Patient Preference and Adherence

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ORIGINAL RESEARCH

Obesity Medication Treatment Perspectives Among People with Overweight or Obesity

John W Ostrominski[1–3], Anindit Chhibber[4], Effie L Kuti[4], Brendan Clark[4], Bonnie MK Donato[4]

[1]Division of Cardiovascular Medicine, Brigham and Women's Hospital, Boston, MA, USA; [2]Division of Endocrinology, Diabetes and Hypertension, Brigham and Women's Hospital, Boston, MA, USA; [3]Division of Cardiovascular Medicine and Obesity Medicine, Harvard Medical School, Boston, MA, USA; [4]HEOR Value Demonstration, Boehringer Ingelheim Pharmaceuticals, Inc., Ridgefield, CT, USA

Correspondence: Anindit Chhibber, Boehringer Ingelheim Pharmaceuticals, Inc., 900 Ridgebury Road, Ridgefield, CT, USA, Email anindit.chhibber@boehringer-ingelheim.com

Background: Obesity is a complex, chronic condition associated with multiple health complications. While obesity medications (OMs), particularly GLP-1 receptor agonists (GLP-1RAs), have demonstrated significant clinical benefits, real-world insights into patient experiences with these therapies remain limited. This study evaluated patients' behaviors and experiences with OMs, including their financial impact; and aimed to identify key decision points for seeking and receiving treatment with OMs.

Methods: Individuals were recruited from a national database to complete a 20-minute online survey between July 8 and July 18, 2024. Eligible participants were adults aged 21 years or older with a body mass index (BMI) of ≥30 kg/m^2, or ≥27 kg/m^2 with at least one obesity-related complication (ORC) and were currently using an OM. Participants reported their experiences with OMs, motivations and barriers for treatment, challenges, interactions with HCPs and financial challenges with OMs.

Results: 100 people with obesity (PwO) participated in the survey. The median age of the respondents was 46 years. Most PwO (94%) had at least one comorbidity in addition to overweight/obesity, and 58% were more concerned about obesity compared with other health conditions. Most PwO (91%) were currently using GLP-1RAs and had previously attempted a median of 3 unique weight management strategies prior to OM initiation. Primary drivers for OM initiation were long-term health improvement (58%) and functional enhancement (53%). Major barriers included insurance restrictions (38%), concerns about side effects (37%), and cost (31%). While on OMs, most (88%) PwO reported a positive experience, citing significant benefits on body weight and appetite reduction; 9% were neutral and 3% reported a negative experience. Participants with longer durations of reported treatment more often reported positive experiences (79% among those with ≥6 months of therapy; 51% among those with <6 months of therapy). The study also found that 56% of PwO expected to be on their current OM for a limited period, with 20% anticipating less than a year and 28% anticipating less than two years. The anticipated treatment duration among PwO varied with reported out-of-pocket (OOP) costs. Communication with HCPs frequently addressed side effects and administration, but discussions about treatment duration and lifestyle integration were less consistent.

Conclusion: This study highlights the multifaceted experiences of PwO in managing obesity, particularly regarding OM use. The findings underscore the importance of early intervention, robust patient-provider communication, equitable access, and financial support to optimize treatment outcomes. Addressing systemic barriers, stigma, education, and access challenges will be essential to maximize the utility of obesity pharmacotherapy in clinical practice.

Keywords: obesity, obesity medications, treatment perspectives

Introduction

Obesity is a multifactorial chronic disease characterized by excess or abnormal adiposity with implications for health and well-being.[1,2] According to the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC), overweight is defined as a body mass index (BMI) of 25.0–29.9 kg/m², while obesity is defined as a BMI of ≥30.0 kg/m².[3,4] In recent decades, the prevalence of obesity has increased sharply in the United States and worldwide.[5,6] According to the CDC, the prevalence of obesity in the US increased from 31% in the 1999–2002 period to a striking 42% in 2017–2018[5,6] and is projected to reach 58% by 2035.[7] Obesity is also linked to a myriad of chronic conditions,

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which contribute to excess morbidity and mortality. These include type 2 diabetes,[8–10] cardiovascular disease,[11–13] liver disease,[14] chronic kidney disease,[15] musculoskeletal disorders,[16–18] site specific cancers,[19,20] and dementia.[21] Furthermore, large observational studies have shown that obesity is associated with a higher risk of premature death compared to individuals with a healthy weight.[22] The increased morbidity and mortality associated with obesity have positioned its prevention and treatment as a leading public health priority. In this context, approaches to obesity treatment have evolved significantly, and now span behavioral and lifestyle interventions, highly efficacious obesity medications (OMs), and metabolic and bariatric surgery.

