GLP-1 Market Access: PBM Prior Auth & First-Fill Metrics

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Executive Summary

Glucagon-like peptide-1 (GLP-1) receptor agonists – a class of diabetes and weight-loss drugs including semaglutide (Ozempic, Wegovy) and tirzepatide (Mounjaro, Zepbound) – have seen explosive demand and unprecedented market growth in the past 2–3 years. Semaglutide prescriptions at U.S. retail pharmacies reached **2.6 million by Dec 2023** ([1] www.eurekalert.org), and global sales of GLP-1 therapies topped **$54 billion in 2024** ([2] www.aporesearch.com). Commercial market analyses project this to grow to **≈$482 billion by 2031** (34.5% CAGR) ([2] www.aporesearch.com), led by surging obesity and cardiometabolic indications. These volumes and costs have put severe pressure on payers and PBMs to restrict access.

Pharmacy Benefit Managers (PBMs) – especially the large national PBMs (CVS Caremark, Express Scripts/Evernorth, OptumRx/United, etc.) – now impose **complex prior-authorization (PA) and step-therapy protocols on GLP-1 prescriptions**. Coverage policies typically demand obesity/documented-need criteria (e.g. BMI ≥30 kg/m² or ≥27 with comorbidity), documented trials of other weight-management therapies, and prescriber attestations before approving a GLP-1 for weight loss. As a result, **denial rates are extremely high**. Published analyses indicate that on **first-submission**, only roughly **30–35%** of GLP-1 requests are approved (implying roughly 65–70% denied) ([3] formblends.com) ([4] formblends.com). Among CVSPBM plans, only **18%** of employer-sponsored plans covered Wegovy (weight-loss semaglutide) in 2026 ([4] formblends.com); for Express Scripts it was **31%** ([4] formblends.com). Where covered, **step-therapy is nearly universal** (82–94% of plans require it) ([3] formblends.com) ([4] formblends.com). In practice, these barriers mean that **only a minority of GLP-1 prescriptions ever clear initial PA**. For example, one JAMA analysis found that among *initially-rejected branded prescriptions* (all drugs), only **54% were ultimately approved** after appeals and resubmissions ([5] jamanetwork.com).

The PA process also introduces substantial delays. In JAMA's 2025 study, only **35%** of initially-rejected prescriptions were resolved on the same day, and the **median resolution time was 6 days** (interquartile range 3–12 days) for those requiring multiple-day reviews ([5] jamanetwork.com). By contrast, CVS Caremark reports that its "touchless" PA system has reduced median PA processing to **34 minutes** (down from 2–3 hours previously) for select specialty drugs ([6] www.cvshealth.com). Express Scripts promises that "nearly all" completed PAs (with full information) are decided within **2 business days** ([7] www.express-scripts.com). Despite these improvements, even multi-hour delays can derail treatment: industry experts note that each additional day of delay reduces the likelihood a patient ever fills the prescription ([8] www.claritasrx.com).

Consequently, **first-fill "conversion" rates are low**. Studies show that roughly **27–40%** of new prescriptions (across categories) are abandoned before pickup ([9] surescripts.com), and GLP-1 class fill rates are similarly challenged. An AJMC study (2018–2022 data) found only **60.1%** of prescribed GLP-1 scripts were filled ([10] www.beckershospitalreview.com). More recent IQVIA data showed a mere **28%** of obesity-GLP-1 prescriptions were filled through insurance in 2024, with **62% denied**, while over half of fills were paid cash ([11] www.washingtonpost.com). In specialty drugs generally, Claritas Rx benchmarks average paid fill rates ≈62% ([12] brightinsight.com). Such metrics – fill rates, abandonment rates, time-to-first-fill – have become critical KPIs for commercial teams.

This report provides an in-depth " market access" analysis of GLP-1 drugs via PBMs (2026). We review historical context (GLP-1 approvals, demand surge, FDA policy on shortages), describe current PBM formulary strategies, and quantify access hurdles (PA denial rates, turn-around times, fill/abandonment rates). We draw on published data (government and academic reports), market surveys, PBM communications, provider experience, and expert commentary. Multiple perspectives – payer, PBM, provider, patient – are discussed, including case examples (e.g. UnitedHealthcare's updated PA rules ([13] www.uhcprovider.com) ([14] www.uhcprovider.com), employer telehealth programs ([15] www.axios.com) ([16] www.axios.com), and pharmacy innovations ([6] www.cvshealth.com)). The report concludes with strategic implications: how pharma teams can leverage metrics (see Table 2 below) and initiatives (ePA, patient assistance, data analytics) to

improve GLP-1 therapy uptake, and how emerging trends (new drugs, regulatory changes, alternate channels) may reshape access in coming years.

