NHS Greater Manchester Incretin Therapies (GLP-1 Receptor Agonists and Tirzepatide) Commissioning Position and Prescribing guidance.

Table of Contents

1. Purpose 1
2. Context 1
3. Incretin therapies: Commissioning position 1
4. Incretin therapies: Horizon scanning 1
5. Document review and future updates 1
6. NHS GM integrated overview of incretin therapies across approved indications 2
7. Incretin Therapy (GLP-1 RA and tirzepatide) Initiation Checklist 3
8. Guidance on adjusting glucose-lowering medications on initiation of incretin therapy 4
9. Switching between incretin therapies 4
10. Guidance on adjusting insulin doses based on capillary blood glucose in people living with Type 2 diabetes 5
11. References 6

1. Purpose

The document provides prescribing, eligibility and governance guidance for GLP-1 receptor agonists (GLP-1 RAs) and tirzepatide (dual GIP/GLP-1 receptor agonist), which are also known as incretin therapies.

2. Context

Incretin therapies were originally developed for glucose-lowering in people living with T2D. Certain incretin therapies are now also licensed for weight loss and secondary prevention of major cardiovascular events in people with established cardiovascular disease. Many people fall within more than one therapeutic pathway, yet commissioning, eligibility, available medications, dosing and arrangements for wrap around care currently differ. As new evidence emerges regarding potential indications for incretin therapies, and delivery models evolve, the landscape has become increasingly complex. Feedback from prescribers indicates uncertainty around eligibility criteria, prescribing pathways and commissioning arrangements.

3. Incretin therapies: Commissioning position

NHS Greater Manchester must prioritise implementation of incretin therapies in line with nationally approved guidance, and locally agreed commissiong arrangements, while also ensuring compliance with established governance processes for GM adoption onto formulary. Given the scale of demand, for incretin therapies, and the associated service capacity and affordability constraints, NHS GM is not able to support requests to commission incretin therapies beyond or in advance of nationally approved guidance. Any non-routine use of incretin therapy outside of the arrangements outlined in Table 1 is not supported.

4. Incretin therapies: Horizon scanning

NICE Technology Appraisal and licensing position:

- **Semaglutide 2.4 mg (Wegovy®) – moderate to advanced liver fibrosis without cirrhosis caused by metabolic dysfunction-associated steatohepatitis.** Licensed in July 2026. NICE appraisal in development [TA11477]. Expected publication date: January 2027.
- **Semaglutide 7.2 mg (Wegovy®) single-dose device – weight management in adults with obesity.** Licensed in April 2026. NICE appraisal in development [TA11920]. Expected publication date: TBC.
- **Retatrutide – weight management in adults with overweight or obesity.** Not yet licensed in the UK. NICE has selected the topic for appraisal [TA11845]. Expected publication date: TBC.
- **Orforglipron (Foundayo®) – weight management in eligible adults.** Licensed in August 2026. NICE appraisal in development [TA11650]. Expected publication date: November 2026.
- **Orforglipron (Foundayo®) – insufficiently controlled T2D.** Licensed in August 2026. NICE has not selected it for a separate T2D appraisal because NG28 makes recommendations for GLP-1 RAs at class level. The NHS price is not yet known, and it is not currently available for NHS prescribing. Use for T2D will be considered through the usual GM formulary process once the price and information required to support review is available.

Following publication of finalised NICE TAs, Greater Manchester adoption will follow established governance processes. While NHS organisations are required to implement TA recommendations within 90 days of publication, precise timescales for adoption cannot be pre-empted and prescribing should not occur in advance of adoption onto the GMMMG formulary.

Current position on oral semaglutide products:

- **Oral semaglutide (Wegovy ®)** was licensed by the MHRA for weight management in June 2026. However NICE discontinued its appraisal for oral Wegovy in May 2025, and oral Wegovy® is not currently available for NHS prescribing in Greater Manchester.
- **Oral semaglutide (Rybelsus®)** is licensed solely for the treatment of T2D, and NICE has recommended its use for this licensed indication only. To ensure patients receive the correct licensed product, please ensure semaglutide tablets prescribed for patients living with T2D diabetes are prescribed as the Rybelsus® brand. Healthcare professionals should not consider Rybelsus® and Wegovy® to be interchangeable. Inappropriate use of Rybelsus® outside of its product license may place pressure on supplies for people with T2D.