Given the growing body of evidence establishing their wide-ranging benefits on health outcomes and health-related quality of life, glucagon-like peptide-1 receptor agonists (GLP-1RAs) have emerged as transformative options for people with excess adiposity[23–27] and related complications, including cardiovascular disease,[28–30] chronic kidney disease,[28–30] type 2 diabetes,[31–33] and metabolic dysfunction-associated steatotic liver disease.[34,35] Although the uptake of GLP-1RA-based therapies has been rapid,[36] and OMs are increasingly recommended in clinical practice guidelines as part of comprehensive strategies to address important health risks in people with obesity (PwO), their adoption and utilization remains low, with only 1% of eligible patients receiving an OM.[37]

The practical understanding of the experiences of people taking OMs remains limited,[38] and further evidence may inform shared decision-making, identify barriers to care, and uncover opportunities for practice improvement. In this contemporary survey of PwO taking OMs, we aimed to 1) evaluate patients' behaviors and experiences with OMs, including their financial impact; and 2) identify key decision points for seeking and receiving treatment with OMs.

Methods

This was a cross-sectional, exploratory survey study conducted among PwO in the United States. PwO were recruited to complete a 20-minute online survey between July 8–18, 2024. Eligible participants were adults aged 21 years or older with a BMI of ≥30 kg/m^2, or ≥27 kg/m^2 with at least one obesity-related complication (ORC) and were currently using an OM. Individuals were excluded if they had participated in a clinical trial within the past 6 months, were bodybuilders or powerlifters, were pregnant, were not currently using OMs, had never used or would not consider using OMs, were covered exclusively by Medicaid or Medicare, or were aged 65 years or older without commercial insurance coverage. Sampling quotas were established (eg, mix of GLP1 users and non-users) to ensure representation from a diverse sample of US adults living with overweight or obesity. Study participants were recruited from national survey panels facilitated by HawkPartners. These panels draw respondents from multiple regions across US to ensure a nationally representative sample. The survey included questions about the patient's health background, decisions to treat obesity, and experience with OMs and other weight loss methods, including economic burden and willingness to pay for treatment. The survey also explored the types of discussions between PwO and their healthcare professionals (HCPs) while on an OM. All responses were collected electronically through a secure survey software system and all respondents received a fair market incentive for their time.

The survey content and themes were derived from exploratory qualitative interviews conducted with a small group of PwO to understand the obesity treatment perspectives and financial impact. Prior to fielding the survey, two pre-tests were completed to refine the instrument and gather additional insights. HawkPartners designed and reviewed the survey to ensure it posed no risk to participants. Recruitment was conducted entirely online through national panels, and no direct contact with patients occurred. All participants provided consent prior to participation and participation was entirely voluntary, with respondents informed that there were no right or wrong answers and that they could choose not to participate or withdraw at any point. The data used in this study were de-identified and did not contain any identifiable protected health information (PHI). All data handling complied with the United States Department of Health and Human Services Privacy Rule requirements for de-identification, as codified at 45 C.F.R. § 164.514(b). Given that the study involved no identifiable patient data and posed minimal risk to participants, it met the criteria for exemption under federal regulations. Specifically, the research involved only the analysis of existing data and did not involve interactions with humans, as outlined in 45 C.F.R. § 46.104(d).[4] Therefore, IRB review was not sought or required. Patient privacy was strictly maintained, and all procedures adhered to Health Insurance Portability and Accountability Act (HIPAA) regulations and ethical principles outlined in the Declaration of Helsinki.[39]

No a priori sample size calculation was conducted as this survey was designed to be hypothesis generating. The sample size was determined pragmatically, based on feasibility considerations with the aim of providing descriptive insights to inform future research. To ensure data integrity, multiple fraud countermeasures were implemented including browser fingerprinting, geolocation verification and knowledge verification checks. In addition, standard quality control procedures were implemented to exclude the responses from speeders, straight-liners, and participants providing poor-quality open-ended answers. In addition, the survey instrument was content validated by experts to ensure that the questions comprehensively and accurately captured the concepts of interest. Descriptive statistics were used to summarize survey responses: categorical variables were reported as frequencies and percentages, and continuous variables as means with standard deviations or medians with interquartile ranges.

