQs); convening a patient focus group; conducting the systematic evidence review; convening a face-to-face meeting with the CPG Champions and Work Group members; and drafting and submitting a final CPG on the management of obesity to the VA/DOD EBPWG.

The Champions and Work Group used the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system to assess the quality of the evidence and assign a grade for the strength for each recommendation. The GRADE system uses the following four domains to assess the strength of each recommendation: balance of desirable and undesirable outcomes; confidence in the quality of the evidence; patient or provider values and preferences; other implications, as appropriate (e.g., resource use, equity).(19) Using this system, the

Champions and Work Group determined the relative strength of each recommendation ("Strong" or "Weak"). A "Strong" recommendation generally indicates that the Work Group is highly confident that the desirable effects of an intervention outweigh undesirable effects. If the Work Group is less confident that the desirable effects of an intervention outweigh undesirable effects, they give a "Weak" recommendation. It is important to note that the GRADE terminology used to indicate the assessment across the four domains (i.e., "Strong" versus "Weak") should not be confused with the clinical importance of the recommendation. A "Weak" recommendation may be just as important to the clinical care of a patient as a strong recommendation.

Occasionally, instances may occur when the Work Group feels there is insufficient evidence to make a recommendation for or against a particular therapy or preventive measure. This can occur when there is an absence of studies on a particular topic that met evidence review inclusion criteria, studies included in the evidence review report with conflicting results, or studies included in the evidence review report with inconclusive results regarding the desirable and undesirable outcomes.

Using these elements, the grade of each recommendation is presented as part of a continuum:

- Strong For (or "We recommend offering this option …")
- Weak For (or "We suggest offering this option …")
- No recommendation for or against (or "There is insufficient evidence …")
- Weak Against (or "We suggest not offering this option …")
- Strong Against (or "We recommend against offering this option …")

The grade of each recommendation made in the 2025 VA/DOD Obesity CPG can be found in the section on Recommendations. Additional information regarding the use of the GRADE system can be found in Appendix A in the full OBE CPG.

The Work Group developed both new and updated recommendations based on the evidence review conducted for the priority areas addressed by the KQs. In addition, the Work Group considered, without a complete review of the relevant evidence, the current applicability of other recommendations that were included in the 2020 VA/DOD Obesity CPG, subject to evolving practice in today's environment. A set of recommendation categories was adapted from those used by National Institute for Clinical Excellence (NICE).(19,20) These categories, along with their corresponding definitions, were used to account for the various ways in which recommendations could have been updated from the 2020 VA/DOD Obesity CPG and can be found in Table 1.

Table 1. Recommendation Categories and Definitions*

Evidence Reviewed*	Recommendation Category	Definition
Reviewed	New-added	New recommendation following review of the evidence
	New-replaced	Recommendation from previous CPG that has been carried over to the updated CPG that has been changed following review of the evidence
	Not changed	Recommendation from previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed but the recommendation is not changed
	Amended	Recommendation from previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed and a minor amendment has been made
	Deleted	Recommendation from previous CPG that has been removed based on review of the evidence
Not reviewed	Not changed	Recommendation from previous CPG that has been carried forward to the updated CPG, but for which the evidence has not been reviewed
	Amended	Recommendation from previous CPG that has been carried forward to the updated CPG where the evidence has not been reviewed and a minor amendment has been made
	Deleted	Recommendation from previous CPG that has been removed because it was deemed out of scope for the updated CPG

*Adapted from the NICE guideline manual (2012)(19) and Garcia et al. (2014)(20)

Abbreviation: CPG: clinical practice guideline

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Patient-centered Care

VA/DOD CPGs encourage providers to use a patient-centered care approach that is individualized based on patient needs, characteristics, and preferences. Intended to consider patient needs and preferences, guideline recommendations represent a whole/holistic health approach to care that is patient-centered, culturally appropriate, and available to people with limited literacy skills and physical, sensory, or learning disabilities. VA/DOD CPGs encourage providers to use a patient-centered, whole/holistic health approach (i.e., individualized treatment based on patient needs, characteristics, values, and preferences). This approach aims to treat the condition while optimizing the individual's overall health and well-being.

Regardless of the care setting, all patients should have access to individualized, evidence-based care. Patient-centered care can decrease patient anxiety, increase trust in providers, and improve treatment adherence.(21,22) A whole/holistic health approach (https:/www.va.gov/wholehealth/) empowers and equips individuals to meet their personal health and wellbeing goals.

