

Reimbursement Recommendation

Tirzepatide (Zepbound)

Indication: For once-weekly administration for chronic weight management, including weight loss and weight maintenance, as an adjunct to a reduced-calorie diet and increased physical activity, in adults with an initial body mass index of: 30 kg/m² or greater (obesity), or 27 kg/m² to less than 30 kg/m² (overweight) in the presence of at least one weight-related comorbid condition (e.g., hypertension, dyslipidemia, prediabetes, type 2 diabetes mellitus, obstructive sleep apnea, or cardiovascular disease).

Sponsor: Eli Lilly Canada Inc.

Recommendation: Reimburse with conditions

Summary

What Is the Reimbursement Recommendation for Zepbound?

Canada's Drug Agency (CDA-AMC) recommends that Zepbound be reimbursed by public drug plans for once-weekly administration for chronic weight management, including weight loss and weight maintenance, as an adjunct to a reduced-calorie diet and increased physical activity, in adults with a body mass index (BMI) of greater than or equal to 27 kg/m² and prediabetes, if certain conditions are met.

Why Did CDA-AMC Recommend Reimbursement?

The Canadian Drug Expert Committee (CDEC) concluded that Zepbound does not demonstrate acceptable clinical value compared with appropriate comparators (reduced-calorie diet and increased physical activity; semaglutide) for the full Health Canada indicated population (adults with a BMI of greater than or equal to 30 kg/m² [obesity], or BMI of 27 kg/m² to less than 30 kg/m² [overweight] in the presence of at least 1 weight-related comorbid condition). However, CDEC concluded that Zepbound demonstrates acceptable clinical value compared with appropriate comparators (reduced-calorie diet and increased physical activity) in the subpopulation of adults with a BMI of greater than or equal to 27 kg/m² and prediabetes. This determination was enough for CDEC to recommend that Zepbound be reimbursed. Given that Zepbound is expected to be an additive treatment to reduced-calorie diet and increased physical activity in this subpopulation, acceptable clinical value refers to added value versus reduced-calorie diet and increased physical activity alone.

Three phase III randomized controlled trials (SURMOUNT-1, SURMOUNT-2, and SURMOUNT-4) showed that Zepbound, when combined with diet and physical activity, resulted in clinically meaningful reductions in body weight and increased the likelihood of achieving 5% or greater weight loss compared with placebo over 52 to 72 weeks in adults with overweight or obesity. In the prediabetes subgroup of the SURMOUNT-1 trial, Zepbound also reduced progression to type 2 diabetes mellitus (T2DM) through 176 weeks. While improvements in quality of life and functioning were observed, their clinical importance remains uncertain. No major safety concerns were identified, although long-term harms are unknown. Evidence on the impact of Zepbound on long-term clinical outcomes (e.g., cardiovascular events, mortality) and its comparative efficacy versus relevant comparators is lacking. Overall, the evidence is most supportive of a clinically meaningful benefit in patients with overweight or obesity and prediabetes since this subpopulation

Summary

demonstrated sustained weight loss over the longest period of follow-up and a reduced risk of developing T2DM.

Which Patients Are Eligible for Coverage?

Zepbound should only be covered for adults who have a BMI of 27 kg/m² or greater and prediabetes, and at least 1 self-reported unsuccessful dietary attempt at weight loss.

What Are the Conditions for Reimbursement?

Zepbound should only be reimbursed for chronic weight management if the patient is following a reduced-calorie diet and engaging in increased physical activity and if the cost of Zepbound is reduced. For continuation of reimbursement after the first year of treatment, at least a 5% reduction in total body weight from baseline must be documented. Thereafter, patients should be reassessed each year. Zepbound should not be reimbursed for use in combination with other glucagon-like peptide-1 (GLP-1) receptor agonists (RAs).

Important budget impact considerations must be addressed for health systems to be able to adopt Zepbound.