Results

Patient Population

100 PwO participated in the survey (9% were overweight and 91% were living with obesity). The median age of the respondents was 46 [39, 57] years and most were women (57%), had self-reported white race (91%) and non-Hispanic ethnicity (84%), were employed (74%), were suburban (50%), had commercial insurance (94%), and had bachelor's or higher level of education (53%) (Table 1). Nearly all participants were formally diagnosed with obesity (91%), with the majority being diagnosed by a primary care physician (PCP) (74%). Fewer had received a diagnosis of obesity from a weight management specialist (8%), or endocrinologist (6%) (Table 1). More than 9 in 10 (94%) had ≥1 health complication of obesity, and 58% were more concerned about obesity compared with other health conditions (Table 2). PwO also reported exploring various obesity management approaches before initiating an OM (ie, self-managed lifestyle changes, exercise plans, meal replacements, and supported lifestyle interventions);

Table 1 Characteristics of Participants

Characteristics of PwO (N=100)		
Median Age (Q1, Q3), years	46 (39, 57)	
Gender (n, %)		
Male	40	40.0%
Female	57	57.0%
Non-Binary	3	3.0%
Race (n, %)		
White	81	81.0%
Black	15	15.0%
Asian	4	4.0%
Ethnicity (n, %)		
Non-Hispanic	84	84.0%
Hispanic	16	16.0%
Region (n, %)		
Urban	35	35.0%
Suburban	50	50.0%
Rural	15	15.0%

(*Continued*)

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Table 1 (Continued).

Insurance Type (n, %)		
Commercial Insurance	94	94.0%
Medicare	7	7.0%
VA Insurance	3	3.0%
Medicaid	1	1.0%
Other Type of Coverage	1	1.0%
Not Insured	2	2.0%
Education Level (n, %)		
Some High School or less	0	0.0%
High School Grad	16	16.0%
Some College	17	17.0%
Associate	14	14.0%
BA/BS	28	28.0%
Graduate or Professional Degree	25	25.0%
Employment Status (n, %)		
Employed	74	74.0%
Retired	13	13.0%
Homemaker	6	6.0%
Self Employed	3	3.0%
Out of Work but not Retired	3	3.0%
Prefer Not to Answer	1	1.0%
Obesity Diagnosis (n, %)		
Formally Diagnosed	91	91.0%
Not Diagnosed	5	5.0%
Not Sure	4	4.0%
HCPs Who Diagnosed Obesity (n, %) (Among Those Diagnosed with Obesity (n=91)		
Primary Care Physician (PCP)	67	73.6%
Weight Management Specialist	7	7.7%
Endocrinologist	5	5.5%
Gastroenterologist	2	2.2%
Nurse Practitioner (NP)/Physician's Assistant (PA)	2	2.2%
Obstetrician-Gynecologist	2	2.2%
Nutritionist/Dietician	2	2.2%
Cardiologist	1	1.1%
Others	3	3.3%

(*Continued*)

Table 1 (Continued).

Current Obesity Medications (n, %)		
GLP-1 RAs	91	91.0%
Non GLP-1 RAs	9	9.0%
1 OM	95	95.0%
≥2 OMs	5	5.0%
Time on Current Obesity Medications (n, %)		
1 Month	15	15.0%
2-5 Months	38	38.0%
6-11 Months	24	24.0%
1-2 Years	19	19.0%
3-5 Years	4	4.0%

Table 2 Obesity and Additional Complications Among Participants

Medical Conditions*	% with Condition[#,a] Total n=100	% Very Concerned About Condition[b] (Among Those with Health Condition)	Most Concerning Condition[c] Total n=100
Obesity or overweight	85%	62%	58%
Type 2 diabetes	52%	71%	25%
High blood pressure	46%	57%	4%
High cholesterol	40%	48%	1%
Depression	35%	54%	1%
Sleep apnea	30%	43%	3%
Steatotic liver disease	15%	43%	1%

Notes: *In descending order of concern about condition. [#]Self-reported conditions. Each PwO may report multiple complications; therefore, totals exceed 100%. Questions asked from PwO. Please refer to the complete survey in the supplement for additional details: [a]S12: What, if any, health conditions are you living with currently. Please select all that apply. [b]A1b: How concerned are you about this health condition? Scale [Not at all concerned':1 to "Extremely concerned":7]. [c]A1c: Which health condition are you most concerned about?