5. Document review and future updates

The NHS GM Type 2 diabetes prescribing pathway is currently under review and this document will be updated as required following agreement of any pathway changes. Further updates are also anticipated following publication of future NICE technology appraisals and/or national commissioning guidance relating to incretin therapies.

6. GM integrated overview of incretin therapy indications and commissioning arrangements.

For people who meet the criteria for more than one indication (for example, T2D and obesity) review the pathway/therapy options and have a shared decision-making conversation with the person, about what to prioritise.

	a. Type 2 Diabetes pathway This currently differs from updated NICE guidance; see NG28 holding statement)	b. Weight Management (obesity) pathway **See also** GM weight management pathway and **GM weight management page**	c. CVD Secondary prevention pathway	d. Incretin therapies in combination with insulin (T1D/T2D)
Primary indication and secondary benefits	**T2D:** Optimise HbA1c, to improve health outcomes in people with T2D Secondary benefits: weight reduction.	**Obesity:** Achieve ≥ 5 % clinically meaningful weight loss. Secondary benefits: improvement in weight-related comorbidities, including glycaemic benefit if T2D or NDH is present.	**CVD risk reduction (secondary prevention):** Preventing major cardiovascular events in people with a BMI of at least 27kg/m2 and previous MI, stroke or symptomatic PAD.	**T2D:** Incretin therapies should not be added to existing insulin therapy as an insulin sparing strategy or for insulin related weight gain **T1D:** Incretin therapies are not licensed for T1D and should not be added to existing insulin therapy as an insulin sparing strategy or for insulin related weight gain. .
Commissioning route	**ICB-funded diabetes services / primary care.**	**NHSE Weight-Management Programme:** Via SWMS and Primary Care. (not for secondary care prescribing outside SWMS). Due to the introduction of QOF indicator OB005, the separately commissioned primary care weight management service is being decommissioned on a run-off basis. Patients commenced treatment 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. Access under Right to Choose, where applicable, remains subject to the same GM eligibility criteria and pathway requirements.	**ICB-funded / primary care.**	• **Not commissioned for T1D** • **Not commissioned for addition to existing insulin therapy as an insulin sparing strategy or for insulin related weight gain.**
Medicines in scope (**Prescribe by brand).**	• Semaglutide SC (Ozempic® up to 1mg) Semaglutide Oral (Rybelsus®) • Tirzepatide SC (Mounjaro ®) • Dulaglutide SC (Trulicity ®) • Liraglutide SC (Victoza ® - biosimilar products are now available)	• Semaglutide SC (Wegovy ® up to 2.4mg) • Liraglutide SC (Saxenda ®) • Tirzepatide SC (Mounjaro ®)	Semaglutide SC (Wegovy ® up to 2.4mg)	Not applicable
GMMMG colour classification	**GMMMG RAG status:** Green. Can be initiated in primary care or diabetes services.	**GMMMG RAG status:** Semaglutide SC (Wegovy ®) and liraglutide SC (Saxenda ®) = Red: Via SWMS only (not for secondary care prescribing outside SWMS) Tirzepatide SC (Mounjaro ®) = Green / Grey • Available via SMWS (not for secondary care prescribing outside of SWMS) • Can be initiated in primary	**GMMMG RAG Status:** Green specialist initiation.	**GMMMG RAG Status:** Ensure oversight from a diabetes specialist or healthcare professional appropriately trained in insulin management. Close monitoring of blood-glucose is required, look to empower the individual and discuss self-titration of therapies where appropriate.See MHRA 2019 report.
Eligibility	Incretin therapies are indicated if one or more of the following apply A. Further therapy in people with a BMI>35kg/m2, **ONLY if** triple therapy with metformin, an SGLT2i and a DPP4i is ineffective, not tolerated, or contraindicated. B. Further therapy in people who do not meet the above criteria and who would otherwise be prescribed insulin, **ONLY if** insulin therapy would have significant occupational implications. Nb. This differs from the updated NICE guidance (NG28), the GM T2D prescribing pathway is currently under review See GM NG28 holding statement.	Eligibility for pharmacotherapy is currently aligned across semaglutide, liraglutide and tirzepatide. **For 2026/27,** all people who meet the NHS England Cohort 1 or 2 criteria are eligible for incretin therapy. i.e. BMI ≥ 35 + 4 weight related comorbidities **Qualifying weight-related comorbidities are** hypertension, dyslipidaemia, obstructive sleep apnoea, ASCVD and heart failure Practices may choose to use the cohort subdivisions below alongside clinical need, local demand and available capacity, to plan implementation, but there is no requirement to treat people in a prescribed sequence Cohort 1a= BMI ≥ 50 + ≥ 4 weight-related comorbidities Cohort 1b= BMI ≥ 45, ≥ 4 weight-related comorbidities Cohort 1c=BMI ≥ 40, ≥ 4 weight-related comorbidities Cohort 2 = BMI ≥ 35-39.9, ≥ 4 weight-related comorbidities	BMI* of at least 27kg/m2 and established CVD **For the purposes of NICE TA1152 established CVD includes** MI, ischaemic or haemorrhagic stroke, symptomatic PAD (intermittent claudication with an ankle-brachial index of less than 0.85 at rest, or peripheral arterial revascularization or an amputation because of atherosclerotic disease)	• People with either T1D or T2D may be prescribed incretin therapy in combination with insulin if eligible under the weight management pathway or if they meet the CVD 2ndry prevention criteria. • People with T2D who are prescribed insulin but not previously offered incretin therapy (e.g. due to stock shortages, or if insulin was started as rescue therapy), and who meet the criteria for use in T2D may have incretin therapy added to existing insulin therapy with a view to potentially discontinuing insulin. Consideration should be given to the length of time they have been receiving insulin and years since diagnosis of diabetes. Nb. If the persons response to medication suggests T2D may not be the correct diagnosis, refer to the Initial diagnosis section of the NICE NG17 guideline on managing type 1 diabetes.