Review Background

- Disease background:** Obesity and overweight are complex chronic diseases where excess body fat impairs health and increases the risk of long-term health complications. They are traditionally measured using BMI, where overweight is defined as a BMI between 25.0 kg/m² and 29.9 kg/m², whereas obesity is defined as a BMI of 30 kg/m² or higher. Up to 68% of adults living in Canada aged 18 to 79 years lived with either obesity or overweight between 2022 and 2024 based on their BMI, which represented an 8% increase from 2016 to 2019. Prediabetes, a condition where blood sugar levels are higher than the normal range but not high enough to be diagnosed as T2DM, is common among adults with obesity or overweight. Although there is a lack of Canadian-specific data for the prevalence of prediabetes among patients with overweight or obesity, studies based in France and the US suggest that prediabetes prevalence ranges between 14.3% and 36.9% for adults with obesity, and between 9.6% and 20.7% for adults with overweight.
- Indication and reimbursement request:** Tirzepatide (Zepbound) has been approved by Health Canada for once-weekly administration for chronic weight management, including weight loss and weight maintenance, as an adjunct to a reduced-calorie diet and increased physical activity, in adults with an initial BMI of 30 kg/m² or greater (obesity), or 27 kg/m² to less than 30 kg/m² (overweight) in the presence of at least 1 weight-related comorbid condition (e.g., hypertension, dyslipidemia, prediabetes, T2DM, obstructive sleep apnea, or cardiovascular disease [CVD]). The sponsor is seeking reimbursement for once-weekly administration for chronic weight management, including weight loss and weight maintenance, as an adjunct to a reduced-calorie diet and increased physical activity, in adults with an initial BMI of greater than or equal to 27 kg/m² and prediabetes.
- Drug under review:** Tirzepatide is a glucose-dependent insulinotropic polypeptide and a GLP-1 RA. It is available as 2.5 mg/0.6 mL, 5 mg/0.6 mL, 7.5 mg/0.6 mL, 10 mg/0.6 mL, 12.5 mg/0.6 mL, and 15 mg/0.6 mL solution in a multidose, prefilled pen for subcutaneous (SC) dose. The product monograph recommends a starting dosage of 2.5 mg once weekly. After 4 weeks, increase the dosage to 5 mg injected SC once weekly. The dosage may be increased in 2.5 mg increments after at least 4 weeks of receiving the current dose. The recommended maintenance dosages in adults are 5 mg, 10 mg, or 15 mg injected SC once weekly. The maximum dosage is 15 mg injected SC once weekly.
- Treatment costs:** At the submitted price of \$300.00 per 2.5 mg or 5 mg multidose prefilled pen, \$420.00 per 7.5 mg or 10 mg multidose prefilled pen, and \$540.00 per 12 mg or 15 mg multidose prefilled pen, the annual cost of tirzepatide is expected to range from \$3,913 to \$7,044 per patient depending on dose.

Highlights of Input From Interested Parties

The patient groups (Diabetes Canada, Gastrointestinal Society, Obesity Matters, and Obesity Canada) noted the following regarding impacts of the disease, unmet needs, and important outcomes:

- Living with obesity affects emotional, physical, and social well-being, and patients value treatments that improve mobility, energy, pain, and obesity-related conditions. They highlighted the importance of reducing “food noise” and regulating hunger cues. For those with diabetes, they noted that key goals include stable blood sugar and blood pressure, reduced cardiovascular risk, avoiding weight gain, and minimizing gastrointestinal side effects.
- The patient inputs emphasized that lifestyle changes alone rarely lead to sustained weight loss. Existing medications are often expensive and have side effects, while surgery — though effective — is viewed as a last resort due to cost, long waits, and potential complications. They indicated a need for safe and effective treatment options that achieve sustainable weight loss, improve comorbidities (such as T2DM, hypertension, dyslipidemia, sleep apnea, CVD), and enhance quality of life, physical function, mobility, and psychosocial well-being, while maintaining long-term weight loss and preventing regain.

The clinician groups (LMC Diabetes and Endocrinology; joint submission from Obesity Canada, Diabetes Canada, Canadian Society of Endocrinology and Metabolism, Canadian Association of Bariatric Physicians and Surgeons, and Canadian Cardiovascular Society; and York Weight Loss Clinical and Internal Medicine Clinic) and the clinical experts consulted by CDA-AMC for this review noted the following regarding unmet needs arising from the disease and place in therapy for the drug under review:

- Current obesity treatments often fall short in achieving adequate and sustained weight loss, as many patients experience plateaus and eventual weight regain. They noted that there is a need for additional treatment options to address obesity earlier in its course, before the onset of complications and comorbidities.
- The clinical experts noted that tirzepatide’s greater weight loss efficacy compared to existing treatments and significant metabolic benefits — particularly for individuals with prediabetes — position it to potentially shift current practice. The experts indicated that tirzepatide would likely be used as a first-line pharmacologic option alongside lifestyle interventions. They also noted that it would not be necessary to require failure of multiple other pharmacologic treatments before initiating tirzepatide.

The participating public drug programs raised potential implementation issues related to considerations for initiation, discontinuation of therapy, and generalizability of trial populations to broader populations.

Recommendation

With a vote of 12 in favour to 3 against, CDEC recommends that tirzepatide be reimbursed for once-weekly administration for chronic weight management, including weight loss and weight maintenance, as an adjunct

to a reduced-calorie diet and increased physical activity, in adults with a BMI of greater than or equal to 27 kg/m² and prediabetes, only if the conditions listed in [Table 1](#) are met.