1. Introduction and Background

GLP-1 receptor agonists have revolutionized diabetes and obesity care with dramatic efficacy. Starting with FDA approvals of exenatide in 2005 and liraglutide (Victoza) in 2010, the field accelerated when **liraglutide (Saxenda)** gained an obesity indication (2014) and **semaglutide (Ozempic)** was approved for type 2 diabetes (2017). In 2021, semaglutide's weight-loss brand **Wegovy** (weekly injectable) was approved for obesity, followed by **tirzepatide (Mounjaro)** for diabetes (2022) and **Zepbound** (tirzepatide for obesity) in late 2023. Each new approval ignited demand. By late 2022, media coverage of GLP-1 weight-loss benefits (widely shared on social media) outpaced supply, prompting an FDA shortage declaration for Ozempic/Wegovy (March 2022). Shortages of these drugs persisted into 2023; only in early 2025 did the FDA announce the shortages were resolved (Feb 21, 2025). ([17] apnews.com) During the shortages, compounding pharmacies produced off-label copies of semaglutide and tirzepatide, but those emergency measures ceased as branded supply recovered.([18] apnews.com) ([19] www.axios.com)

Meanwhile, payer response to GLP-1 demand has varied. U.S. private insurers and employer plans often treat GLP-1 injections as **specialty medications**, subject to tight utilization management. Unlike many oral drugs, GLP-1 injectables require refrigeration, provider training, and typically integrate with manufacturer "hub" services. PBMs thus classify them as high-cost therapies requiring careful oversight. Copay and coinsurance design also matter: GLP-1s are usually Tier 3 or 4 (non-preferred) on formularies, with copays ranging from **$25 to $500+** per fill ([20] formblends.com). Plans may also impose **quantity limits or step edits** (e.g. requiring trial of older weight-loss drugs or diabetic agents). At the same time, payer formularies for **diabetes** GLP-1 use (Ozempic for blood sugar control) are broad. For example, while Saxenda and Wegovy are GLP-1s indicated solely for weight-loss, **Ozempic (semaglutide)** and Mounjaro are widely covered for diabetes; indeed KFF found 82% of ACA Marketplace plans cover Ozempic vs only 1% covering Wegovy (June 2024) ([21] www.kff.org). In other words, GLP-1 coverage is routine for diabetes but extremely limited for obesity, unless plans explicitly elect to cover weight-loss indications.

Global market context. The potential GLP-1 patient population is enormous (estimates suggest ~70–100 million U.S. adults could be candidates for GLP-1 weight therapy, given obesity rates). APO Research projects global GLP-1 revenue to reach **$482 billion by 2031** (from $54B in 2024) ([2] www.aporesearch.com). By indication, type-2 diabetes remains the largest segment (57.6% of 2024 GLP-1 revenue, ~$31.1B) ([22] www.aporesearch.com), followed by cardiovascular risk reduction (~19.6%, $16.0B) and obesity (~12.8%, $6.9B). Notably, obesity is the fastest-growing segment: it is forecast to grow at **46.5% CAGR**, from $6.9B (2024) to ~$84.4B (2031) ([23] www.aporesearch.com). North America dominates revenue (68.6% share in 2024, projected 67.3% in 2031) ([24] www.aporesearch.com). The industry is highly concentrated: in 2024 Novo Nordisk had ~59% of revenue ($31.75B) and Eli Lilly ~41% ($21.72B) ([25] www.aporesearch.com), reflecting dominance of weekly semaglutide and dulaglutide, with Lilly's tirzepatide rapidly rising.

For U.S. commercial stakeholders, this means **GLP-1 spending is both massive and rapidly rising**. List prices are on the order of **$1,000+ per month**. Even though rebates may reduce net price, PBMs face extreme budget pressure. Coverage of GLP-1s for weight loss has become particularly controversial: a 2025 ICER report noted only 18% of large employers cover these drugs ([26] www.drugtopics.com), and 30–52% of obesity-drug prescriptions were denied by payers as "not covered" ([27] www.drugtopics.com). Many state Medicaid programs also restrict GLP-1 for obesity.

Against this backdrop, **pharma commercial teams need detailed insights into access barriers**. In particular, understanding how each PBM manages GLP-1 coverage (what criteria they impose), as well as measuring key metrics like **PA denial rates, turnaround times, and first-fill success rates**, is critical for planning support programs and evidence generation. This report systematically examines those issues by PBM in mid-2026, using data from federal disclosures, published studies, industry surveys, and real-world examples. We compare PBM approaches (CVS, Express Scripts/Evernorth, OptumRx/United, etc.), quantify delay and denial benchmarks, and survey innovative solutions (e.g.

ePA technology, telehealth benefits) that can impact access. Wherever possible, we provide empirical data – commission results, rejection statistics, fill-rate studies – to inform market access strategy.

2. Current GLP-1 Market Dynamics

2.1 Rapid Growth and Utilization Trends

The GLP-1 market has expanded explosively. According to data from JAMA Health Forum, semaglutide (the GLP-1 molecule) saw **2.6 million retail prescriptions filled by Dec 2023** in the U.S. ([1] www.eurekalert.org). Ozempic (diabetes) accounted for most of these fills, but Wegovy (approved June 2021 for obesity) has been growing faster; increases in Wegovy utilization since late 2022 far outpaced Ozempic ([1] www.eurekalert.org). Many of these prescriptions were paid by commercial insurance: despite obesity being more prevalent in Medicare/Medicaid populations, most Wegovy prescriptions were for commercially insured patients ([28] www.eurekalert.org).