86% had used ≥1 weight management method prior to OM treatment, with a median of 3 [1, 5] unique weight management strategies attempted prior to OM initiation. The majority of PwO were currently taking a GLP-1RA (91%) (67% semaglutide; 20% tirzepatide; and 4% liraglutide) for weight management, with 5 PwO (5%) reporting use of multiple OMs and the majority (53%) having been on their current OM for less than 6 months (Table 1).

Drivers and Barriers to Initiate OM Treatment and Key Experiences

The primary drivers for OM initiation were long-term health benefits (58%), desire to lose weight to improve activity levels (53%), and to manage other health conditions in addition to obesity (50%). Major barriers to OM treatment included insurance coverage limitations (38%), concerns about potential side effects (37%), and high costs or copays (31%) (Figure 1). While on OMs, most (88%) PwO reported a positive experience, citing significant benefits on body weight and appetite reduction; 9% were neutral and 3% reported a negative experience. Participants with longer durations of reported treatment more often reported positive experiences (79% among those with ≥6 months of therapy; 51% among those with <6 months of therapy).

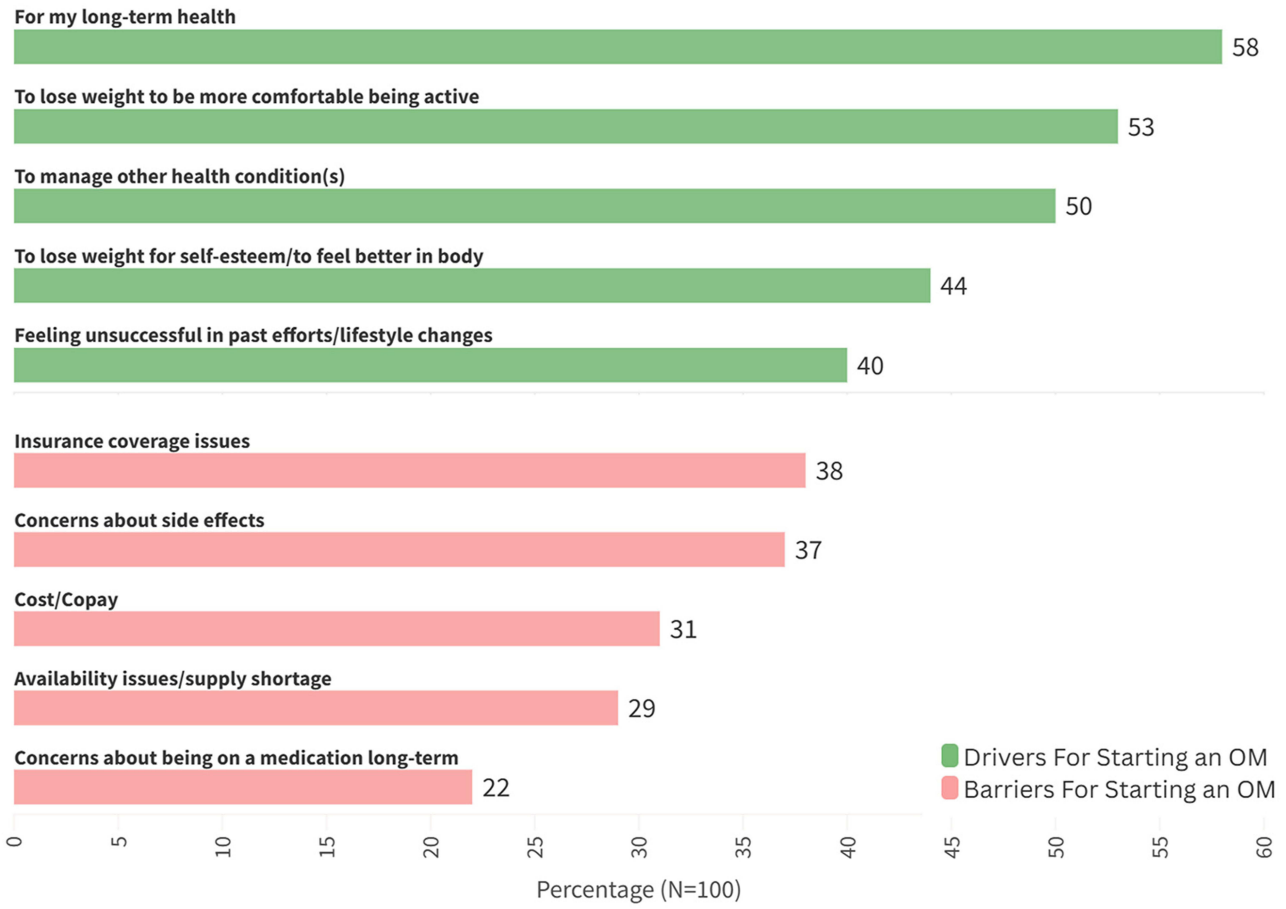

Figure 1 Key Drivers and Barriers for Starting an OM Among PwO. Questions asked from PwO. Please refer to the complete survey in the supplement for additional details: C8: What were the main reasons you wanted to start taking your current OM? Select all that apply. C9: What were the challenges for you before starting your current OM? Select all that apply.