Wrap-around care	'Wrap-around care' is not commissioned. Healthy living support is available via: NHS Better Health, Healthy Living for people with T2D, MyWayDiabetes, and the NHS Digital Weight Management Programme (requires a GP or community pharmacy referral).	'Wrap-around care' i.e. structured dietetic, behavioural and physical-activity support is mandatory. This is available in primary care via Reed Wellbeing (in 2025/26). In SWMS, wrap-around care is already established and should continue as part of the commissioned service.	'Wrap-around care' is not commissioned. Wegovy® should be offered alongside a reduced calorie diet and physical activity. In addition to support available via stroke/cardiac rehab services, healthy living support is available via: NHS Better Health, and for people with T2D or HTN via NHS Digital Weight Management Programme (requires a GP or community pharmacy referral).	Not applicable.
Dose and titration	**As per SPCs/Guided by HbA1c** **Semaglutide** (Ozempic®):0.25mg initially, increased after 4weeks to 0.5mg (maximum dose 1mg). There is evidence of improved CV outcomes with 0.5 mg and 1mg Ozempic®. Doses greater than 1mg have incrementally less effect on HbA1c and increase the cost of treatment, therefore effectively reducing the number of people who can be treated within the available drug budget. **Tirzepatide:** 2.5mg initially, increased after 4weeks to 5 mg weekly. Dose increases above 5mg should be considered only if (after at least 3 months on 5mg) further HbA1c optimisation is required and there has been a beneficial metabolic response to 5mg Nb. In RCT more than 80% of people achieved a HbA1c < 7% with a 5mg dose. If HbA1c is optimised but weight loss goals have not, further dose increases should not be made under the T2D pathway.	**As per SPCs** **Tirzepatide:** 2.5mg initially, titrate at 4 weekly intervals up to a maximum dose of 15 mg weekly (if needed and tolerated). Consider slower titration if the person experiences GI side-effects. **During dose titration, follow up the person every 4 weeks**. Review co-morbidities and adjust concomitant medication as required in response to weight loss e.g. BP, glucose-lowering medicines.	**Semaglutide Wegovy®:** As per SPC. 0.25mg initially, titrate at 4 weekly intervals up to a maximum of 2.4mg (if tolerated). NICE TA1152 does not specify when Wegovy® should be initiated post event, decisions on timing of initiation should be made using clinical judgement and based on individual patient circumstances. Review co-morbidities and adjust concomitant medication as required in response to weight loss e.g. BP, glucose-lowering medicines.	**Incretin therapy:** SPC dosing should be used as a guide; slower titration may be required. Therapy should be individualised, with oversight from a diabetes specialist or healthcare professional appropriately trained in insulin management. **Insulin:** Review dose of insulin before starting incretin therapy, consider reducing insulin if there is risk of hypoglycemia Any reduction in insulin dose should be calculated and recorded. **Close monitoring of blood-glucose is required**, look to empower the individual and discuss self-titration of therapies where appropriate.
Review criteria	**Initial review at 3–6 months** (HbA1c, weight, tolerability), then every 3-6 months until HbA1c is stable on unchanging therapy. **Stop if it does not help the person reach their individualised glycaemic target.** **Stop if the person becomes underweight** (BMI <18.5 kg/m^2)	**Semaglutide** (Wegovy®): consider stopping if weight loss is < 5% after 6 months on treatment **Liraglutide** (Saxenda ®)**:** discontinue if weight loss is < 5% after 12 weeks on the 3.0 mg/day dose. **Tirzepatide** (Mounjaro®)**:** consider stopping if weight loss is < 5% after 6 months on the highest tolerated dose. Ongoing 6–12-monthly reviews thereafter.	**Stop if the person becomes underweight** (BMI <18.5 kg/m^2)	If the person does not meet the eligibility criteria for incretin therapy (as listed for T2D, weight management or CVD risk reduction) treatment should be reviewed and (with advice/ oversight from an appropriately trained diabetes specialist) – stopped. **Stop if the person becomes underweight** (BMI <18.5 kg/m^2)
Data/coding /approvals	Record indication, drug and dose, baseline HbA1c/BMI, review dates and therapy changes.	Record indication, cohort, BMI, ≥ 4 comorbidities (each coded), wrap-around enrolment, % of weight loss. **Use NHSe SNOMED codes** **Prior approval (via Blueteq) is required for SWMS.**	Record indication, drug and dose, baseline HbA1c/BMI, review dates and therapy changes.	Record indication, drug and dose, baseline HbA1c/BMI, review dates and therapy changes.