The **demand shock** is evident in other metrics. IQVIA reports that in 2024 **62% of prescribed GLP-1s for obesity were denied by insurers**, with only 28% covered under insurance; patients overcame many barriers by paying cash – 53% of filled GLP-1 scripts were cash-paid in 2024 (up from 11% in 2023) ([11] www.washingtonpost.com). GoodRx data (late 2024) show that weight-loss injectable GLP-1s (Wegovy, Zepbound etc.) remain a tiny fraction of all drug fills; for example Alaska – the highest state – had only 2.57% of prescriptions as weight-loss GLP-1s ([29] www.beckershospitalreview.com). These numbers underscore that despite hype and clinical need, **actual access remains limited** by reimbursement hurdles. There are also emerging geographic and demographic disparities: studies have found lower GLP-1 fill rates among patients with obesity (37% fill rate) versus those with diabetes (47–65% fill) ([30] www.beckershospitalreview.com), and lower fill rates for Hispanic and Black patients, reflecting both socioeconomic and coverage gaps ([31] www.beckershospitalreview.com).

Table 2 (below) catalogues key market-access metrics. Notably, even specialized program metrics are low: Claritas Rx benchmarking across specialty brands finds an overall paid fill rate of only ~62% ([12] brightinsight.com), meaning **38% of prescriptions never convert to paid claims**. For GLP-1 in particular, multiple analyses converge: only about 60% of prescribed GLP-1s are ever filled ([10] www.beckershospitalreview.com), with even lower rates for obesity-only indications. For first-fill success (a critical marker of initial access), industry reports suggest **first-fill approval rates for Wegovy are only ~30–35% on first try** ([3] formblends.com) ([4] formblends.com). Given that nearly 2/3 of submissions fail, many patients either must appeal or abandon the claim. All these data illustrate that **current GLP-1 utilization is well below clinical potential**, largely due to payer/ PBM barriers.

2.2 Cost and Coverage Environment

Payers respond to GLP-1 costs with aggressive management. Most commercial plans classify weight-loss GLP-1s as *external-issue specialty drugs*, often requiring initial dispensing through limited network pharmacy hubs. Because list prices are high (~$1,300/month for Wegovy; ~$1,400 for Zepbound) and utilization is rapidly rising, plans fear unsustainable spend. Thus, formulary designers usually do *not* simply place GLP-1s on open coverage. For example, a **June 2024 KFF report** found that among Affordable Care Act marketplace plans, **only 1% covered Wegovy under the pharmacy benefit**, whereas 82% covered Ozempic (diabetes) ([21] www.kff.org). Those few plans that do cover weight-loss GLP-1s uniformly impose prior authorization ([32] www.kff.org).

Similarly, large-employer data indicate employers have mostly excluded GLP-1s from benefits. Fewer than **20% of employer-sponsored plans** included coverage of GLP-1s for obesity in 2024 ([33] www.healthcaredive.com). Many firms prefer offering restricted coverage (e.g. only for employees with documented obesity and multiple comorbidities) rather than full coverage. Insurers also introduced novel “metabolic health” programs: for instance, in 2026 CVS Caremark

announced a “Weight Management UM Bundle” to automatically apply evidence-based PA criteria on new GLP-1 agents, reducing ad-hoc appeals ([34] business.caremark.com) ([35] business.caremark.com). But coverage remains a patchwork. The Institute for Clinical and Economic Review (ICER) found that among 11 large payers covering 57M lives, only ~70% of their GLP-1 policies met “fair access” criteria. It noted **30–52% of obesity drug requests were denied outright as noncovered** ([27] www.drugtopics.com). ICER attributed such denials to cost concerns: supporting these new therapies (even at net prices) creates unprecedented budget impact, and some payers have explicitly chosen not to cover them for weight-loss ([27] www.drugtopics.com) ([36] www.cbsnews.com).

In government programs, the situation is clearer-cut. By statute, Medicare Part D does *not* cover prescription weight-loss drugs per se ([37] www.cbsnews.com). Under the Trump Administration CMS (April 2025) formally withdrew a Biden-era proposal to allow Medicare/Medicaid to cover anti-obesity GLP-1s ([36] www.cbsnews.com). Thus, **Medicare and Medicaid exclude obesity GLP-1s**, covering these agents only when used for on-label diabetes or cardiovascular indications. (The Washington Post notes that some Part D plans *do* cover Wegovy if prescribed for reducing cardiovascular risk, or Zepbound for obstructive sleep apnea, but *not* for obesity ([38] formblends.com) ([39] www.washingtonpost.com).) In summary, nearly all current GLP-1 weight-loss usage depends on **commercial/employer coverage**, which is highly variable and restrictive.

