September 2026

Tirzepatide for weight management in adults – interim commissioning statement

Recommendation	NHS Greater Manchester (GM) recommends a staged implementation of tirzepatide (Mounjaro®) for weight management in adult patients. In line with the NHS England Interim Commissioning Guidance (Implementation of the NICE Technology Appraisal TA1026 and the NICE Funding Variation for Tirzepatide (Mounjaro®) for the Management of Obesity, published 27 March 2025 and updated in April 2026), NHS GM has adopted the eligibility criteria set out by NHS England for primary care and specialist weight management services . Tirzepatide for weight management has a GREEN formulary status with a caveat. Prescribing is commissioned only in primary care and within commissioned specialist weight management services. It is not commissioned for prescribing in other secondary care settings. Access under Right to Choose, where applicable, remains subject to the eligibility criteria and pathway requirements set out in this statement. For 2026/27, NHS GM supports implementation for all eligible patients within NHS England Cohorts 1 and 2. This replaces the previous locally prioritised approach and reflects the introduction of QOF indicator OB005. The indicator applies to eligible patients within the NICE TA1026 funding variation cohorts and supports the offer of NICE-approved pharmacotherapy in primary care where clinically appropriate. Expanding access to Cohorts 1 and 2 enables general practices to deliver OB005. NHS GM is implementing this expansion despite significant financial and operational pressures for NHS GM and general practice. During 2025/26, tirzepatide was provided in primary care through the GM Primary Care Weight Management Service under a commissioned service specification, with access limited to patients within NHS England Cohort 1 in line with the local prioritisation framework. From 2026/27, following changes to NHS England's national implementation arrangements and the embedding of this activity within QOF, the separately commissioned primary care weight management service is being superseded on a run-off basis. It will not accept new patients during 2026/27. Patients who commenced treatment through the service during 2025/26 will continue under the existing service arrangements until treatment is completed or discontinued. New patients will be managed through routine general practice under the GP contract, with nationally commissioned wrap-around care. NHS GM must prioritise the implementation of tirzepatide and other incretin-based therapies for weight management in accordance with nationally approved guidance, locally agreed commissioning arrangements and established GM governance processes for adoption onto the GM Joint Formulary.

Given the scale of demand and the associated service-capacity and affordability constraints, NHS GM cannot support incretin-based weight-management treatment beyond, or in advance of, nationally approved guidance and the applicable phased implementation arrangements.

Patients who do not meet the applicable eligibility criteria set out in this statement cannot access NHS-funded tirzepatide or the other incretin-based weight-management medicines covered by this statement. This applies across primary care, specialist weight management services and Right to Choose pathways. Referral to a specialist weight management service or under Right to Choose does not override the eligibility criteria and commissioning arrangements set out in this statement.

NHS England has defined three cohorts of eligible patients based on clinical prioritisation criteria and the applicable funding variation years. These are outlined in Table 1.

Table 1. NHS England-defined patient cohorts eligible for tirzepatide for weight management

Funding variation year	Cohort	Qualifying comorbidities	BMI*
Year 1 (2025/26)	Cohort 1	≥4: hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, type 2 diabetes mellitus	≥40
Year 2 (2026/27)	Cohort 2	≥4: hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, type 2 diabetes mellitus	35–39.9
Year 3 (2027/28 and 2028/29)	Cohort 3	3: hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, type 2 diabetes mellitus	≥40

*For people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic backgrounds, lower BMI thresholds (usually reduced by 2.5 kg/m²) should be applied.

Local implementation in GM

Within GM, local prioritisation has been applied within Cohort 1 during 2025/26, dividing patients into three subgroups by BMI. The existing subdivisions and cohort-specific searches may continue to be used by practices to support manageable local implementation, as shown in Table 2.

Table 2. Local prioritisation within Cohort 1 based on BMI* (advisory for 2026/27)

Medicine	NHS England eligibility for Cohort 1	Existing local Cohort 1 subdivisions
Tirzepatide	BMI ≥40 plus ≥4 qualifying weight-related comorbidities defined by NHS England	Cohort 1a (BMI ≥50) Cohort 1b (BMI ≥45) Cohort 1c (BMI ≥40) All subgroups must also have ≥4 qualifying comorbidities defined by NHS England

*For people from the minority ethnic backgrounds listed above, lower BMI thresholds (usually reduced by 2.5 kg/m²) should be applied.