7. Incretin Therapy (GLP1-RA and tirzepatide) Initiation Check list (Applies to all NHS GM approved indications)

- ☐ Confirm eligibility criteria (as per GM T2D pathway/Obesity pathway/or CVD secondary prevention; see Table 1) For people where there is more than 1 use for the medicine (for example, treating T2D and obesity) compare the pathway/therapy options as per the table columns to reach a decision with and for the person, taking into account their personal preferences
- ☐ Review medical history. Assess contraindications/cautions: severe GI disease, pancreatitis, hepatic impairment
- ☐ If on insulin therapy, ensure oversight from an appropriately trained diabetes specialist- it can take several weeks after initiation and/or dose increases for incretin therapies to take full effect – ensure appropriate monitoring and follow-up arrangements are in place
- ☐ In diabetes, ensure diabetic retinopathy screening is up to date and review results. Caution in people undergoing active retinopathy treatment or with increased frequency of surveillance e.g. with diabetic macular oedema, proliferative diabetic retinopathy, or non-proliferative diabetic retinopathy requiring acute therapy. For more information. See SPC, Diabetic Eye Screening:14. early worsening phenonomen and NG242: 1.1Managing diabetes to support best eye care
- ☐ For weight management, ensure wrap around care, and use of NHSe SNOMED Codes. For SWMS - prior approval via blueteq is required
- ☐ Explain rationale for therapy; primary indication and additional benefits (HbA1c optimisation, weight loss, CVD risk reduction)
- ☐ Explain how the medication works
- ☐ Discuss goal setting: HbA1c, weight loss, personal and comorbidity goals
- ☐ Discuss possible duration of treatment and potential reasons for stopping
- ☐ Advise removal of excess skin after weight loss is not commissioned. Offer advice on gradual weight loss, hydration, skin care and resistance training; address psychological impact and signpost to support
- ☐ Advise on appropriate dietary intake (including whole foods and adequate protein), and physical activity (including resistance training), to avoid potential sacropenia