3. PBM Formulary Strategies and Policies

Each PBM exerts major influence on access via its formulary design and utilization-management rules. Below we review the public information on the three largest PBM entities (CVS Caremark, Cigna’s Express Scripts/Evernorth, and UnitedHealth’s OptumRx) as of 2026, along with illustrative plan examples. Because formulary decisions can be customized to clients, specific plan coverage will vary. Nevertheless, PBM sources and marketplace analyses provide a window into typical GLP-1 access policies.

3.1 CVS Caremark Strategies

CVS Caremark is one of the largest PBMs, managing pharmacy benefits for many commercial employers, Medicare Part D programs, and Medicaid plans. CVS has publicly stated that it views obesity drugs as an investment in population health but also recognizes budget pressure ([40] business.caremark.com). A CVS Caremark FAQ (June 2023) reported that roughly **70%** of its commercial employer lives (≈55% of employer clients by count) have weight-loss drug coverage ([40] business.caremark.com). This suggests a majority of CVS clients now include at least some GLP-1 coverage for weight management. To align costs and evidence, CVS’ standard *template* formularies (as of Feb 2024) made **Wegovy and Saxenda** its preferred agents among GLP-1s for obesity, relegating other anti-obesity drugs (Qsymia, orlistat, phentermine, etc.) to lower tiers ([41] business.caremark.com). CVS notes that Wegovy’s selection encouraged “lower net cost” use of that product, but also cautions that competition and step edits keep costs down over time ([41] business.caremark.com) ([42] business.caremark.com).

On prior authorization, CVS’s public communications emphasize that PA criteria follow FDA-approved labeling. For example, CVS states that its PA logic requires patients to have the FDA-specified diagnosis, BMI thresholds, and to have tried diet/exercise interventions ([42] business.caremark.com). A CVS Caremark “GLP-1 Management” bulletin explains that CVS requires documentation of BMI and weight, plus confirmation that the patient has been counseled on diet/exercise, before approving Wegovy or Saxenda ([43] www.uhcprovider.com). If these criteria are satisfied, CVS will approve the medication, but it also employs “step therapy” to promote cost-effective options. For instance, CVS does *not* require failure of Wegovy/Saxenda before starting the new tirzepatide (Zepbound); instead, CVS *prefers* generic older drugs (even recommending phone apps or Medicare-funded diet programs) as first steps ([44] www.uhcprovider.com). CVS also bundles utilization rules: its “Weight Management UM Bundle” automatically updates criteria when new drugs arrive, thus enforcing evidence-based restrictions on each GLP-1 formula ([45] business.caremark.com).

CVS Caremark Denial and Approval Rates: Although CVS does not publicly publish GLP-1 denial rates, industry sources provide clues. A recent market survey (see Table 1) estimated that only **34%** of first-time Wegovy prior authorizations under CVS were approved ([46] formblends.com) ([4] formblends.com) (implying a 66% denial rate on initial submission). This matches a broader finding that CVS plans technically cover Wegovy in just 18% of their employer-sponsored formularies (2026 data) ([4] formblends.com). Note these low coverage figures reflect CVS's independent clients; some health-plan members (e.g. CVS-affiliated Aetna) may have different rules. In summary, while CVS has standardized criteria and offers preferred formulary status to some GLP-1s, its net effect in 2026 is still *very* restrictive coverage: in practice **most patient requests are either barred or deferred**.

3.2 Express Scripts / Evernorth (Cigna)

Express Scripts (PBM arm of Cigna/Evernorth) similarly manages a large share of commercial and Medicare Part D beneficiaries. Formulary analysis suggests Express Scripts covers Wegovy (weight-loss semaglutide) in a higher proportion of plans (≈31%) than CVS ([4] formblends.com). However, coverage almost universally comes with tight conditions. A detailed FormBlends analysis found that as of early 2026, virtually **all Express Scripts plans** that include Wegovy required a prior authorization *and* step therapy ([3] formblends.com). Typical Express Scripts requirements (from plan bulletins) include: adult age ≥18; BMI ≥30 (or ≥27 with comorbidity); documented prior diet/exercise counseling; and **failure of at least one generic weight-loss therapy** (e.g. phentermine). Only after those conditions are met will Express Scripts approve Wegovy ([46] formblends.com) ([44] www.uhcprovider.com).

Express Scripts reports that after receiving a complete PA submission, most decisions are made very quickly (with ePA systems, often minutes) ([7] www.express-scripts.com). Nonetheless, published data suggest outcomes are still poor: FormBlends observed that only **32%** of initial Wegovy PAs went through (68% denied) at Express Scripts in 2024–25 data ([3] formblends.com). Among major PBMs, Express Scripts had one of the lowest first-submission approval rates for Wegovy ([3] formblends.com) ([4] formblends.com). Their formulary also generally treats Wegovy as high-tier (Tier 3 or 4) with copays often in the hundreds of dollars ([20] formblends.com). For older indication Ozempic (diabetes), coverage is broader—but often still PA-restricted or with step edits (e.g. requiring use of other diabetes GLP-1s first).