For 2026/27, NHS GM does not place additional mandatory local restrictions on access beyond the nationally defined eligibility criteria for Cohorts 1 and 2. The subdivisions in Table 2 are advisory only. Practices may use them, alongside clinical need, local demand and available capacity, to plan implementation. They do not introduce additional eligibility criteria, exclude otherwise eligible patients or require practices to treat patients in a prescribed sequence.

	Key prescribing and implementation principles are as follows: • The decision to initiate and continue tirzepatide should be made on a case by case basis by an appropriately trained healthcare professional, following shared decision-making with the patient. • If at least 5% of initial body weight has not been lost after 6 months at the highest tolerated dose, healthcare professionals should reassess whether it is appropriate to continue treatment. This decision must take into account the clinical benefits and risks of treatment and consider alternative approaches if clinical benefits, including weight loss, are not seen. • All patients prescribed tirzepatide must receive wrap-around care, including support for a reduced-calorie diet and increased physical activity, to optimise outcomes. • Wrap-around care is already established in specialist services and should continue as part of the commissioned service. • In primary care, wrap-around care for eligible patients will continue to be commissioned by NHS England and delivered by Reed Wellbeing in 2026/27 **Specialist weight management services in GM** The commissioning arrangements for specialist weight management services in GM remain unchanged for 2026/27. The availability and scope of these services continue to vary across GM and are managed at locality level. Enquiries should be directed to the relevant locality teams in the first instance. • Tirzepatide may be prescribed only within specialist weight management services that are specifically commissioned and operationally able to provide pharmacotherapy, and where the patient meets the applicable eligibility and pathway requirements. • Not all specialist weight management services in GM are commissioned or equipped to prescribe weight-management medicines. Some services provide lifestyle and behavioural interventions only. Referral to a specialist service therefore does not automatically provide access to pharmacotherapy. • Where pharmacotherapy is commissioned, the service must provide an appropriate multidisciplinary pathway, including clinical assessment, prescribing, dose titration, monitoring, wrap-around care and consideration of bariatric surgery where appropriate. • Under current NHS GM commissioning arrangements, patients being considered for bariatric surgery must first access and be assessed through a commissioned specialist weight management service. Progression to the bariatric surgery pathway should take place only following specialist multidisciplinary assessment and confirmation that the applicable clinical and commissioning requirements are met. **FP10 prescribing and the commercial access arrangement** Tirzepatide should be prescribed in quantities appropriate to the patient's clinical need. One tirzepatide pen provides four once-weekly doses and therefore constitutes one month's supply; prescriptions should normally be limited to one pen per month to avoid over-ordering.

	In September 2025, the manufacturer increased the NHS list price of tirzepatide. NICE updated TA1026 to reflect the revised list prices and added a commercial access agreement to the guidance. The commercial arrangement makes tirzepatide available to the NHS at a cost-effective price determined by NICE. The details of the arrangement are commercial in confidence. To access the applicable commercial NHS price, tirzepatide prescribed through specialist weight management services must be supplied through the FP10 dispensing route. Direct procurement or prescribing through alternative secondary care routes may not attract the commercial price and may result in substantially higher medicine costs. The need to establish FP10 prescribing arrangements presented a significant implementation barrier for some specialist weight management providers following the September 2025 pricing changes. Services commissioned to prescribe tirzepatide must therefore have an appropriate FP10 prescribing and dispensing route, together with the necessary clinical governance, medicines reconciliation, record-sharing, monitoring and financial assurance arrangements. Where these arrangements are not in place, the service should not initiate tirzepatide until a compliant and financially sustainable pathway has been agreed with NHS GM. **Prior approval and assurance** Blueteq has been established in NHS GM to support confirmation of patient eligibility, prescribing governance, data capture, financial oversight and audit for tirzepatide prescribed for weight management. Use of Blueteq is mandatory within commissioned specialist weight management services and remains part of the required assurance arrangements for these services. It was also established for use within the GM Primary Care Weight Management Service commissioned during 2025/26. Under the new primary care arrangements for 2026/27, use of Blueteq by individual GP practices is voluntary and is not a mandatory condition of prescribing. However, NHS GM strongly encourages all practices to use Blueteq as an important mitigation and assurance tool. Consistent use will support verification of the NHS England eligibility criteria, improve the quality and completeness of prescribing data, facilitate monitoring and audit, and help NHS GM manage the significant financial risks associated with implementation. Regardless of whether Blueteq is used, practices must maintain clear and auditable clinical records demonstrating that patients meet the applicable eligibility criteria and that prescribing is consistent with this commissioning statement. Records should be made available for audit or review when required. **Other GLP-1 Receptor Agonists** Eligibility criteria for semaglutide (Wegovy®) and liraglutide (Saxenda® and biosimilars) for weight management have been aligned locally with the NHS England-defined criteria and phased access arrangements applied to tirzepatide. For 2026/27, this includes eligible patients within Cohorts 1 and 2. Both medications remain RED in the GM Joint Formulary and are commissioned only for use in commissioned specialist weight management services. NHS GM intends to use Blueteq in specialist weight management services for semaglutide and liraglutide, in line with the approach adopted for tirzepatide. The GM Joint Formulary reflects all prescribing positions and should be used as the reference for the most up-to-date prescribing status.