Review concomitant medication

- ☐ Review and adjust other glucose-lowering therapies. **See also section 3.** Stop DDP4i, reduce sulphonylurea, if co-prescribed insulin and/or a sulphonylurea discuss self-monitoring of blood glucose; empower self-titration. Nb a stepwise reduction in insulin is recommended
- ☐ Consider potential drug interactions: slower gastric emptying may affect absorption. Think about potential impact on narrow therapeutic index medications e.g. warfarin, digoxin, and time-sensitive medications e.g. levodopa. Caution with antimotility medications e.g. loperamide, opioid medications.
- ☐ Review HRT and consider switching to transdermal routes. See BMS guidance April 25
- ☐ Expect improvement in blood pressure with weight loss; review and adjust antihypertensives if needed (note general practices can refer patients to a participating community pharmacy for a clinic blood pressure reading)
- ☐ Review other medications if weight loss could potentially affect control of the condition, or the dose required. e.g. DOACs may require dose adjustment if significant weight loss

Pregnancy and contraception considerations

- ☐ Ensure robust contraception for people of childbearing potential. See FSRH Statement 2025 and Patient information GP1-agonists and contraception Nb: For tirzepatide - additional contraception is required (for 4 weeks) at initiation and when increasing the dose (consider switching to a non-oral or barrier method)
- ☐ Avoid use in pregnancy; advise that a 'washout' period is recommended before planned pregnancy, during which the person should continue to use contraception. See MHRA guidance on GLP-1 medicines for weight loss and diabetes
- ☐ For anyone who has been taking incretin therapy during pregnancy or who has conceived during the advised 'washout' period, encourage use of the MyBump Portal and reporting to the UKTIS Reporting an exposure – UKTIS
- ☐ There is a lack of safety data regarding breastfeeding and use of incretin therapy. The current advice is to avoid using incretin therapy whilst breastfeeding

Discuss potential side effects and management

- ☐ **Gastrointestinal effects**: nausea, vomiting, diarrhoea; reassure they are mostly mild and transient, advise smaller meals, low fat content and consider slower titration
- ☐ Provide **sick day guidance**: ensure adequate fluid intake and know when to seek help
- ☐ **Acute pancreatitis**: There is a risk of acute pancreatitis in people receiving incretin therapies, including rare reports of necrotising and fatal pancreatitis (See MHRA Alert Jan 2026). Advise to seek immediate help/contact 111 if severe, sudden stomach pain, any other symptoms. Encourage participation in the Yellow Card Biobank study for suspected cases of pancreatitis
- ☐ Advise there is **a risk of pulmonary aspiration** during general anaesthesia or deep sedation. MHRA Alert Jan 2025
- ☐ **NAION.** Semaglutide may be very rarely associated with NAION, a condition which can cause vision loss, typically in one eye. People reporting a sudden loss of vision (including partial loss) should be urgently referred for specialist examination by an ophthalmologist. (See MHRA Alert Feb 2026)
- ☐ Rapid reductions in HbA1c can cause transient **worsening of diabetic retinopathy**, particularly in people with: long duration of diabetes, suboptimal baseline glycaemia levels and pre-existing retinopathy. Ensure retinopathy screening is up to date prior to commencing therapy
- ☐ Report adverse drug reactions to Yellow Card scheme