Table 1: Reimbursement Conditions and Reasons

Reimbursement condition	Reason	Implementation guidance
Initiation, renewal, and prescribing		
1. Treatment with tirzepatide should be reimbursed as an adjunct to a reduced-calorie diet and increased physical activity, for chronic weight management in adults who have all the following: 1.1. a BMI $\geq$ 27 kg/m² and prediabetes 1.2. at least 1 self-reported unsuccessful dietary attempt at weight loss.	Evidence from the SURMOUNT-1 trial demonstrated that treatment with tirzepatide resulted in a clinical benefit in weight loss and delaying progression to T2DM in patients with these characteristics.	Patient should maintain a 500 kcal/day energy deficit through dietary caloric restriction and engage in at least 150 minutes of physical activity per week while receiving tirzepatide treatment. The clinical experts noted that it would be reasonable to reimburse tirzepatide per definition of prediabetes used in the SURMOUNT-1 trial. For defining eligibility in patients with prediabetes, at least 1 of the following is required: • 1 hemoglobin A1C level between 5.7% and 6.4% • 2 fasting plasma glucose levels between 5.6 and 6.9 mmol/L measured independently on different dates • 1 two-hour blood glucose level between 7.8 and 11.0 mmol/L on the oral glucose tolerance test. The clinical experts noted that, although these criteria differ slightly from those used in the trial (where at least 2 abnormal values of A1C, fasting plasma glucose, or oral glucose tolerance test were required), they are considered more pragmatic for implementation in clinical practice.
2. The maximum duration of initial authorization is 1 year.	An initial authorization of 1 year was recommended to allow the patient time to reach a therapeutic dose of tirzepatide (2.5 mg or maximum tolerated dose up to 15 mg) and then evaluate the benefit of continued treatment at that dose, while also providing flexibility based on patient and clinician availability.	The clinical experts indicated that tirzepatide treatment should not be discontinued in patients who progress to T2DM.
Renewal		
3. For renewal after initial authorization, the physician must document a beneficial clinical effect when requesting continuation of reimbursement, defined as at least a 5% reduction in total body weight from baseline.	A 5% reduction in total body weight was identified as a clinically meaningful improvement in weight for the management of overweight and obesity based on input from clinical experts. In the prediabetes subgroup of the SURMOUNT-1 trial, in which a delay in	Patient should maintain a reduced-calorie diet and increased physical activity while receiving tirzepatide treatment.

Reimbursement condition	Reason	Implementation guidance
	progression to T2DM with tirzepatide treatment was observed, most patients had $\geq 5\%$ weight reduction from baseline at week 176.	
4. For subsequent renewal, the physician must provide proof that the initial response achieved after the first year of treatment with tirzepatide has been maintained. Subsequent renewals should be assessed annually.	Annual assessments will help ensure the treatment is used for those benefiting from the therapy and would reduce the risk of unnecessary treatment. The clinical experts indicated to CDEC that weight loss is expected to plateau even with effective treatments, and maintenance of reduced weight is sufficient for subsequent renewals.	—
Prescribing		
5. Tirzepatide should not be reimbursed for use in combination with other GLP-1 RAs.	Tirzepatide has a shared mechanism of action with GLP-1 RAs. There is no evidence to support whether tirzepatide offers additional benefit when used in combination with other GLP-1 RAs.	—
Pricing		
6. A reduction in price.	Using the CDA-AMC scenario analysis reflecting the requested reimbursement population, the ICER for tirzepatide 5 mg was \$77,871, 10 mg was \$97,940, and 15 mg was \$123,265 per QALY gained, respectively, compared to diet and exercise. For tirzepatide 5 mg, a band 2^a price reduction would be required to achieve cost-effectiveness at a \$50,000 per QALY threshold in this population. No price reduction would be required to achieve cost-effectiveness at a \$100,000 per QALY threshold. For tirzepatide 10 mg, a band 2^a price reduction would be required to achieve cost-effectiveness at a \$50,000 per QALY threshold in this population. No price reduction would be required to achieve cost-effectiveness at a \$100,000 per QALY threshold. For tirzepatide 15 mg, a band 2^a price reduction would be required to achieve cost-effectiveness at a \$50,000 per QALY threshold in this population. A band 1^a price reduction would be required to achieve cost-effectiveness at a \$100,000 per QALY threshold. Price reductions for tirzepatide for any	The CDA-AMC analysis is based on public list prices for all treatments. Further price reductions may be required if there are price arrangements (discounts) currently in place for any treatment included in the economic analysis.

Reimbursement condition	Reason	Implementation guidance
	given willingness-to-pay threshold are available in the CDA-AMC Main Report and Supplemental Material document. Due to uncertainty in the economic analysis further price reductions might be required.	
Feasibility of adoption		
7. The economic feasibility of adoption of tirzepatide must be addressed.	At the submitted price, the incremental budget impact of tirzepatide is expected to be greater than \$40 million in years 1, 2, and 3. At the submitted price, the magnitude of uncertainty in the budget impact must be addressed to ensure the feasibility of adoption, given the difference between the sponsor's estimate and the CDA-AMC estimate(s).	—

BMI = body mass index; CDA-AMC = Canada's Drug Agency; CDEC = Canadian Drug Expert Committee; GLP-1 RA = glucagon-like peptide-1 receptor agonist; ICER = incremental cost-effectiveness ratio; T2DM = type 2 diabetes mellitus; QALY = quality-adjusted life-year.