	Access under Right to Choose Before referral, clinicians should confirm that the patient meets the nationally defined eligibility requirements for Cohort 1 or Cohort 2 and that there is a reasonable expectation of clinical benefit. The local subdivisions in Table 2 are advisory and do not constitute additional mandatory referral criteria. Right to Choose does not provide an alternative route outside the eligibility and commissioning requirements set out in this statement. Before referral under Right to Choose, patients must have actively engaged with an appropriate structured behavioural weight-management intervention, commonly referred to as Tier 2. Access may be through referral or self-referral, depending on the pathway, and may include the nationally commissioned NHS Digital Weight Management Programme or a locally commissioned Tier 2 service where available. Eligibility criteria for pharmacological treatment accessed under Right to Choose are aligned across all incretin-based medicines for weight management covered by this statement, including tirzepatide, semaglutide and liraglutide. This must be taken into account when considering a referral or selecting a treatment. Patients who do not meet the applicable criteria cannot access NHS-funded incretin-based treatment through Right to Choose. NHS GM informs the system, through formal communications, which Right to Choose providers are funded under the applicable NHS GM commissioning arrangements. Clinicians should refer to the most recent NHS GM communication before making a referral. Any provider accepting NHS GM-funded referrals under Right to Choose must deliver interventions in accordance with the NHS GM commissioning arrangements set out in this statement. The provider must also : • Deliver the service through an appropriately constituted clinical multidisciplinary team (MDT), ensuring that patients are triaged, counselled, and assessed appropriately, including consideration of bariatric surgery where appropriate; and • Provide appropriate prescribing, monitoring and wrap-around care. Where bariatric surgery may be appropriate, the Right to Choose provider must ensure that the patient receives an appropriate specialist multidisciplinary assessment and can progress through the applicable commissioned bariatric surgery pathway. Referral under Right to Choose must not bypass the requirement for specialist weight management service assessment before progression to bariatric surgery.
Background	Tirzepatide (Mounjaro®) is a novel dual GIP/GLP-1 receptor agonist recommended by NICE TA1026 (published 23 December 2024 and last updated 1 September 2025) for managing overweight and obesity in adults, alongside a reduced-calorie diet and increased physical activity, only if all the following apply: • An initial BMI of ≥35 kg/m², and • At least one weight-related comorbidity For people from minority ethnic backgrounds (South Asian, Chinese, other Asian, Middle Eastern, Black African, African-Caribbean), lower BMI thresholds (usually by 2.5 kg/m²) should be applied.

