Obesity Medicine Association

Anti-Obesity Medication Position Statement
Approved April 2020

It is the position of the Obesity Medicine Association (OMA) that long-term pharmacotherapy represents one important evidence-based treatment strategy for obesity.
Obesity has been recognized as a disease by the American Medical Association. [i] Obesity is a chronic disease that worsens over time. Weight loss does not cure obesity – instead, it triggers adaptations that restore the lost weight. [ii] It is estimated that 85% of self-directed weight loss efforts are met by weight regain.

Pharmacotherapy has been approved by the FDA for chronic weight management. This is different than the prevailing opinion about medications for obesity treatment. Prior to 2012, most medications were indicated only for short-term use to induce weight loss. This is incongruent with current knowledge about the chronic disease of obesity.
Pharmacotherapy has been shown to be both safe and effective. It doubles to triples the odds of losing 5-10% body weight (or more), and also the odds of keeping that weight off. Unfortunately, if treatment is stopped, weight is regained. [iii]

Recent studies have shown the older agents including Phentermine to be safe and effective for long-term use. A study published in 2019 of nearly 14,000 patients on long-term phentermine demonstrated it to be safe and effective for low-risk individuals with responders losing 10.5% body weight. [iv] And, the FDA approved a new version of Phentermine, marketed as Qsymia, for chronic use in 2012.

As a progressive, chronic disease, obesity gets worse over time. Therefore, we also believe that prevention of obesity is just as important as treatment. Drug labels recommend use at a Body Mass Index (BMI) of 27 or more with a compelling comorbidity, or 30 or more without. However, as with other chronic diseases, we know that medications can also be useful in prevention. For example, in an individual with pre-diabetes, metformin can be used off-label to prevent diabetes. Similarly, for a patient at high risk of obesity, medications may be helpful in prevention.
Many studies have demonstrated the safety and efficacy of pharmacotherapy. Studies have also shown the older agents to be non-habit-forming. [v]

We would welcome further studies into the safety and efficacy of both old and new agents. In particular, we hope to see well-done, long-term studies on generic phentermine. Nevertheless, we also oppose the current practice of not treating obesity. For example, it is estimated that only 2% of patients with an on-label indication for obesity pharmacotherapy receive treatment. [vi] A more recent study shows only 1.6% of 2.2 million eligible patients are prescribed pharmacotherapy for obesity. [vii] This is in contrast to 85% of those with type 2 diabetes.

Obesity threatens the health of our nation. It is estimated that due to this rise in obesity, by 2030, type 2 diabetes rates will rise from 8.6% to 25% of the population. [viii] Obesity is costing our nation 1.72 trillion dollars annually (47.1% of healthcare spending on chronic disease) and is responsible for 320,000 deaths per year. [ix] Normalizing the BMI can save $14,059 in healthcare costs and $28,020 in societal costs per patient over their lifetime. [x]

Only by reducing the burden of the obesity epidemic can we prevent improve these numbers. While we understand that this will take significant work in the public health sector, we cannot continue to deny treatment to those who need it.

Our view is not alone – recent studies published in Obesity Journal, and also in Endocrine Journal [xi] recommend chronic treatment, even with older agents including phentermine. In spite of this, many providers continue to stop treatment after 3 months, 12 months, or after weight loss stops. Some do this out of fear of repercussion from their state medical, pharmacy and nursing boards. In fact, some states have laws making it illegal to use anti-obesity medications in an off-label way, and specifically single-out phentermine, threatening to take physician licenses if prescribing phentermine for over 3 months. Nurse practitioners and Physician Assistants also sometimes have limitations depending on their local and national certifying organizations that block their ability to provide the current standard of care with regards to anti-obesity pharmacotherapy.

The OMA applauds the AMA for adopting as policy that it is inappropriate for state or federal rules to interfere with evidence-based treatments for obesity that would prohibit a physician from providing the current standard of care with regards to obesity treatment. It is the position of the OMA that long-term prescribing of medications constitutes the current standard of care for obesity treatment, and the OMA opposes these restrictive rules.

Therefore, it is the position of the OMA that:

1) The current standard of care with respect to obesity pharmacotherapy is that medications should be prescribed long-term.
2) It is medically inappropriate for licensing boards to interfere with a provider's ability to offer standard of care treatment to patients affected by obesity.
3) Short-term use of obesity pharmacotherapy is not recommended as it has not been proven to provide a benefit.

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[i] AMA Policy H440.842, 2013 Annual Meeting of the HOD
[ii] Chaput JP et al. Obes Rev. 2012;13:681-691, NHLBI. 2012. www.nhlbi.gov/health/health-topics/topics/obe/causes#. Accessed May 23rd, 2017.
Schwartz MW et al. Diabetes. 2003;52:232-238.
[iii] Lancet 2017; Feb 22, 2017, N Engl J Med 2010;363:245-56.
[iv] Lewis, K. Obesity. 2019; 27(4):591-602
[v] Hendricks EJ et al. Addiction potential of phentermine prescribed during long-term treatment of obesity. International Journal of Obesity 38, 292-298 (2014). Doi: 10.1038/ijo.2013.74.
[vi] Thomas CE, Mauer EA, Shukla AP, Rathi S, Aronne LJ. Low adoption of weight loss medications: a comparison of prescribing patterns of antiobesity pharmacotherapies and SGLT2s. Obesity (Silver Spring). 2016; 24(9):1955–61.
[vii]Saxon et al. Antiobesity Medication Use in 2.2 Million Adults. 2019;27(12)1975. doi:10.1002/oby.22581
[viii] Rowley WR, Bezold C, Arikan Y, Byrne E, Krohe S. Diabetes 2030: Insights from Yesterday, Today, and Future Trends. Popul Health Manag. 2017;20(1):6–12. doi:10.1089/pop.2015.0181
[ix] Milken Institute Report. http://milkeninstitute.org/reports/americas-obesity-crisis-health-and-economic-costs-excess-weight. Accessed 11/18/2019
[x] Obesity (2017) 25, 1809-1815. doi:10.1002/oby.21965
[xi] Apovian, CM et al. J Clin Endocrinol Metab. 2015 Feb;100(2):342-62. doi: 10.1210/jc.2014-3415. Epub 2015 Jan 15.