*For the statement regarding the size of the price reduction required, band 1 = 1% to 24%; band 2 = 25% to 49%; band 3 = 50% to 74%; and band 4 = 75% or greater.

Rationale for the Recommendation

Clinical Value

Based on the totality of the submitted clinical evidence, CDEC concluded that tirzepatide does not demonstrate acceptable clinical value compared with appropriate comparators for the full Health Canada indicated population (adults with a BMI of greater than or equal to 30 kg/m², or BMI of 27 kg/m² to less than 30 kg/m² in the presence of at least 1 weight-related comorbid condition). Appropriate comparators for the full Health Canada indicated population refer to reduced-calorie diet and increased physical activity; additionally, semaglutide (Ozempic) is an appropriate comparator in the subpopulation with overweight or obesity and T2DM, and semaglutide (Wegovy) is an appropriate comparator in the subpopulation with overweight or obesity and established CVD. However, CDEC concluded that tirzepatide demonstrates acceptable clinical value compared with appropriate comparators (reduced-calorie diet and increased physical activity) in the subpopulation of adults with a BMI of greater than or equal to 27 kg/m² and prediabetes. Given that tirzepatide is expected to be an additive treatment to reduced-calorie diet and increased physical activity in this subpopulation, acceptable clinical value refers to added value versus reduced-calorie diet and increased physical activity alone.

Three phase III, randomized, double-blind, placebo-controlled trials (SURMOUNT-1 [N = 2,539], SURMOUNT-2 [N = 938], SURMOUNT-4 [N = 640]) evaluating the efficacy and safety of tirzepatide versus placebo as an adjunct to reduced-calorie diet and increased physical activity demonstrated that treatment with tirzepatide 5 mg, 10 mg, and 15 mg in adults with obesity or overweight and at least 1 weight-related

comorbidity resulted in added benefit in reduction of body weight and in achieving 5% or greater weight loss at 52 to 72 weeks. However, it is unknown whether this translates into a reduction in important long-term clinical outcomes such as major adverse cardiovascular events, osteoarthritis, obstructive sleep apnea, or premature mortality since they were not evaluated in the trials. Additionally, there was no evidence to inform how tirzepatide compares with relevant comparators in subpopulations, including semaglutide (Ozempic) in adults with obesity or overweight and T2DM, or with semaglutide (Wegovy) in adults with obesity or overweight and established CVD. The committee further considered results in the prediabetes subgroup from the SURMOUNT-1 trial, which demonstrated that compared with placebo, tirzepatide likely leads to a clinically important reduction in the proportion of those who progressed to T2DM, in addition to benefits in reduction of weight, through week 176 when added to a reduced-calorie diet and increased physical activity. Improvements in quality of life and functioning were observed at 52 to 72 weeks and were maintained in the prediabetes subgroup of the SURMOUNT-1 trial at 176 weeks; however, CDEC noted that the clinical meaningfulness of this improvement in quality of life and functioning is uncertain in all trials. Across trials, there were no notable safety signals identified, and CDEC considered the safety profile of tirzepatide to be manageable, although harms occurring with longer duration of treatment are not known. Taken together, the committee concluded that the evidence is most supportive of a clinically meaningful benefit in patients with overweight or obesity and prediabetes, in whom sustained effects on weight over the longest follow-up and a reduction in progression to T2DM were demonstrated.

Further information on the committee's discussion around clinical value is provided in the Summary of Deliberation section.

Developing the Recommendation

The determination of acceptable clinical value was sufficient for CDEC to recommend reimbursement of tirzepatide. As part of the deliberation on whether to recommend reimbursement, the committee also considered unmet clinical need, unmet nonclinical need, and health inequity. Information on this discussion is provided in the Unmet Clinical Need and Distinct Social and Ethical Considerations domains in the Summary of Deliberation section.

Because CDEC recommended that tirzepatide be reimbursed, the committee also deliberated on whether reimbursement conditions should be added to address important economic considerations, health system impacts, or social and ethical considerations, or to ensure clinical value is realized. The resulting reimbursement conditions, with accompanying reasons and implementation guidance, are stated in [Table 1](#).

Summary of Deliberation

CDEC considered all domains of value of the deliberative framework before developing its recommendation: clinical value, unmet clinical need, distinct social and ethical considerations, economic considerations, and impacts on health systems. For further information on the domains of value, refer to [Expert Committee Deliberation at Canada's Drug Agency](#).