Shared Decision Making

This CPG encourages providers to practice shared decision making, a process in which providers, patients, and family/friend/caregiver consider clinical evidence of benefits and risks as well as patient values and preferences to make decisions regarding the patient's treatment.(23) Shared decision making is emphasized in Crossing the Quality Chasm, an Institute of Medicine report from 2001(24), and is a core component of a holistic health approach. Providers must be adept at presenting information to their patients regarding individual treatments, expected risks, expected outcomes, and levels or settings of care, or both, especially where patient heterogeneity in weighing risks and benefits might exist. The Veterans Health Administration and the Military Health System have embraced shared decision-making. Providers are encouraged to use shared decision-making to individualize treatment goals and plans based on patient capabilities, needs, and preferences.

Dietary Approaches to Support Weight Loss

Dietary Approaches	Description
American Heart Association (AHA) Dietary Guidance	• Dietary patterns rather than isolated nutrients, recommending a flexible, food-based approach that prioritizes high intake of fruits, vegetables, whole grains, healthy protein sources (mostly plants, fish/seafood, low-fat dairy, lean unprocessed meats if chosen), use of liquid plant oils, minimal added sugars and salt, and avoidance of ultra-processed foods. The AHA guidance is designed to be adaptable to personal, cultural, and economic preferences and is intended for lifelong adherence to support cardiometabolic health and weight management.

Dietary Approaches	Description
Dietary Approaches to Stop Hypertension (DASH) diet[b](25)	Dietary pattern that is moderate in fat (25–30% of energy, low in saturated fat), high in fruits, vegetables, and low-fat dairy, and has the strongest evidence for blood pressure reduction and cardiometabolic benefit.
High Protein Diet	Dietary pattern in which protein provides more than 20% of total daily energy intake, or typically 1.2–1.6 g/kg body weight per day, with some studies using up to 30–45% of energy from protein. These diets often reduce carbohydrate and/or fat intake to maintain energy balance.
Ketogenic diet	Dietary pattern that is very high in fat (>70% of energy), very low in carbohydrates (<10% of energy). Short-term weight loss is similar to low-fat diets, but ketogenic diets may increase LDL cholesterol and have less favorable long-term cardiovascular profiles.
Intermittent Fasting	• **Intermittent fasting**: a general term for dietary regimens that alternate periods of voluntary fasting (no or minimal caloric intake) with periods of normal eating • **Alternate day fasting**: a form of intermittent fasting in which individuals alternate between days of significant caloric restriction (typically 0–600 kcal, or about 25% of energy needs) and days of ad libitum (unrestricted) food intake. This regimen induces repeated cycles of fasting and feeding, leading to metabolic adaptations such as increased fatty acid oxidation, ketone body production, and improved insulin sensitivity. • **5:2 diet**: a form of intermittent fasting in which individuals consume a very low-calorie diet (typically 500–600 kcal) on two non-consecutive days per week and eat ad libitum (without restriction) on the remaining five days. This regimen is designed to create an overall weekly caloric deficit while allowing flexibility and fewer days of restriction compared to alternate-day fasting (ADF) • **Time-restricted eating (TRE)**: a form of intermittent fasting in which all caloric intake is confined to a consistent daily window, typically 4–10 hours, with fasting (zero-calorie beverages allowed) for the remaining hours of the day. TRE does not prescribe specific foods or calorie targets but instead focuses on the timing of food intake, often aligning eating with circadian rhythms to optimize metabolic health.
Lacto-ovo vegetarian diet	Dietary pattern that excludes all meat, poultry, and fish but includes dairy products and eggs, along with plant-based foods.
Low-carbohydrate diet	Dietary pattern in which carbohydrates provide less than 40–45% of total daily energy intake, or, in some protocols, less than 130 g/day. These diets typically increase fat and/or protein intake to compensate for the reduction in carbohydrates.
Low-fat diet	Dietary pattern in which less than 30% of total daily energy intake is derived from fat, with saturated fat typically limited to less than 10% of energy. Carbohydrates generally comprise 55–60% or more of total energy, and protein intake is moderate. This pattern emphasizes fruits, vegetables, whole grains, and lean proteins, while minimizing added fats and high-fat animal products.
Low-glycemic index (GI) diet	Dietary pattern that emphasizes carbohydrate-containing foods with a GI less than 55, resulting in smaller and slower postprandial glucose excursions. Such diets are rich in non-starchy vegetables, legumes, whole grains, and certain fruits, and are designed to flatten postprandial glycemia and insulin response, which may promote satiety and improve glycemic control.
Mediterranean diet(26)	Dietary pattern that is higher in total fat (35–40% of energy, mostly unsaturated from olive oil and nuts), moderate in carbohydrates, and associated with the most consistent and robust improvements in weight, glycemia, and cardiovascular outcomes.