OM Discussions Between Healthcare Professionals and PwO

Results revealed alignment between HCPs and PwO on themes of side effects (HCP-initiated: 68%, PwO-initiated: 58%), long-term benefits of OMs (HCP-initiated: 58%, PwO-initiated: 37%), and medication administration (HCP-initiated: 57%, PwO-initiated: 34%). However, discussions involving concomitant lifestyle interventions appeared more commonly initiated by HCPs (HCP-initiated: 64%, PwO-initiated: 27%) (Figure 2). The study also found that 56% of PwO expect to be on their current OM for a limited period, with 20% anticipating less than a year and 28% anticipating less than two years. In addition, only 42% reported discussing anticipated treatment timelines with their HCPs, but such discussions were more common among PwO who had been taking OMs for over six months. PwO engaging in active conversations with HCPs reported less uncertainty about their treatment timeline (Among those who had discussed treatment duration with an HCP, 5% indicated they were unsure vs 40% among those who had not engaged in such discussions) (Table 3). However, even among those who discussed OM treatment timelines with their HCPs, most (64%) anticipated an OM treatment duration of ≤1-2 years.

OM Switching Preferences

More than 1 in 5 (23%) PwO reported contemplating switching from their current OM. Among those who had considered a change, the primary drivers included the prospect of improved efficacy (22%), reduced side effects (17%), and dissatisfaction with weight loss outcomes (13%). Notably, PwO using newer-generation OMs less often considered switching to an alternative OM (Table 4).