The committee considered the following key discussion points, organized by the 5 domains of value.

Clinical Value

- **Appropriate comparators:** CDEC considered the appropriate comparator for tirzepatide in the full Health Canada indicated population to be lifestyle therapy. Additional appropriate comparators were identified in subpopulations, including semaglutide (Ozempic) in adults with obesity or overweight and T2DM, and semaglutide (Wegovy) in adults with obesity or overweight and established CVD. No additional comparators were identified in adults with obesity or overweight and prediabetes.
- **Efficacy versus placebo:** CDEC discussed 3 phase III, randomized, double-blind, placebo-controlled trials (SURMOUNT-1, SURMOUNT-2, and SURMOUNT-4) evaluating the efficacy and safety of tirzepatide versus placebo as an adjunct to reduced-calorie diet and increased physical activity. The trials demonstrated that treatment with tirzepatide 5 mg, 10 mg, and 15 mg in adults with obesity or overweight and at least 1 weight-related comorbidity resulted in added benefit in reduction of body weight and in achieving 5% or greater weight loss at 52 to 72 weeks. In the SURMOUNT-1 trial, these results remained consistent in patients with prediabetes at baseline through 176 weeks and tirzepatide treatment likely led to a clinically important reduction in the proportion of those who progressed to T2DM. The trials also demonstrated an improvement in quality of life and functioning at 52 to 72 weeks, and this result was maintained in the prediabetes subgroup of the SURMOUNT-1 trial at 176 weeks.
- **Clinical importance of treatment effects:** Based on input from patient and clinician groups, and the clinical experts consulted for this review, the primary goals of managing obesity and overweight are achieving sustainable weight loss of at least 5% of body weight, improving comorbidities (such as T2DM, hypertension, dyslipidemia, sleep apnea, and CVD), and enhancing quality of life. CDEC acknowledged the weight outcomes in the evidence for the full Health Canada indicated the population favoured tirzepatide. However, the absence of evidence for important long-term clinical outcomes such as major adverse cardiovascular events, osteoarthritis, obstructive sleep apnea, or premature mortality is an important gap in the evidence for this population. CDEC discussed the outcome of time to onset of T2DM assessed in the prediabetes subgroup in the SURMOUNT-1 trial and considered the delay in progression to T2DM with tirzepatide to be a clinically meaningful benefit, given the established association between T2DM and microvascular and macrovascular complications. CDEC also discussed that all 3 trials showed improvements in quality of life and functioning. However, because no established between-group minimal important differences exist in the literature, the clinical meaningfulness of these improvements in quality of life and functioning remains uncertain.
- **Certainty of the evidence:** CDEC discussed the Grading of Recommendations Assessment, Development and Evaluation (GRADE) assessment of selected outcomes from the SURMOUNT-1, SURMOUNT-2, and SURMOUNT-4 trials. The committee noted that the certainty of the results for reduction in body weight, the proportion of patients achieving at least 5% weight loss, the proportion of patients with prediabetes who progressed to T2DM, and improvements in quality of

life and functioning was considered moderate at 52 to 72 weeks, and at 176 weeks for T2DM onset. The evidence for these outcomes was rated down from high to moderate certainty due to missing outcome data and deviations from the intended interventions.

- **Efficacy versus semaglutide:** CDEC noted that semaglutide (Wegovy) and semaglutide (Ozempic) plus diet and exercise are appropriate comparators for a subset of the Health Canada indication, which includes patients with a BMI of 27 kg/m² or higher and established CVD, and patients with a BMI of 27 kg/m² or higher and T2DM, respectively. Direct or indirect comparative evidence for tirzepatide versus semaglutide (Wegovy) and semaglutide (Ozempic) was not submitted.
- **Eligible population:** CDEC considered clinical expert input that prediabetes should not be the sole requirement for tirzepatide treatment eligibility and that obesity itself — especially when accompanied by weight-related comorbidities — is a chronic disease that warrants early intervention. The experts also noted that limiting access to therapy until prediabetes develops may delay appropriate care and reduce opportunities to prevent future complications. While CDEC acknowledged this input, the committee considered that the available evidence most strongly supports a clinically meaningful benefit of tirzepatide in patients with prediabetes, in whom sustained effects on weight over the longest follow-up and a reduction in progression to T2DM were demonstrated.
- **Harms findings versus placebo:** CDEC noted that evidence from the SURMOUNT-1, SURMOUNT-2, and SURMOUNT-4 trials suggested that the harms profile of tirzepatide was consistent with that of other injectable GLP-1 RAs. CDEC noted that patients in the tirzepatide groups reported more gastrointestinal treatment-emergent adverse events (TEAEs), particularly nausea and diarrhea, and more treatment discontinuations due to gastrointestinal TEAEs than placebo, although the incidence of serious TEAEs was similar between groups. CDEC noted that across the 3 trials, the safety profile of tirzepatide was generally consistent with the known safety profile of this drug class and that the TEAEs in general are expected to be manageable based on clinical expert input. However, harms occurring with longer duration (beyond 176 weeks) of treatment are not known.
- **Clinical value:** Based on the submitted evidence and all the preceding considerations, CDEC considered that tirzepatide likely has added clinical value versus placebo as an adjunct to a reduced-calorie diet and increased physical activity in patients with overweight or obesity and prediabetes.