Meal Replacement	Dietary pattern that includes commercially prepared products such as shakes, bars, or portion-controlled packaged meals – formulated to provide a defined amount of calories and essential nutrients designed to substitute one or more conventional meals per day.
MyPlate	Dietary guideline developed by the United States Department of Agriculture that divides the plate into four sections: fruits, vegetables, grains (with an emphasis on whole grains), and protein, with a side of dairy. It emphasizes variety, nutrient density, and portion control, and limits added sugars, saturated fat, and sodium. MyPlate is designed to be flexible and adaptable to individual preferences and cultural traditions, and aligns with the Healthy US-Style dietary pattern referenced in the American Heart Association dietary guidance.
Vegan diet	Dietary pattern that excludes all foods and beverages derived wholly or partly from animals, including meat, poultry, fish, dairy, eggs, and often honey, relying exclusively on plant-based foods such as vegetables, fruits, grains, legumes, nuts, and seeds.

More Dietary Approaches can be found in Medical Nutrition Therapy Interventions provided by Dietitians for Adult Overweight and Obesity Management: An Academy of Nutrition and Dietetics Evidence-Based Practice Guideline. J Acad Nut Diet 2023:23(3):520-545. doi: https://doi.org/10.1016/j.jand.2022.11.014(27)

[a] For further information about the Mediterranean eating pattern, see the 2020-2025 Dietary Guidelines for Americans, available at: https://www.dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf

[b] For further information on the DASH dietary pattern visit: https://www.nhlbi.nih.gov/health-topics/dash-eating-plan and https://www.dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf

Abbreviations: ACC: American College of Cardiology; ADF: alternate-day fasting; AHA: American Heart Association; DASH: Dietary Approaches to Stop Hypertension; g: grams; kg: kilograms; LDL: low-density lipoprotein; mg: milligrams; RDA: recommended dietary allowance; SR: systematic review; TOS: The Obesity Society; TRE: Time-restricted eating; USDA: United States Department of Agriculture

Pharmacologic Information for Obesity Medications[a]

Medication	Dosing	Monitoring	Common Side Effects	Contraindications	Warnings
Semaglutide (Wegovy®) Two Additional FDA-approved indications for: (1) secondary prevention of MACE in adults with overweight or obesity; and (2) metabolic dysfunction-associated steatohepatitis (MASH) irrespective of BMI	▪ Initial dose-escalation: ▪ Week 1-4: 0.25 mg subQ weekly ▪ Week 5-8: 0.5 mg subQ weekly ▪ Week 9-12: 1 mg subQ weekly ▪ Week 13-16: 1.7mg subQ weekly ▪ Week ≥17: 2.4mg subQ weekly ▪ Maintenance doses are 2.4 mg weekly (preferred) or 1.7 mg weekly (if 2.4 mg is not tolerated) ▪ Dose in Renal Impairment*:* Use with caution when initiating or increasing dose	<u>Common to all NuSHes/GLP-1 RA containing agents listed except where agent-specific information is listed:</u> ▪ Weight ▪ Blood pressure ▪ Heart rate ▪ Glucose and/or signs/symptoms of hypoglycemia. Use additional caution if the patient is using another glucose-lowering agent ▪ Mood (symptoms of depression) and sleep disorders ▪ Delayed gastric emptying may impact absorption of some oral medications. Tirzepatide PI recommends women using oral hormonal contraceptives to switch to a non-oral contraceptive method or add a barrier method of contraception for 4 weeks after initiation and for 4 weeks after each dose escalation.	<u>Common to all NuSHes/GLP-1 RA containing agents listed except where agent-specific information is listed:</u> ▪ Increased heart rate ▪ Headache ▪ Hypoglycemia ▪ Nausea ▪ Diarrhea ▪ Constipation ▪ Vomiting ▪ Dyspepsia ▪ Abdominal pain ▪ Fatigue ▪ Injection site reactions	<u>Common to all NuSHes/GLP-1 RA containing agents listed except where agent-specific information is listed:</u> ▪ Personal or family history of medullary thyroid carcinoma or MEN2 **[U.S. Boxed Warning]** ▪ Pregnancy: Liraglutide PI recommends discontinuation if a woman wishes to become pregnant or pregnancy occurs. Semaglutide PI recommends discontinuation at least 2 months prior to planning pregnancy. Tirzepatide PI recommends women using oral hormonal contraceptives to switch to a non-oral contraceptive method or add a barrier method of contraception for 4 weeks after initiation and for 4 weeks after	<u>Common to all NuSHes/GLP-1 RA containing agents listed except where agent-specific information is listed:</u> ▪ Thyroid C-cell tumors **[U.S. Boxed Warning]** ▪ Injection site reactions ▪ Hypersensitivity reactions (caution if previous reactions to GLP-1 agonist) ▪ Gallbladder disease ▪ Pancreatitis ▪ Renal impairment ▪ Acute/chronic renal failure exacerbation ▪ Suicidal behavior and ideation ▪ Hypoglycemia ▪ Pulmonary aspiration risk during general anesthesia or deep sedation ▪ Tachycardia (not a warning in tirzepatide PI, but is increased
Tirzepatide (Zepbound®) Additional FDA-approved indication for treatment of moderate to severe OSA in adults with obesity	▪ Initial dose-escalation: 2.5 mg subQ weekly for 4 weeks. Increase by 2.5mg/week every 4 weeks ▪ Maintenance doses are 5 mg, 10 mg, and 15 mg weekly (for OSA, recommended doses are 10 mg or 15 mg weekly)				
Liraglutide (Saxenda®)	▪ Initiate dose titration with 0.6 mg daily, subcutaneously for 1 week; increase daily dose by 0.6 mg per week until reaching a target dose of 3 mg; slow titration to every other week if the patient cannot tolerate weekly titration ▪ Per the product information, discontinue if 4% weight loss is not achieved by week 16 as it is				