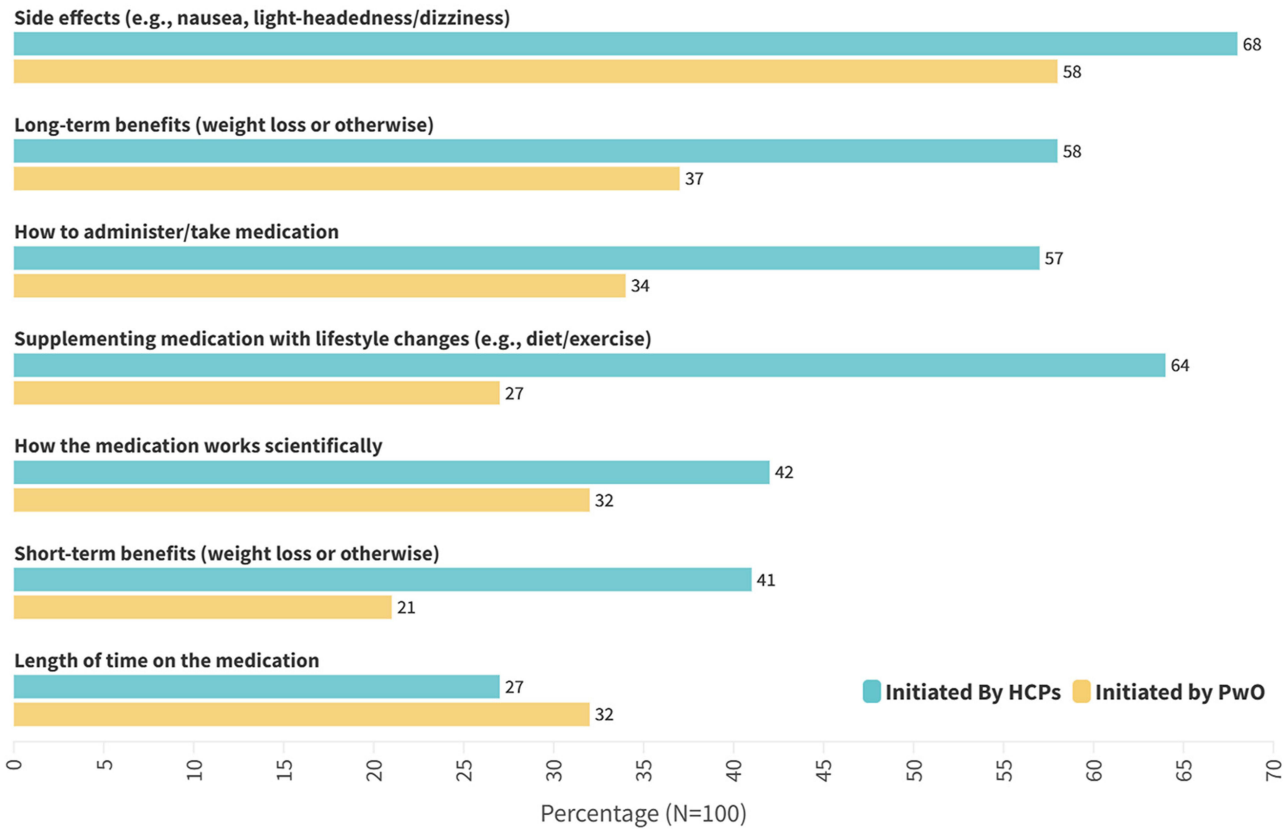

Figure 2 Topics of Discussion Between HCPs and PwO. Questions asked from PwO. Please refer to the complete survey in the supplement for additional details: C5: Before starting your current OM, which of the following topics did a healthcare professional discuss with you about? Select all that apply. C6: What type of questions did you ask a healthcare professional about your OM? Select all that apply.

Person-Level Financial Implications of OM Treatment

Overall, 57% of PwO reported OOP expenses of $50 or less per month for their OM, and 25% reported an OOP cost of $100 or more per month. The anticipated treatment duration among PwO varied with reported OOP costs. Among PwO who expected to use their current OM for a limited time (n=56), 41% were paying $100 or more in OOP expenses per month. In contrast, only 18% of those planning to remain on treatment indefinitely (n=17) reported

Table 3 HCP Discussions and Expected Duration of OM Therapy

How Long Do You Expect to Be on OM?	Total Cohort (N=100)		Discussed Timeline with HCP			
			Yes		No	
2-5 months	3	3.0%	3	7.1%	0	0.0%
6-11 months	17	17.0%	10	23.8%	7	12.1%
1-2 years	28	28.0%	14	33.3%	14	24.1%
3-5 years	6	6.0%	3	7.1%	3	5.2%
6-10 years	1	1.0%	1	2.4%	0	0.0%
11-20 years	1	1.0%	0	0.0%	1	1.7%
Indefinitely	17	17.0%	8	19.1%	9	15.5%
Until a specific event	2	2.0%	1	2.4%	1	1.7%
Do not know/not sure	25	25.0%	2	4.8%	23	39.7%

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Table 4 Switching Preferences by OM Type

Current OM	Total Cohort		Considered Switching			
			Yes		No	
Semaglutide (T2D)	55	55.0%	10	18.2%	45	81.8%
Tirzepatide (T2D)	18	18.0%	2	11.1%	16	88.9%
Semaglutide (Obesity management)	12	12.0%	3	25.0%	9	75.0%
Liraglutide	4	4.0%	2	50.0%	2	50.0%
Naltrexone/bupropion	4	4.0%	3	75.0%	1	25.0%
Orlistat	4	4.0%	3	75.0%	1	25.0%
Phentermine/topiramate	3	3.0%	1	33.3%	2	66.7%
Phentermine	3	3.0%	2	66.7%	1	33.3%
Tirzepatide (Obesity management)	2	2.0%	0	0.0%	2	100.0%

OOP costs of $100 or more OOP expenses per month. Substantial individual-level variation in cost-sharing for the same OM was also observed (Table 5). For instance, OOP expenditures for semaglutide and tirzepatide ranged from $0 to $400 or more per month. In addition, 58% reported being willing to spend more on OMs over alternative interventions. However, only 59% reported being able to sustain their current OM-related expenditure for up to two years, irrespective of the income level.