Unmet Clinical Need

- **Input on unmet clinical need:** Patient groups, clinician groups, and clinical experts consulted by CDA-AMC noted that current obesity treatments often fall short in achieving adequate and sustained weight loss, as many patients experience plateaus and eventual weight regain. They noted that there is a need for additional treatment options to address obesity earlier in its course, before the onset of complications and comorbidities.
- **Severity of the disease:** The committee noted that obesity and overweight are complex chronic diseases where excess body fat impairs health and increases the risk of long-term health complications if left untreated.

- **Availability of treatment options:** CDEC discussed the available treatment options for chronic weight management. The committee noted that lifestyle interventions were considered as available treatment options when reviewing the clinical evidence for the full Health Canada indication. Orlistat is currently reimbursed by at least 1 public drug program for patients with a BMI of 27 kg/m² or higher and T2DM but is not widely used. Semaglutide (Ozempic) is publicly reimbursed for the treatment of T2DM but may be used off-label for weight management in patients with T2DM with overweight or obesity, and bariatric surgery is an option for patients with a BMI of 40 kg/m² or higher, or a BMI of 35 kg/m² or higher with comorbidities. Semaglutide (Wegovy) plus diet and exercise was previously recommended for public reimbursement by CDEC for patients with a BMI of 27 kg/m² or higher and established CVD; however, it is not currently reimbursed by any public drug plans for chronic weight management in Canada since the pan-Canadian Pharmaceutical Alliance process concluded without an agreement as the manufacturer declined negotiation. CDEC acknowledged that current treatment options are limited and often inaccessible, and that they frequently fail to achieve adequate and sustained weight loss. CDEC also noted that there is no available data on the efficacy or safety of combining tirzepatide with other GLP-1 RAs; therefore, tirzepatide should not be reimbursed when used in combination with other GLP-1 RAs (e.g., semaglutide).



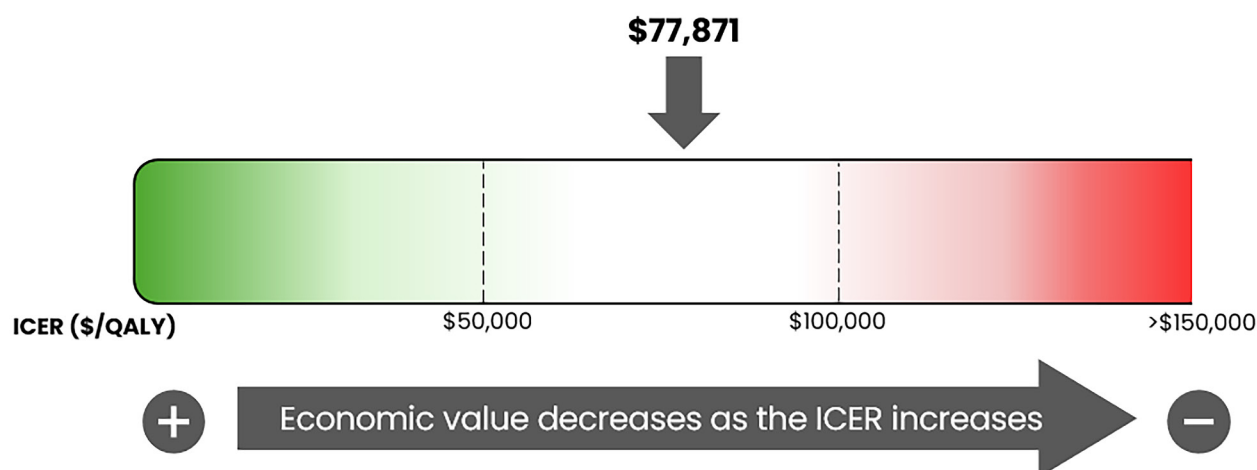
Distinct Social and Ethical Considerations

- **Input on unmet nonclinical need:** Patient groups, clinicians, and the committee highlighted that obesity disproportionately affects individuals experiencing economic disadvantages in Canada, yet access to current available pharmacologic treatments, including semaglutide, depends almost entirely on private insurance or out-of-pocket payment. This creates a structural inequity in which patients with the highest disease burden have the least access to effective therapy, representing a significant unmet nonclinical need. CDEC also noted the stigma associated with obesity and overweight and weight-related comorbidities.
- **Equity considerations:** CDEC and the clinical experts noted that socially and geographically disadvantaged groups face higher rates of obesity and cardiometabolic disease due to systemic barriers such as limited access to nutrient-dense food, fewer opportunities for physical activity, chronic stress, and reduced access to care. In particular, CDEC and the clinical experts highlighted that patients who are South Asian (who are more likely to have prediabetes and T2DM at lower BMI levels) and patients who are Indigenous (who in Canada have a higher prevalence of obesity and T2DM than non-Indigenous populations) are disproportionately affected. The committee and experts further noted that access to current treatments is constrained by high costs, limited public coverage, and concentration in specialized or urban centres, underscoring the need for additional and accessible treatment options for these populations.