Medication	Dosing	Monitoring	Common Side Effects	Contraindications	Warnings
	unlikely that a meaningful weight loss will be achieved and sustained with continued treatment ▪ <u>Patients on secretagogues (such as sulfonylureas) or insulin:</u> Consider reducing the dose of the secretagogue (e.g., by 50%) or insulin to avoid hypoglycemia ▪ <u>Dose in Renal Impairment:</u> Use with caution in renal impairment			each dose escalation.	heart rate was experienced in clinical trials) ▪ Severe GI effects and not recommended in patients with severe gastroparesis (not a warning in liraglutide PI, but listed in post-marketing experience) ▪ Diabetic retinopathy (in semaglutide and tirzepatide PIs only) ▪ De-escalate BP medication
Phentermine / topiramate ER (Qsymia®) Controlled Substance: CIV	▪ Phentermine 3.75 mg/topiramate 23 mg capsule each morning for 14 days; then 7.5 mg/46 mg each morning for additional 12 weeks ▪ If a 3% loss of baseline body weight is not achieved after 12 weeks, increase dose to 11.25 mg/69 mg each morning for 14 days; then increase to 15 mg/92 mg daily ▪ If a 5% loss of baseline body weight is not achieved after 12 weeks, it is unlikely that the patient will achieve a clinically meaningful weight loss with further treatment; discontinue by tapering (one dose every other day for ≥1 week) ▪ <u>Moderate/Severe Renal Impairment (CrCl <50 mL/min):</u>	▪ Weight ▪ Blood pressure ▪ Resting heart rate ▪ Serum bicarbonate, especially if taking another carbonic anhydrase inhibitor ▪ Serum potassium, especially if taking another carbonic anhydrase inhibitor ▪ Glucose and/or signs/symptoms of hypoglycemia in patients with diabetes ▪ Mood (depression) and sleep disorders ▪ Pregnancy tests in women of reproductive potential ▪ Baseline and periodic monitoring of serum	▪ Increased heart rate ▪ Paresthesia ▪ Dizziness ▪ Dysgeusia ▪ Headache ▪ Insomnia ▪ Decreased serum bicarbonate ▪ Xerostomia ▪ Constipation ▪ Upper respiratory tract infection ▪ Nasopharyngitis	▪ Pregnancy (REMS program exists to inform prescribers and patients of risks) ▪ Glaucoma ▪ Hyperthyroidism ▪ MAOI use during or within 14 days ▪ Allergy to Yellow dye No 5	▪ Metabolic acidosis ▪ Cognitive impairment ▪ Elevated heart rate ▪ Nephrolithiasis ▪ Hypokalemia ▪ Mood and sleep disorders ▪ Depression or suicidal ideation ▪ Increased creatinine ▪ Oligohidrosis/hyperthermia ▪ Serious skin reactions ▪ Hypoglycemia: May require