Discussion

This study contributes to the growing body of literature exploring the real-world experiences of PwO, specifically regarding their treatment decision-making, use of OMs, perceived challenges and benefits, and financial burden

Table 5 Monthly OOP by OM Type

Current OM	Total Cohort		Average OOP per Month															
			$0		$1 -$24		$25-$49		$50-$99		$100-$199		$200-$399		$400+		Do Not Recall	
Semaglutide (Obesity management)	12	12.0%	1	8.3%	1	8.3%	4	33.3%	2	16.7%	0	0.0%	4	33.3%	0	0.0%	0	0.0%
Tirzepatide (T2D)	18	18.0%	1	5.6%	0	0.0%	10	55.6%	3	16.7%	1	5.6%	1	5.6%	2	11.1%	0	0.0%
Liraglutide	4	4.0%	0	0.0%	1	25.0%	2	50.0%	1	25.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Semaglutide (T2D)	55	55.0%	7	12.7%	8	14.6%	13	23.6%	7	12.7%	8	14.6%	7	12.7%	3	5.5%	2	3.6%
Tirzepatide (Obesity management)	2	2.0%	0	0.0%	0	0.0%	1	50.0%	1	50.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Phentermine/topiramate	3	3.0%	0	0.0%	1	33.3%	1	33.3%	1	33.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Naltrexone/bupropion	4	4.0%	1	25.0%	0	0.0%	3	75.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Orlistat	4	4.0%	0	0.0%	1	25.0%	1	25.0%	2	50.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Phentermine	3	3.0%	1	33.3%	0	0.0%	1	33.3%	1	33.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	105	100.0%	11	10.5%	12	11.4%	36	34.3%	19	18.1%	9	8.6%	11	10.5%	5	4.8%	2	1.9%

associated with such treatments. The results underscore how multimorbidity, health perceptions, insurance coverage, and patient-provider communication patterns shape the uptake, continuation, and satisfaction with OMs.

Most PwO in this study were formally diagnosed with obesity, primarily by PCPs, reflecting national trends where the bulk of medical care and OM prescribing occurs in primary care settings. An analysis of 2.2 million adults in US reported that PCPs were the leading prescribers of OMs,[40] a finding supported by a recent analysis showing that most OM prescriptions were issued by PCPs and advanced practice practitioner (APPs), as opposed to cardiologists, endocrinologists, general surgeons, and all other specialists.[41] This highlights the critical role of PCPs, physician assistants (PAs), nurse practitioners (NPs), and advanced practice provider in frontline obesity care. Collaborative care models involving PCPs, PAs, NPs, APPs along with specialists can improve obesity outcomes.[42–44] Yet, many PCPs face knowledge gaps, limited training in obesity pharmacotherapy and limited time to provide guideline-based care, all of which lead to underutilization of treatment.[45–48] Future obesity care may benefit from stronger PCP-specialist collaboration, supported by education and system-level frameworks to equip PCPs for active, evidence-based obesity management.

The majority of PwO in this analysis, among whom the prevalence of complications of obesity was high, identified obesity as their primary health concern. While this might be considered unsurprising in a population treated for obesity, it suggests that clinical efforts to contextualize obesity as an upstream cause or contributor to other health conditions might inform personalized and targeted obesity treatment decisions. Such efforts should additionally incorporate psychological and social sequelae of obesity, including exposure to stigma, reduced self-esteem, and impaired daily functioning. These insights emphasize the need for healthcare providers to take a holistic approach when discussing treatment pathways, addressing not just physical health but also the emotional and psychosocial dimensions of living with obesity. By recognizing the role of weight-related concerns in patients' lives, clinicians can foster more empathetic, personalized, and effective care.

The study revealed that most PwO attempt several distinct weight loss methods before initiating OMs. Specifically, 86% of participants reported using at least one prior weight management strategy, with a median of 3 attempts. These findings align with clinical guidelines, which recommend initial therapy with behavioral interventions such as calorie restriction, increased physical activity, and lifestyle counseling in most persons.[49–51] This observation additionally underscores the relapsing and remitting nature of obesity[52] and, when used in isolation, the limited health improvements with lifestyle interventions once obesity and its complications are established.[53] Indeed, body weight reduction achieved through lifestyle interventions alone is rapidly counter regulated through maladaptive neurometabolic and enteroendocrine mechanisms that antagonize durable weight reduction and promote weight recurrence.[54,55] This highlights the need for therapeutic approaches that consider obesity as a chronic and relapsing disease requiring timely and sustained multimodal intervention.