Economic Considerations

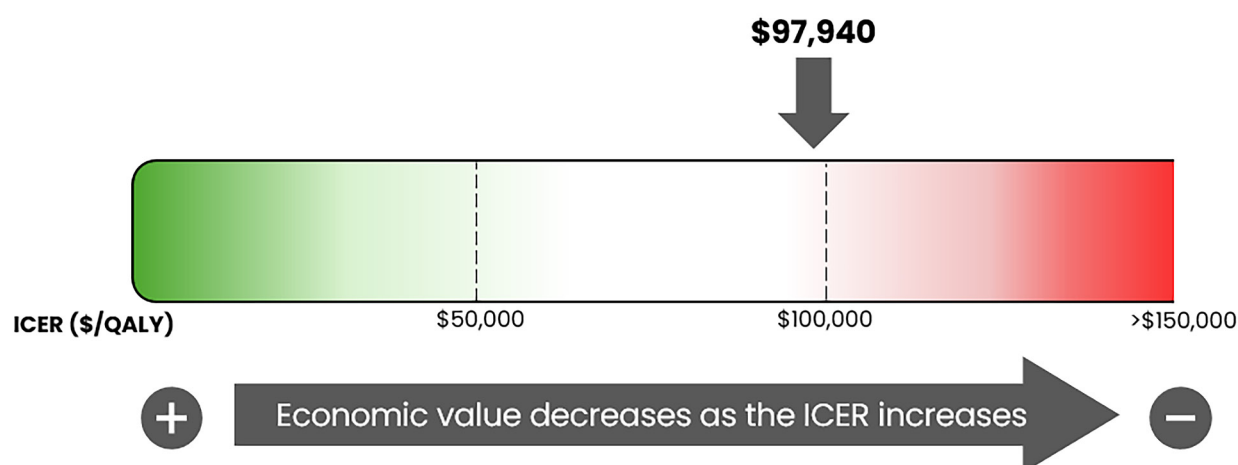
- **Health impacts of tirzepatide versus relevant comparators:** Compared to diet and exercise, tirzepatide may be associated with a gain of 0.06 to 0.10 life-years and 0.71 to 0.98 quality-adjusted life-years (QALYs) among patients with prediabetes over a lifetime horizon, depending on dose.
- **Cost of tirzepatide versus relevant comparators:** Tirzepatide is predicted to be associated with higher costs to health care systems than diet and exercise among patients with prediabetes alone over a lifetime horizon (incremental costs = \$55,517 to \$120,811, depending on dose), primarily driven by drug acquisition costs associated with tirzepatide.
- **Key findings of the economic evaluation:** Based on the submitted evidence using the sponsor's cost-utility analysis, the CDA-AMC base-case analysis estimated that the incremental cost-effectiveness ratio (ICER) for tirzepatide 5 mg compared to diet and exercise was \$77,871 per QALY gained among patients with prediabetes, while the ICERs for tirzepatide 10 mg and tirzepatide 15 mg were \$97,940 and \$123,265 per QALY gained, respectively, in the CDA-AMC scenario analysis ([Figure 1](#), [Figure 2](#), and [Figure 3](#)).

Figure 1: Estimate of the ICER Used by CDEC to Inform the Price Condition for Tirzepatide 5 mg