Medication	Dosing	Monitoring	Common Side Effects	Contraindications	Warnings
	Maximum dose: 7.5 mg/46 mg daily ▪ Moderate Hepatic Impairment (Child-Pugh score 7 - 9): Maximum dose: 7.5 mg/46 mg daily	creatinine / estimated glomerular filtration rate			adjustment of hypoglycemic medications ▪ Abuse potential: Phentermine is pharmacologically related to amphetamines, which have a high abuse potential; prolonged use may lead to dependency ▪ Avoid abrupt discontinuation to minimize the risk of seizure; taper recommended (see Dosing) ▪ Avoid concomitant consumption of alcohol due to increased CNS depressant effect
Naltrexone / bupropion ER (Contrave®)	Naltrexone 8mg/bupropion 90 mg dose-escalation schedule (Morning Dose/Afternoon Dose): ▪ Week 1: 1 tablet / None ▪ Week 2: 1 tablet / 1 tablet ▪ Week 3: 2 tablets / 1 tablet ▪ Week ≥4 (Maintenance dose): 2 tablets / 2 tablets ▪ If a 5% loss of baseline body weight is not achieved after 12 weeks, it is unlikely that the patient will achieve a clinically meaningful weight loss with further treatment; consider discontinuation	▪ Weight ▪ Pregnancy ▪ Glucose and/or signs / symptoms of hypoglycemia in patients with diabetes ▪ Blood pressure ▪ Heart rate ▪ Signs and symptoms of depression, suicidal thought or behavior, cognitive impairment, or changes in mood	▪ Headache ▪ Sleep disorder ▪ Nausea ▪ Constipation ▪ Diarrhea ▪ Vomiting ▪ Dizziness ▪ Xerostomia	▪ Opioid use (agonists or partial agonists) ▪ Uncontrolled hypertension ▪ Seizure disorder ▪ Increased seizure risk in concurrent (bulimia, anorexia nervosa, other eating disorders, abrupt discontinuation of alcohol,	▪ Suicidal thinking/ behavior **[U.S. Boxed Warning]** ▪ Neuropsychiatric symptoms ▪ May precipitate acute opioid withdrawal in patients receiving opioids ▪ Seizures

Medication	Dosing	Monitoring	Common Side Effects	Contraindications	Warnings
	▪ Moderate to Severe Renal Impairment (CrCl <50mL/min): Maximum dose 1 tablet twice a day. Not recommended in patients with end-stage renal disease. ▪ Moderate Hepatic Impairment (Child-Pugh score 7-9): Maximum dose: 1 tablet twice daily. Not recommended in patients with severe hepatic impairment.	▪ Baseline and periodic monitoring of renal and hepatic function		opioid, or benzodiazepine ▪ Concomitant MAOI use or initiation in patients receiving linezolid or IV methylene blue	▪ Increase blood pressure, heart rate ▪ Hepatotoxicity ▪ Adjust hypoglycemic medications to avoid hypoglycemia ▪ Angle-closure glaucoma
Orlistat (Xenical®, Alli®)	▪ Xenical®: 120 mg 3 times daily with each main meal containing fat (during or up to one hour after the meal); omit dose if meal is occasionally missed or contains no fat. ▪ Alli®: OTC labeling: 60 mg 3 times daily with each main meal containing fat There are no dosage adjustments provided in the manufacturer's labeling for either renal or hepatic impairment	▪ Weight ▪ Blood pressure ▪ Glucose and/or signs/symptoms of hypoglycemia in patients with diabetes ▪ Liver function tests if signs or symptoms of hepatic dysfunction ▪ Renal function in patients at risk of renal impairment ▪ Interference with absorption of fat-soluble vitamins, cyclosporine, thyroid hormone, and anticonvulsants	▪ GI effects (e.g., oily rectal leakage, abdominal distress/pain, flatulence with discharge, bowel urgency, steatorrhea). Frequency may decline over time and low-fat diet. ▪ Headache ▪ Menstrual irregularity ▪ Back and lower extremity pain ▪ URTI / Influenza	▪ Pregnancy ▪ Chronic malabsorption syndrome ▪ Cholestasis	▪ Increased urinary oxalate, nephrolithiasis, and nephropathy ▪ Hepatotoxicity ▪ Cholelithiasis
Setmelanotide (Imcivree®)	▪ **For use only in patients with obesity due to Bardet-Biedl syndrome (BBS), or due to pro-opiomelanocortin (*POMC*), proprotein convertase subtilisin/kexin type 1 (*PCSK1*), or leptin receptor (*LEPR*) deficiency confirmed by genetic testing demonstrating variants in *POMC*, *PCSK1*, or *LEPR* genes**	▪ Monitor sexual adverse reactions (e.g., spontaneous penile erection, priapism, labial hypersensitivity) ▪ New or worsened depression (including suicidal ideation)	▪ Skin hyperpigmentation ▪ Injection site reactions ▪ GI effects (e.g., vomiting, constipation, diarrhea) ▪ Nasophyaryngitis / URTI ▪ Headache	▪ Not listed as a contraindication, however prescribing information recommends discontinuation when pregnancy is known	▪ Disturbance in sexual arousal for men and women ▪ Development or worsening of depression ▪ Suicidal ideation/behavior ▪ Hypersensitivity