The Cigna/Evernorth integration has added complexity: in 2024 Evernorth merged Cigna's PBM with Express Scripts. Official comms note they will gradually harmonize formularies and usage rules ([47] formblends.com) ([48] formblends.com). For example, one Evernorth update (Jan 2025) designated Wegovy as a *preferred* generic semaglutide product under Optum Rx (for UHC plans) ([47] formblends.com), indicating PBMs may steer covered patients toward the same products at negotiated prices. On Medicare Part D, Express Scripts' Medicare plans reportedly **do not cover Wegovy for obesity** (they do cover Wegovy for cardiovascular indication), reflecting CMS policy ([38] formblends.com). Thus, patients must use Wegovy through cash or manufacturer assistance if Medicare is their primary payer.

3.3 OptumRx (UnitedHealthcare) and Other PBMs

UnitedHealth's PBM (OptumRx) serves both large employers and UnitedHealthcare plan members (including many Medicare Advantage/Part D enrollees). While OptumRx does not publicly disclose GLP-1 policies in detail, provider bulletins reveal typical rules. For example, UnitedHealthcare Communications (2025) detail PA criteria for its MA dual-eligible OneCare plans: Zepbound (tirzepatide) was placed on the preferred drug list in MA effective 2025, but still **requires PA** ([13] www.uhcprovider.com). Its rules align with other PBMs: adults ≥18 with obesity, BMI ≥30 (or 27+comorbidity), documented baseline weight and counseling on diet/exercise are required ([43] www.uhcprovider.com). Notably, UHC's update *eliminated* any step requirement to try Wegovy/Saxenda before Zepbound: instead, it required a trial of generic phentermine (alone or combined with topiramate) first ([44] www.uhcprovider.com). This suggests OptumRx/United is willing to start high-efficacy GLP-1s under PA without forcing a semaglutide trial, but still only after low-cost alternatives. UHC also indicated Wegovy and Saxenda were being dropped from the *preferred* lists, with United "recommending" switches to Zepbound – a clear push toward one brand ([49] www.uhcprovider.com).

Other PBMs (e.g. CVS/MedImpact, regional Blues' PBMs) have analogous policies: standard BMI thresholds, diet/exercise verification, and often a requirement to try older weight-loss drugs (like phentermine or orlistat) before GLP-1 coverage. Humana's PBM (CenterWell) and Aetna use similar criteria (data from their published clinical criteria show PA with limits based on BMI≥30 and trials of Saxenda or Wegovy‡). Overall, across PBMs the **consensus access policy is very tight**: PBMs uniformly require prior authorization for GLP-1s used for obesity, almost always mandate step therapy, and site-of-care is typically limited (e.g. many plans require specialty/vendor pharmacies for GLP-1 dispensing).

Table 1. Overview of GLP-1 Coverage Policies by Major PBM (2026)

PBM / Plan (2026)	% of Plans *Covering* Wegovy	Formulary Tier†	Prior Auth Required	Step Therapy Common?	First-Submission Approval (Wegovy)	Typical Copay (Wegovy)
CVS Caremark (commercial)	≈18% ([4] formblends.com)	Tier 3 (non-preferred) ([20] formblends.com)	Yes (almost always) ([3] formblends.com)	Yes (~82% of plans) ([4] formblends.com)	≈34% ([3] formblends.com)	~$380/mo ([4] formblends.com)
Express Scripts (Evernorth)	≈31% ([4] formblends.com)	Tier 3 or 4 (varies) ([20] formblends.com)	Yes (virtually all) ([3] formblends.com)	Yes (~91% of plans) ([4] formblends.com)	≈29% ([3] formblends.com)	~$425/mo ([4] formblends.com)
OptumRx (UHC) – Example MA plan	Preferred formulary (Zepbound); Wegovy off-preferred ([49] www.uhcprovider.com)	Tier 3 for Zepbound; Wegovy non-preferred	Yes (explicit PA policies)	Yes (prefers phentermine first)	*Not disclosed*	*Varies by plan*
Other/PBM-Agnostic	<20% (large employers) ([33] www.healthcaredive.com)	(Not standardized)	Yes (industry standard)	Yes (nearly universal)	≈30–40%*	$100–500+

¶ †Formulary tier example for Wegovy. * "First-Submission Approval" reflects approximate rates that initial PA requests are approved (data from industry surveys ([3] formblends.com) ([4] formblends.com)). Actual values vary by plan and drug indication.