	Tirzepatide is recommended by NICE for use in primary care and specialist weight management services. Access in primary care is subject to the phased cohorts within the NICE funding variation and NHS England interim commissioning guidance. NHS England's arrangements for 2026/27 embed primary care weight-management activity within the GP contract through QOF. The resulting NHS GM commissioning changes are summarised in the Recommendation section.
Efficacy and Safety	Tirzepatide has demonstrated superior weight loss outcomes compared with placebo and has also been associated with improvements in glycaemic control and cardiovascular risk factors. In an indirect comparison with semaglutide, tirzepatide was found to be more effective for weight loss in the target population. There were no comparisons to liraglutide and orlistat submitted to NICE for evaluation. Tirzepatide (Mounjaro®) currently holds a Black Triangle medicine status, meaning it is subject to additional monitoring. Suspected adverse reactions should be reported via the MHRA Yellow Card Scheme. More information can be found on MHRA GLP-1 receptor agonists: reminder of the potential side effects and to be aware of the potential for misuse Prescribers should also be aware that pancreatitis is a recognised risk with tirzepatide. Caution is advised in patients with a history of pancreatitis. For further details, refer to the Summary of Product Characteristics (SPC) and MHRA updates guidance for GLP-1 prescribers **Contraceptive and HRT Considerations:** • Tirzepatide should not be used during pregnancy. Women of child-bearing potential should use contraception during treatment. At least 1 month washout period is required after stopping tirzepatide before attempting conception. • Tirzepatide may reduce the effectiveness of oral contraceptives. Women using oral contraceptives should be advised to use an alternative barrier method or additional non-oral barrier method for four weeks after treatment initiation, and for four weeks after any increase in dose. • Consideration of alternative formulations or doses of HRT should be taken into account when prescribed concurrently with tirzepatide . • For further information on the use of tirzepatide with contraception or HRT, refer to MHRA guidance GLP-1 medicines for weight loss and diabetes: what you need to know and British Menopause Society guidance on incretin-based therapies and HRT
Cost Effectiveness / Affordability	• NICE recommends tirzepatide as a cost-effective treatment for adults with obesity and weight-related comorbidities who meet the criteria in TA1026, provided that the company supplies it in accordance with the commercial arrangement. • The anticipated financial and service impact of implementing TA1026 exceeded the NICE budget impact threshold. A NICE funding variation was therefore agreed to support phased implementation. NHS England's interim

	commissioning guidance translates this into three nationally defined cohorts, introduced over the funding variation years set out in Table 1. • During 2025/26, implementation in primary care was limited to eligible patients within Cohort 1. For 2026/27, NHS GM is expanding access to all eligible patients within Cohorts 1 and 2, in line with the national phased implementation arrangements and the introduction of QOF indicator OB005. Access to Cohort 3 is not currently commissioned and will be considered in accordance with the applicable national implementation timetable. • Local exploratory modelling undertaken by RDTC, based on 14,390 unique patients prescribed tirzepatide in GM primary care between October and December 2025, indicates potential longer-term population-health benefits. Within an estimated subgroup of 12,563 patients with diabetes, 3,236 of whom are also likely to have obesity, the modelling suggests that 24 months of treatment may avert approximately 290 fatal and non-fatal myocardial infarctions and strokes. Among 1,827 patients without a concurrent diabetes-related prescribing marker, 18 months of treatment was estimated to avert up to 160 new cases of type 2 diabetes. These figures are modelled projections rather than outcomes observed directly within the NHS GM weight-management pathway. The prescribing data cannot reliably establish the treatment indication for individual patients, particularly where diabetes and obesity coexist. The estimates should therefore be interpreted in the context of the modelling assumptions and limitations. • From September 2025, the NHS list price increased to between £133 and £330 per four-weekly supply, depending on strength. NICE updated TA1026 to reflect the revised list prices and added a commercial access agreement to the guidance. The commercial arrangement makes tirzepatide available to the NHS at a cost-effective price determined by NICE. The details of the arrangement are commercial in confidence. • For 2026/27, NHS England funding contributes towards the medicine costs associated with phased implementation. Activity relating to the management of new patients in primary care is embedded within the GP contract through QOF, while wrap-around behavioural support is funded separately and commissioned nationally. • The available NHS England funding allocation for NHS GM does not meet the full anticipated cost of implementation across Cohorts 1 and 2. Expansion therefore creates significant financial and operational pressure for NHS GM and general practice. • NHS GM will manage implementation through the nationally defined eligibility criteria and phased commissioning arrangements set out in this statement. Prescribing outside these arrangements is not commissioned. • The actual financial impact will depend on patient uptake, clinical appropriateness, the doses prescribed and treatment continuation. NHS GM will monitor implementation and keep the commissioning position under review in response to actual activity, service capacity and any changes to national funding or guidance.
Monitoring	• Providers must maintain clear and auditable clinical records demonstrating that patients meet the applicable eligibility criteria and that prescribing is consistent with this commissioning statement. • General practices should use the available cohort-specific clinical system searches to identify patients who may be eligible for treatment and before