Medication	Dosing	Monitoring	Common Side Effects	Contraindications	Warnings
	▪ Initial dose: 2 mg subQ daily for 2 weeks ▪ Maintenance dose if initial dose tolerated: 3 mg subQ daily ▪ Maintenance dose of initial dose not tolerated: 1 mg subQ daily	▪ GI adverse reactions during dose initiation and titration	▪ Dry mouth / dry skin ▪ Insomnia ▪ Vertigo ▪ Back pain		▪ Skin hyperpigmentation/development or darkening of melanocytic nevi

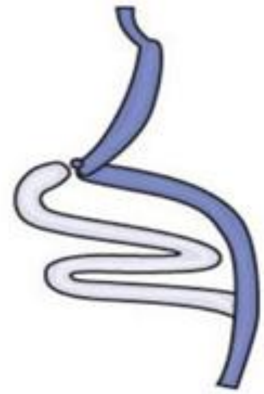
[a] If applicable, refer to VA (http://www.pbm.va.gov) or DOD (http://www.health.mil/PandT) guidance/criteria for further recommendations on use of these agents.

Abbreviations: CIV: Schedule IV controlled substance; CNS: central nervous system; CrCl: creatinine clearance; ER: extended-release; FDA: U.S. Food and Drug Administration; GI: gastrointestinal; GLP-1: glucagon-like peptide-1; IV: intravenous; MACE: major adverse cardiovascular events (for semaglutide this includes cardiovascular death, non-fatal myocardial infarction, and non-fatal stroke); MAOI: monoamine oxidase inhibitor; MEN2: multiple endocrine neoplasia type 2; NuSH: nutrient-stimulated hormonal therapies; OSA: obstructive sleep apnea; PI: prescribing information; REMS: Risk Evaluation and Mitigation Strategy; subQ: subcutaneously; URTI: upper respiratory tract infection; XR: extended-release

Most Common Types of Bariatric Procedures Performed in the United States(28)

Roux-en-Y Gastric (RYGB)

Sleeve Gastrectomy (SG)



Biliopancreatic Diversion with a Duodenal Switch (BPD-DS)

Post-Surgical Schedule for Clinical/Biochemical Monitoring(29)

	Pre-operative	1 Month	3 Months	6 Months	12 Months	24 Months	Continue Annually
Complete Blood Count	X	X	X	X	X		X
Complete Metabolic Panel	X	X	X	X	X		X
Liver Function Tests	X	X	X	X	X		X
Lipid Panel	X		X	X	X		X
Iron	X		X	X	X		X
Folate	X	X	X	X	X		X
Vitamin B1	X	+/-	+/-	+/-	+/-		+/-
Vitamin B2	X		X	X	X		X
Vitamin 25(OH)D/Calcium/PTH	X		X	X	X		X*
Vitamin A	X			X			+/-
Vitamin E**	X						
Vitamin K**	X						
Zinc	X				X		X
Copper	X				X		X
Bone mineral density and body composition						X	X***

X: Indicate the suggested schedule for laboratory monitoring after metabolic/bariatric surgery.

+/-: Recommended for high-risk patients, including those with excessive weight loss

*24-h urinary calcium excretion measurement at 6 months and annually for BPD-DS

**Selectively for symptomatic patients or patients at increased risk for deficiency

***Continue annually for patients with ongoing weight loss or increased risk

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Access to the full guideline and additional resources are available at the following link:
https://www.healthquality.va.gov/guidelines/CD/obesity/