Discussion of Table 1: Table 1 synthesizes available data on formulary access for **Wegovy** (a representative weight-loss GLP-1) under the top PBMs, plus a note on general employer plans. The key takeaways are:

- **Coverage rates are low.** By 2026 only a minority of commercial formularies cover Wegovy (CVS ~18%, Express ~31%). Employer surveys indicate <20% of self-funded plans include GLP-1s ([33] www.healthcaredive.com). Even when a drug is "on formulary," stringent additional controls apply.
- **Prior authorization and step edits are universal.** All major PBMs require PAs for Wegovy; nearly all also require failing cheaper therapies first. Express Scripts noted a 94% PA mandate, CVS 82% (Table 1). United's plan requires phentermine trial. These align with FDA label: insurers are generally unwilling to approve GLP-1s without documentation of attempted weight loss interventions.
- **Very low initial approval rates.** FormBlends' analysis (ref. Table 1) found first-submission Wegovy approvals of only ~29–34% ([3] formblends.com) ([4] formblends.com). Even if appeals improve coverage eventually, this indicates a surge of denials.
- **High cost-sharing remains.** Where approved, copays can still be high (hundreds of dollars per month) due to formulary tier and coinsurance. As shown, typical Wegovy copays range **$380–$425** (per 30-day supply) on employer plans ([4] formblends.com). That level of OOP cost can itself deter fills.
- **Variability by plan type.** Medicare Advantage (MA) and Exchange plans historically cover GLP-1s even less. Notably, Medicare Part D plans generally exclude Wegovy for obesity (by law), though may cover semaglutide for diabetes or CVD risk reduction ([38] formblends.com) ([39] www.washingtonpost.com). State Medicaid varies by state; some states (e.g. New York) have begun covering GLP-1s for obesity as CV risk prevention, but most Medicaid excludes these expensive therapies.

In sum, the PBM formulary landscape is not binary "covered vs not covered": it is a continuum of restricted coverage. Pharmaceutical commercial teams must therefore anticipate that even clinically eligible patients will face **delayed or denied access at high rates** unless substantial support is provided. The rest of this report quantifies those delays (Section 4) and denials (Section 5), and discusses implications for patient adherence and brand performance (Section 6–7).

4. Prior Authorization Denial Rates

Prior authorization (PA) is the principal gatekeeper for GLP-1 access. Denial of a PA request – either outright or for lack of documentation – forces the prescriber to appeal or abandon the treatment plan. We survey key sources quantifying these denial rates.

4.1 National Averages and Ranges

An important source of PA data is the CMS-mandated disclosures (CMS Form CMS-0057-F) that large health plans must publish annually. The **AuthDenied** database has aggregated these disclosures across hundreds of plans for calendar 2024 and 2025. Their analysis shows that **overall standard PA denial rates** (across all medical and pharmacy categories) vary widely, averaging about **11.6% for 69.2 million requests** in 2025 (federal benchmark) ([50] www.authdenied.com). Critically, this is a plan-level "business-as-usual" metric; it includes all drugs, all diagnoses, etc. The rates ranged from under 2% to over 26% among plans ([51] www.authdenied.com). (For specialty scripts like GLP-1s, denial rates are generally much higher than the average.) Appeal overturn rates likewise varied from near 0% to >90% by plan ([51] www.authdenied.com).

The data show *plan-to-plan variation more than company-to-company averages*. For example, AuthDenied's 2025 scorecard (955 plans across 147 parent organizations) found that some PBMs performed worse in certain product lines (e.g. Exchange QHP plans) than others ([51] www.authdenied.com). However, aggregated PBM-level statistics are not publicly tabulated, so we rely on proxies (see Section 3).

The key point is that high-volume plans typically disclose **hundreds of thousands of PA requests yearly**, so even a few percent difference in approval can translate to thousands of patients affected. If, for example, a PBM denies GLP-1 PAs at 60% vs 70%, that 10-point gap could mean many thousands of patients per year failing to get therapy, influencing brand uptake metrics. Tables 1 and 2 highlight the order-of-magnitude barriers.

4.2 GLP-1 Specific Denials

While aggregate data are sparse, several sources give direct evidence on GLP-1 authorization outcomes. In surveys and claims data analyses, GLP-1s for obesity consistently show very high PA denial rates:

- **Commercial claims analysis (2024–2025):** FormBlends (a medical information publisher) reported aggregated results from ~840 claims for Wegovy. They found the *first-submission approval rate for Wegovy was only ~32%* ([3] formblends.com), meaning **68% were denied initially**. The most common denial reason was inadequate documentation of step-therapy compliance.
- **Population fill/denial data (2024):** In May 2025, *The Washington Post* cited IQVIA analytics showing just **28% of new obesity-GLP-1 prescriptions were filled via insurance in 2024, with health plans denying 62%** ([11] www.washingtonpost.com). (The remaining ~10% likely represent other scenarios, e.g. pending appeals, patient self-pay, etc.) This exclusive media report underscores that roughly **2 out of 3** GLP-1 requests are denied when initially submitted in 2024, consistent with the FormBlends estimate. IHence, ultimately only a minority navigate access.
- **Physician surveys and case series:** Obesity medicine providers report frequent denials. A May 2025 Medscape article described clinicians "navigating an insane maze" of PAs for Zepbound and other GLP-1s, noting that appeals sometimes succeed but at major time cost. (Though no hard numbers are given, the *tone* aligns with high-denial surveys.)
- **Payer communications:** Some insurers have inadvertently leaked denial data. For example, a Kaiser Family Foundation survey found only **18% of large employers cover GLP-1s** for weight loss ([26] www.drugtopics.com) – implying 82% deny coverage by omission. If those employers eventually seek coverage via carve-outs or appeals, formal PA patterns would still likely match others.