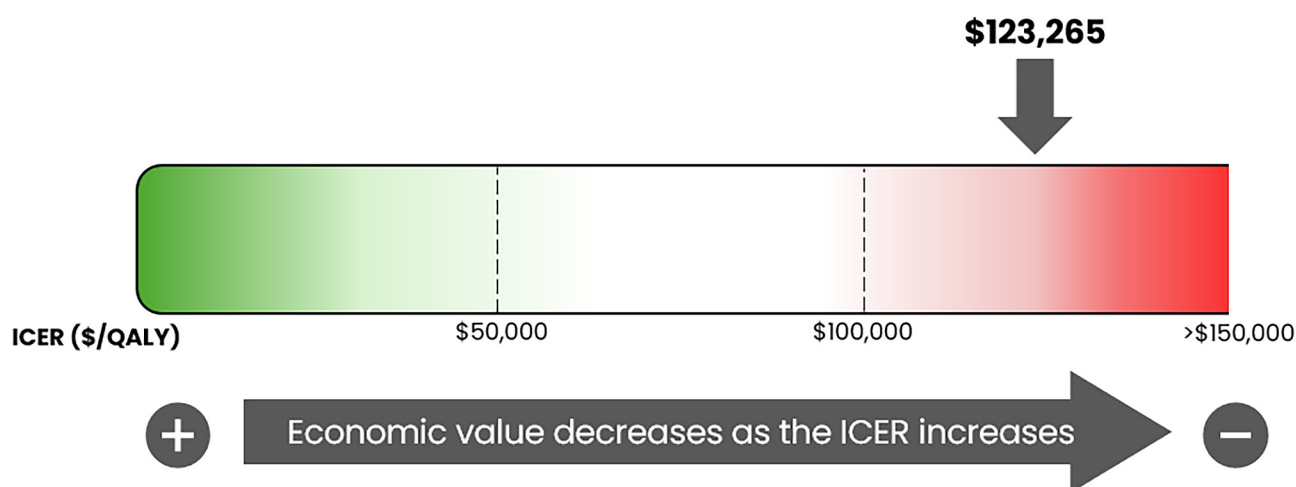
CDEC = Canadian Drug Expert Committee; ICER = incremental cost-effectiveness ratio; QALY = quality-adjusted life-year.

Figure 2: Estimate of the ICER Used by CDEC to Inform the Price Condition for Tirzepatide 10 mg



CDEC = Canadian Drug Expert Committee; ICER = incremental cost-effectiveness ratio; QALY = quality-adjusted life-year.

Figure 3: Estimate of the ICER Used by CDEC to Inform the Price Condition for Tirzepatide 15 mg



CDEC = Canadian Drug Expert Committee; ICER = incremental cost-effectiveness ratio; QALY = quality-adjusted life-year.

- **Certainty of the evidence:** CDEC discussed that the estimated ICERs for tirzepatide are highly uncertain due to limitations in the underlying clinical evidence, model structure and assumptions,

and unresolved uncertainty regarding treatment pathways in clinical practice. Given the identified limitations with the submitted model structure and uncertainty in the long-term efficacy data, the economic analysis may not accurately assess the impact of tirzepatide on patient health and health care resources. As a result, the cost-effectiveness estimates are highly uncertain and higher price reductions may be required to achieve a given willingness-to-pay threshold.



Impacts on Health Systems

- **Anticipated budget impact:** CDA-AMC estimates that the budget impact of reimbursing tirzepatide for chronic weight management among patients with prediabetes will be approximately \$2.4 billion over the first 3 years of reimbursement compared to the amount currently spent on comparators, with an estimated expenditure of \$2.4 billion on tirzepatide. The actual budget impact of reimbursing tirzepatide in this patient group is uncertain and will depend on the prevalence of prediabetes and the distribution of tirzepatide doses used in clinical practice. CDEC noted that the economic feasibility of adoption must be addressed.

Sources of Information Used by the Committee

To make its recommendation, the committee considered the following information (links to the full documents for the review can be found on the [project webpage](#)):

- the CDA-AMC review of the clinical and pharmacoeconomic evidence submitted by the sponsor, as well as relevant ethical issues related to tirzepatide (refer to the Main Report and Supplemental Material document)
- the sponsor's comments on the draft report and the responses from CDA-AMC
- patients' perspectives gathered by 4 patient groups, Diabetes Canada, Gastrointestinal Society, Obesity Matters, and Obesity Canada (refer to the Patient and Clinician Group Input document)
- input from 3 clinician groups, LMC Diabetes and Endocrinology; joint submission from Obesity Canada, Diabetes Canada, Canadian Society of Endocrinology and Metabolism, Canadian Association of Bariatric Physicians and Surgeons, and Canadian Cardiovascular Society; and York Weight Loss Clinical and Internal Medicine Clinic (refer to the Patient and Clinician Group Input document)
- input from public drug programs that participate in the reimbursement review process (refer to the Supplemental Material document)
- input from 2 clinical experts with expertise in the management of chronic weight management consulted by CDA-AMC.

CDEC Information

Members of the Committee

Dr. Peter Jamieson (Chair), Dr. Kerry Mansell (Vice-Chair), Sally Bean, Daryl Bell, Dan Dunskey, Dr. Ran Goldman, Dr. Trudy Huyghebaert, Dr. Dennis Ko, Dr. Christine Leong, Alicia McCallum, Dr. Srinivas Murthy, Dr. Nicholas Myers, Dr. Krishnan Ramanathan, Dr. Marco Solmi, Carla Velastegui, Dr. Edward Xie, and Dr. Peter Zed.

Meeting date: June 24, 2026

Regrets: One expert committee member did not attend.

Conflicts of interest: None



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