Prescribing, administration and waste disposal

Injectable therapies (Prescribe by brand)

- ☐ Advise dosing regimen. **Weekly:** semaglutide, tirzepatide, dulaglutide **Daily:** Liraglutide
- ☐ Advise on injection technique to include rotation of injections sites (air shot before 1st use for injectable semaglutide, two clicks air shot before every dose of tirzepatide).
- ☐ If prescribed tirzepatide, ensure prescription includes appropriate needles (e.g. 4mm 32G) (needles are provided with semaglutide, dulaglutide and liraglutide)
- ☐ Prescribe sharps bin, and advise on handling and disposal of sharps (see Information on Clinical Waste – Community Pharmacy Greater Manchester)
- ☐ If prescribed semaglutide S/C encourage recycling via PenCycle return boxes can be ordered directly via PenCycle - You return it. We recycle it.

Oral semaglutide (Rybelsus®) Confirm choice of therapy – Rybelsus® is approved for use in T2D only, and as a 2nd line incretin therapy (i.e. only if SC semaglutide or tirzepatide are indicated for glucose-lowering but are not suitable for the individual)

- ☐ Advise on administration, i.e. one tablet daily taken on an empty stomach (6-8hrs fasting is advised), swallowed whole with no more than 120mls of water, wait at least 30 minutes before eating, drinking or taking other oral medicinal products. Advise that waiting less than 30 minutes decreases medication absorption and effectiveness
- ☐ Advise that (if tolerating), after one month the dose should be increased from 1.5mg to a 4mg daily maintenance dose. Further titration may be required based on HbA1c

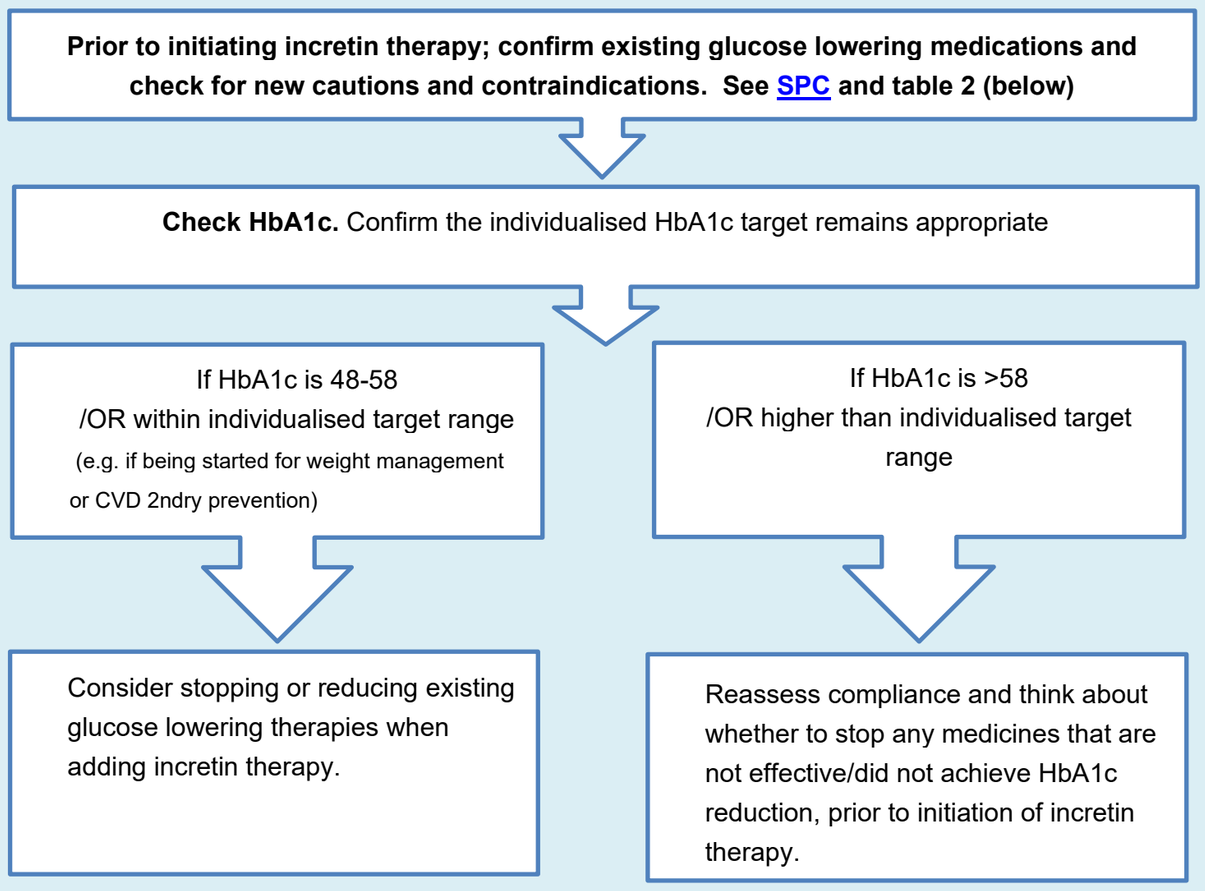
Follow up & monitoring:

- ☐ Agree frequency of follow up, titration of doses and set next appointment date. During dose titration, the person should be followed up every 4 weeks to review co-morbidities and adjust concomitant medication as required in response to weight loss e.g. BP, glucose-lowering medicines
- ☐ Arrange monitoring of response and side effects
- ☐ Signpost/advise who to contact if any concerns
- ☐ Review need for continued prescribing

8. Guidance on adjusting glucose-lowering medications on initiation of incretin therapy (relevant to all NHS GM approved indications)

- Review glucose-lowering therapy on/prior to initiation of incretin therapy.
- There should be a follow up review at least every 4 weeks to assess tolerability and response during dose titration. This should include weight, glycaemic response, and if there is a need to adjust concomitant medicines (including glucose lowering medications). Follow up reviews to assess medication tolerance/response can be undertaken remotely, or an in-person review may be more appropriate if indicated by the wider clinical picture.
- Check HbA1c at 3 months, then 3-6 monthly until stable on unchanged therapy.

Figure 1: Approach to adjusting glucose lowering medicines on initiation of incretin therapy



Nb. HbA1c thresholds are provided for guidance, treatment should be individualised, and clinical judgement used when adjusting therapies. If advice is needed, for example, because the person is on a complex regimen or guidance around insulin de-escalation is required, discuss with a diabetes specialist.

Table 2: Adjusting Glucose lowering medicine on initiation of incretin therapy

Therapy	Recommended action
DPP4-is e.g. sitagliptin	**STOP:** Both drugs work on the incretin pathway, and studies have shown that there is no additional clinical benefit from taking these medications in combination**.**
Insulin	****CAUTION**** • Ensure oversight from a health care professional appropriately trained in insulin management or a diabetes specialist. • Review insulin regimen before starting incretin therapy, consider reducing insulin if there is risk of hypoglycemia. • A **stepwise reduction** in insulin **based on capillary blood glucose** or CGM data is advised. There is a risk of DKA if insulin therapy is rapidly reduced • See section 5 for guidance on adjusting insulin doses in response to CBG or CGM data in people living with T2D. • Close monitoring of blood-glucose is required, look to empower the individual, and discuss self-titration of therapies where appropriate.
Sulfonylureas (SU), e.g. gliclazide, glimepiride	**Review - cumulative risk of hypoglycaemia** • Consider stopping or reducing based on capillary blood glucose levels and if HbA1c within ~10% of individualised target. • Always review use of SU in people who are frail, >75 yrs, and /or at increased risk of hypoglycaemia (e.g. CKD)
Pioglitazone	**Consider stopping/swapping pioglitazone for the incretin therapy if additional glucose lowering is not required, or if it is not effective** (HbA1c reduction <5.5 mmol/mol or 0.5% in 6 months) **Review and stop if** • Heart Failure (or a deterioration in cardiac function is seen). • Previous bladder cancer (or uninvestigated macroscopic hematuria). • Consider stopping if at risk of fractures or low bone density (e.g. post-menopausal women).
Metformin	**Usually continued** (at the same dose). SGLT2 inhibitors should be continued in combination with metformin (unless contraindicated or not tolerated). Do not prescribe metformin if eGFR < 30.
SGLT2 Inhibitor	**Usually continued** (at the same dose). • Reassess DKA risk and provide advice about sick day guidance and signs of DKA. GMMMG SGLT2i Prescribing Guidance • Consider continuing SGLT-2 inhibitors for their cardiovascular or renal benefits, even if they do not help the person reach their individualised glycaemic targets.