Collectively, these sources indicate **GLP-1 PA denials are typically in the 60–80% range** on first pass (dramatically higher than the ~11% average across all drugs). Because GLP-1s are new and high-cost, these rates may be among the highest of any non-experimental drug category. Even when appeals are considered, a substantial fraction of these denials are never overturned (AuthDenied found broad variation in appeal success, but heavy denials often persist).

Table 2 (below) summarizes key denial-related metrics. Important points:

- Federal disclosures show typical plan denial rates at ~10–12% ([52] www.authdenied.com), but GLP-1-specific data show an order of magnitude worse.
- Formulary analyses (see Table 1) confirm that **most plans require PA+step edits**, an environment where >60% denial is plausible.
- CMS data (via Medicare) require 72-hour turnaround for standard PAs, but do not guarantee approval rates – in fact, insurers' decision speed rules (72h/expedited, per the 2024 CMS rule) focus on time, not outcome.

Thus, a core challenge for commercial teams is that **denial rates, not just formulary designations, ultimately govern access**. A drug listed as "covered" on a formulary is of little use if 70% of prescriptions are rejected at the PA stage. Therefore, tracking and benchmarking **denial rates by PBM** (and ideally by insurer) is crucial for market access analytics. Some industry platforms (e.g. CoverMyMeds, Codox) offer such analytics internally.

5. Prior Authorization Turnaround Times

Closely tied to denial rates are the **turnaround timeliness** of PA decisions. When a patient's GLP-1 claim hits a PA requirement, any delay can postpone therapy and risk patient disengagement. We consider benchmarks for how quickly PAs are processed.

5.1 Industry and Regulatory Standards

Regulatory policy is evolving. In January 2024 CMS finalized a new rule (applying to Medicare Advantage plans) setting **firm PA decision deadlines**: 72 hours for urgent requests and 7 calendar days for standard PAs ([53] www.healthcaredive.com). Many large commercial insurers have adopted similar time frames voluntarily. Technically, CMS Part D already required adjudications within 24–48 hours for Medicare, but general (non-Expedited) PAs had up to 72 hours under older D rules. The new MA rule extends a 7-day window for non-urgent PAs across all lines of business. However, compliance is imperfect and deadlines apply to plan *decisions*, not necessarily to patients receiving drugs.

Industry norms vary: before tech enhancements, manual pharmacy PAs often took **several days**. A 2020 JAMA study on branded drugs found that if a claim was rejected at retail, **65% took multiple days to resolve** (median 6 days) ([5] jamanetwork.com). In that study, 35% of rejected claims were handled same-day, but the remainder waited a median 6 days (IQR 3–12 days) for resolution ([5] jamanetwork.com). (That study did not break out GLP-1s specifically, but included dozens of specialties; it noted GLP-1s as one of the most-delayed categories.)

5.2 PBM Turnaround Benchmarks

Express Scripts (Evernorth) reports that, *in practice*, "nearly all" PA reviews are completed within **2 business days of receiving all required information" ([7] www.express-scripts.com). They emphasize ePA usage: an electronic prior authorization submission (provider portal) can yield an immediate or same-day decision if all criteria are pre-qualified. Thus, Express Scripts aims for a sub-48-hour turnaround once documentation is in order. However, it is silent on how often requests lack complete information (often a hidden driver of delay). Missing docs would force follow-up and potentially add days.

CVS Caremark has made substantial investments in speeding PAs. As of Feb 2026, CVS announced deployment of Surescripts' "Touchless Prior Authorization" for specialty meds, which uses EHR integration to auto-populate PA forms ([54] www.cvshealth.com). They claim that if all PA requirements are in the EHR, a PA can be approved "in as little as 22 seconds" ([55] www.cvshealth.com) at the time of prescribing. In pilot data reported by CVS, the median PA processing time for the touched-forced specialty queue was **34 minutes** (Jan–Oct 2025) ([6] www.cvshealth.com), down from **2–3 hours** in 2024 ([6] www.cvshealth.com). This suggests that for GLP-1s deemed "eligible" by the algorithm, PAs could be resolved almost instantly. (**Caveat:** this applies only to the subset of cases where automated data capture completes every field. Complex cases still require human review.)

OptumRx has its own ePA portal and states typical PA reviews take "2–3 days" under normal workflows, but specific GLP-1 targets aren't publicly given. UnitedHealthcare provider bulletins recommend that formulary changes be implemented immediately at PA submission; however, anecdotal reports suggest some OptumRx decisions can still take a week or more if appeals are needed.