A central finding of this study is the strong motivation among PwO to initiate OMs for long-term health improvement, better physical function, and complication management. This aligns with prior research showing that patients view weight loss as a critical step toward reducing disease burden and enhancing quality of life.[56] Despite this motivation, financial and structural barriers significantly limit OM uptake. In this analysis, insurance coverage issues, concerns about side effects, and high OOP costs were the leading barriers to OM use, findings consistent with previous studies documenting limited OM access.[57–59] Nevertheless, two-thirds of participants reported positive experiences with OMs, particularly among those who continued treatment for six months or longer. These findings reinforce the need for clinical and policy efforts to promote increased access and adherence.[60,61]

An important insight from the study centers on communication between PwO and their HCPs about OM treatment. While these conversations commonly addressed side effects and medication administration, discussions around integration of lifestyle interventions with pharmacotherapy were primarily initiated by HCPs. This gap emphasizes the need to ensure optimal education around concomitant use of OMs and lifestyle interventions to minimize side effects, ensure safety, and enhance achievement of health goals.[62] Additionally, fewer than half of PwO discussed treatment duration and most expected therapy to last less than 2 years despite evidence from clinical trials supporting longitudinal use to maintain treatment benefits,[23,26,27] including maintenance of disease control and prevention of recurrence. Those on medication for over 6 months were more likely to have had these discussions, suggesting that ongoing treatment fosters deeper communication. In addition, anticipated treatment duration appeared to be influenced by financial considerations,

particularly OOP costs which aligns with prior published research work.[38,63] However, the lack of early dialogue on treatment timelines represents a missed opportunity to set expectations and provide anticipatory support, with implications for premature discontinuation and subsequent clinical outcomes. These findings highlight the need for evidence-based provider training that emphasizes open, empathetic, and stigma-free communication. Optimal conversations should go beyond medication logistics to include lifestyle behaviors, emotional well-being, and long-term care planning. Research has consistently demonstrated that when patients feel heard and respected, their clinical outcomes and treatment satisfaction improve.[64,65]

The financial impact of OMs emerged as a significant concern, with 57% of participants paying $50 or less per month OOP, yet only 59% reporting they could sustain this cost for up to two years. These findings highlight the disconnect between willingness to pay and actual financial capacity of these PwO. The variation in cost-sharing for the same medication type may also reflect important inter-individual differences in insurance design and access, which may shape resultant OM access and health outcomes. Addressing these differences will require coordinated efforts among policy-makers, payers, and clinicians to reduce financial barriers and ensure equitable access to effective obesity treatments.

This study has several strengths. It adds to a limited literature reporting on patient perspectives of OMs,[38,63,66,67] capturing a broad range of factors including treatment motivations, barriers, patient-provider communication, and financial impacts. The survey design was informed by qualitative interviews and expert input, ensuring that key patient concerns and clinical insights were comprehensively assessed. The detailed exploration of multimorbidity, prior weight management efforts, and treatment adherence adds depth to the understanding of patient experiences. However, several limitations should also be acknowledged. First, selection of PwO actively receiving OM therapy may have underestimated barriers to receiving such treatment. Second, the survey respondents were predominantly White, employed or retired, and had commercial insurance. As such, the generalizability of these findings to more diverse, underinsured, or socioeconomically disadvantaged populations is uncertain. Third, the cross-sectional survey design captures patient experiences and perceptions at a single time point, which precludes assessment of longitudinal changes in treatment adherence, outcomes, or attitudes. However, the inclusion of forecasting-oriented survey questions (eg, expected treatment duration) offers some temporal insights. Fourth, self-reported data may be subject to recall bias. Lastly, this hypothesis generating study was limited by its small sample size and focus on commercially insured patients. However, despite these constraints, it provides comprehensive insights into the OM treatment experiences among PwO. Future research should focus on larger, more representative samples and incorporate longitudinal designs to enhance understanding of long-term treatment trajectories and outcomes across varied patient subgroups.

In conclusion, this study highlights the multifaceted experiences of PwO in managing obesity, particularly regarding OM use. The findings underscore the importance of early intervention, robust patient-provider communication, equitable access, and financial support to optimize treatment outcomes. As new pharmacologic agents continue to reshape the obesity treatment landscape, it is critical to ensure that these innovations translate into real-world benefits for all patients. Addressing systemic barriers, stigma, education, and communication gaps will be essential to fulfilling the promise of obesity pharmacotherapy in clinical practice.

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Author Contributions

JWO contributed to data interpretation, offered critical insights, and was responsible for drafting and revising the manuscript. AC, ELK, and BC were involved in the conceptualization of the study, survey design, data interpretation, and provided critical revisions to the manuscript. BMKD oversaw the study, contributed to the interpretation of findings, and provided critical revisions to the manuscript. All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published;

have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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