	treatment is offered, the clinician must confirm that the patient meets all the applicable eligibility criteria and that treatment is clinically appropriate. • Where appropriate, treatment should be initiated in primary care and the patient referred to the nationally commissioned wrap-around care service. For patients with complex clinical or weight-management needs, referral to a commissioned specialist weight management service should be considered where clinically appropriate and in accordance with the applicable referral criteria and local commissioning arrangements. • Patients must be monitored during dose titration and ongoing treatment in accordance with the relevant national guidance. Monitoring should include treatment response, adverse effects, engagement with wrap-around care and whether continued treatment remains clinically appropriate. • For patients prescribed tirzepatide, treatment response must be assessed after six months at the highest tolerated dose. If the patient has lost less than 5% of their initial body weight, the prescriber should reassess whether treatment should continue. This decision should be made with the patient and take account of the clinical benefits and risks of continuing treatment, including whether alternative treatment options should be considered. • In primary care, all relevant stages of the pathway must be recorded using the nationally defined SNOMED CT codes specified by NHS England for the QOF obesity indicators. Practices that do not participate in QOF are strongly encouraged to use the same codes, in accordance with NHS England's interim commissioning guidance. The codes support consistent recording of clinical activity, treatment outcomes, and monitoring of implementation. They do not, by themselves, confirm that a patient meets all the applicable treatment eligibility criteria. • Blueteq is established within NHS GM as an additional assurance mechanism. It supports confirmation that only patients meeting the applicable eligibility criteria are initiated on treatment and that the required review after six months at the highest tolerated dose has been undertaken. • Under the 2026/27 routine primary care arrangements, use of Blueteq by GP practices is voluntary and is not a condition of prescribing. However, NHS GM strongly encourages all practices to use it to support consistent application of the eligibility criteria, prescribing governance, data capture and audit. Blueteq serves a different purpose from the nationally defined SNOMED CT codes and does not duplicate QOF recording requirements. • Where Blueteq is not used, GP practices must ensure that equivalent information is recorded clearly within the patient's primary care clinical record and is available for audit. • Use of Blueteq remains mandatory within commissioned specialist weight management services. These services must maintain clear and auditable

	records of eligibility, prescribing, monitoring, treatment response and continuation or discontinuation decisions. • NHS GM will monitor implementation, prescribing activity and access across GM. Where data are available, implementation and prescribing patterns will also be reviewed at GP practice level by the NHS GM Data Quality Team and locality Medicines Optimisation teams. This will support assurance, identification of unwarranted variation and targeted support for practices. • The BeCCoR MO6 programme supports accurate clinical coding and review of tirzepatide prescribing. • Monitoring findings will inform future reviews of this interim commissioning statement and NHS GM's implementation arrangements.
Patient perspective	Obesity is a complex, chronic condition with significant physical, psychological and social impacts. For many individuals, existing dietary, physical activity and behavioural interventions alone have not resulted in meaningful or sustained weight loss. Tirzepatide offers an additional evidence-based treatment option, used alongside wrap-around care, with the potential to improve quality of life and long-term health outcomes. Expansion to Cohorts 1 and 2 will increase access to treatment for eligible patients across GM. Access will be managed in accordance with the nationally defined eligibility criteria, phased implementation arrangements and this commissioning statement. Eligibility does not automatically mean that tirzepatide will be clinically appropriate for every patient; treatment should be offered following an individual clinical assessment and shared decision-making. Patients should understand the potential benefits, risks and practical requirements of treatment. This includes possible adverse effects, dose titration, engagement with wrap-around behavioural support and ongoing clinical monitoring and review. Patients should also understand that continuation of treatment will depend on clinical benefit and treatment response.
References	1. NHS England, Interim commissioning guidance, Implementation of the NICE Technology Appraisal TA1026 and the NICE funding variation for tirzepatide (Mounjaro®) for the management of obesity, 27 March 2025, updated 2 April 2026, https://www.england.nhs.uk/publication/interim-commissioning-guidance-implementation-of-the-nice-technology-appraisal-ta1026-and-the-nice-funding-variation-for-tirzepatide-mounjaro-for-the-management-of-obesity/ 2. NICE TA1026, Tirzepatide for managing overweight and obesity, 23 December 2024, updated 1 September 2025 https://www.nice.org.uk/guidance/ta1026 3. Summary of product characteristics, tirzepatide (Mounjaro®) KwikPen 10mg solution for injection in pre-filled pen, https://www.medicines.org.uk/emc/product/15484/smpc accessed via eMC on 04.08.2026 4. FSRH statement: Glucagon-like peptide-1 (GLP-1) agonists and oral contraception, published 07 February 2025, https://www.fsrh.org/Public/Public/Documents/FSRH-statement-Glucagon-like-peptide-1-agonists-and-oral-contraception-Feb-2025.aspx

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