9. Switching between incretin therapies

There is very little data for switching between different incretin therapies and there are no direct equivalent charts. It is advised to:

- Start the new therapy at the next scheduled dose (i.e. if previously on a daily dose - start the next day, if it is weekly, start the next week).
- Follow the licensed titration schedule, starting at the lowest dose.
- If GI side-effects occur, consider slower titration or waiting until symptoms have resolved before starting the new medication.

10. Guidance on adjusting insulin doses based on capillary blood glucose or CGM data in people living with Type 2 diabetes

A stepwise approach to insulin reduction based on capillary blood glucose or CGM data is recommended.
See GMMMG formulary for approved insulins.

Note: This guidance may not be appropriate for everyone, an individualised approach may be required for some people e.g. where frailty or risk of hypoglcaemia affects the balance of benefits and harms.
ALWAYS USE YOUR CLINICAL JUDGEMENT AND SEEK ADVICE WHERE NECESSARY

Basal	
Pre-breakfast CBG (mmol/L)	**Action**
<4	**Reduce** insulin by 10%
4 to 7	No change
7.1 to 15	**Increase** insulin by 10%
15.1 to 20	**Increase** insulin by 15%
>20	**Increase** insulin by 20%

Basal bolus					
CBG (mmol/L)	**<4**	**4 to 7**	**7.1 to 14**	**14.1 to 20**	**>20**
Pre-breakfast	Reduce **basal** insulin by 10%	No change	Increase **basal** insulin by 5–10%	Increase **basal** insulin by 15–20%	**Increase** insulin by 20%
Pre-lunch	Reduce **breakfast** insulin by 10%	No change	Increase **breakfast** insulin by 5–10%	Increase **breakfast** insulin by 15–20%	
Pre-tea	Reduce **lunch** insulin by 10%	No change	Increase **lunch** insulin by 5–10%	Increase **lunch** insulin by 15–20%	
Pre-bed	Reduce **teatime** insulin by 10%	No change	Increase **teatime** insulin by 5–10%	Increase **teatime** insulin by 15–20%	

Twice Daily					
CBG (mmol/L)	**<4**	**4 to 7**	**7.1 to 14**	**14.1 to 20**	**>20**
Pre-breakfast	Reduce **basal** insulin by 10%	No change	Increase **basal** insulin by 5-10%	Increase **basal** insulin by 15-20%	**Increase** insulin by 20%
Pre-tea	Reduce **breakfast** insulin by 10%	No change	Increase **breakfast** insulin by 5-10%	Increase **breakfast** insulin by 15-20%	
Pre-bed	Reduce **lunch** insulin by 10%	No change	Increase **lunch** insulin by 5-10%	Increase **lunch** insulin by 15-20%	

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Version control

Version	Date	Author	Summary of changes	Approval status
Draft 2.0	10 September 2026	Susan McKernan, NHS Greater Manchester ICB	Updated from version 1 commissioning position to include NICE TA1152, updated weight-management eligibility, the initiation checklist, guidance on adjusting glucose lowering medicines and insulin, and horizon-scanning information.	
Draft 2.1	11 September	Susan McKernan, NHS Greater Manchester ICB	Updated post GMMMG. Terminology changed from diabetes specialist to a healthcare professional appropriately trained in insulin management Horizon scanning section updated to reflect 10 September 2026 letter to ICBs re: oral semaglutide.	