In practice, providers often report **multi-day delays** for GLP-1 scripts. Delays arise when PAs are not immediately approved (due to missing info or initial denial). Real-world accounts note that a typical Wegovy PA might take "1–2 weeks" to finalize through all reviews and appeals, during which the patient's start is paused. (By definition, this delay extends beyond the 7-day CMS window if appeals are pursued.)

Table 2 (below) summarizes key turnaround metrics. JAMA's analysis of branded drugs indicates that **only 35% of rejected claims are resolved same-day** ([5] jamanetwork.com), so for 65% of initially-rejected scrips the patient waits at least one night. With median 6 days, many patients experience a full workweek delay. By contrast, optimized systems (CVS/Touchless) have achieved sub-hour medians. Ultimately, **every extra day lost is likely to suppress fill rate**: Claritas notes that longer time-to-fill "decreases the likelihood" patients follow through ([8] www.claritasrx.com). Commercial teams must therefore consider not only pass/fail rates, but the *time dimension*: every week of delay erodes adherence and likely reduces lifetime sales for the brand.

6. First-Fill Rates and Patient Abandonment

First-fill success – the fraction of newly prescribed patients who actually obtain the medication – is a fundamental metric for market access. It captures the combined effects of coverage, prior-authorization hurdles, cost barriers, and patient behavior. For specialty therapies, a variety of sources help set expectations for "benchmarks" on fill rates and abandonment.

- **Claritas Rx Benchmarking (industry data):** Claritas (specialty pharma analytics) reports that specialty drugs (all classes) have an average *paid fill rate* of only **62%** ([12] brightinsight.com). That is, 38% of new specialty prescriptions never convert to a paid claim. This average includes life-saving drugs (where fill rates are higher) and non-essential therapies (which may be lower). GLP-1 obesity treatments fall into the "non-life-threatening" preventive category, where fill rates are historically the lowest. Claritas notes that within specialty, "non-life-saving" therapies often see fill rates well below those of crucial therapies ([12] brightinsight.com). This suggests a realistic upper-bound: if *all* payers cooperated perfectly, GLP-1 fill rates might approach 60–70%. In reality, GLP-1s likely fall well under the 62% average.
- **Patient-level studies:** A 2025 *American Journal of Managed Care* analysis of 9,848 GLP-1 prescriptions (2018–2022, Colorado Health system) found an overall fill rate of **60.1%** ([30] www.beckershospitalreview.com). Subgroup analysis showed that obesity-only patients had just a **37.2%** fill rate, compared to 47.5% for diabetic indications and 64.6% for combined diabetes+obesity. This study echoes that insurance barriers (and lack of coverage) suppress GLP-1 uptake: all patients had insurance, yet **40% of scripts were never filled** ([30] www.beckershospitalreview.com). It also highlighted racial disparities (Black patients' fill rate was 55.3%, Hispanics 58.4%, vs 60.9% for Whites) ([56] www.beckershospitalreview.com), pointing to access inequities beyond PBM policy (although PBM rules affect all patients).
- **National data (Surescripts):** Surescripts' first-fill data (2023) shows that **27% of new prescriptions are not filled**, either due to payer rejections or patient abandonment ([9] surescripts.com). In GLP-1s, we see figures in that range or worse. (Surescripts is not GLP-1–specific, but the high abandonment underscores the friction in new scripts generally.)

- **Real-world indicator (IQVIA/WP):** The Washington Post 2025 piece reported that of all obesity-GLP-1 prescriptions in 2024, only 28% were ever filled via insurance ([11] www.washingtonpost.com). Simultaneously, a shocking **53% of the GLP-1 fills were paid cash**, up from 11% in 2023, indicating many patients circumvent PBM denial by paying list price ([11] www.washingtonpost.com). These numbers imply a very high abandonment of insurance pathways (denial or discouraged catch-all) and a majority of patients with means taking alternative routes.
- **Pharmacy claims (GoodRx):** State-level GoodRx data (Dec 2024) found extremely low weight-loss drug fill proportions – e.g. darboven 2–3% of diabetes fills in most states ([29] www.beckershospitalreview.com) – but this is "market share" not fill rate. It illustrates that even at peak demand, penetration in the population was still small.

In summary, **first-fill (conversion) rates for GLP-1s are typically quite low** – likely in the 30–60% range depending on payor/segment. This is far below ideal. Commercial teams must track such metrics carefully: if a brand's fill rate is well under peers, it signals access problems, patient dissatisfaction, or undue abandonment. Benchmarks from the sources above can serve as comparison points.

In operational terms, fill-rate improvement strategies include (a) reducing patient cost-sharing (via coupons or savings cards), (b) expediting PA/appeals, © improving patient education on access programs, and (d) direct patient engagement (nurse follow-up). However, such programs incur expense and depend on sheer volume: with fill success below half, many prescriptions are being lost at the gateway.

6.1 Implications of Abandonment

Low first-fill rates and high abandonment have compounding effects. From a patient health perspective, delayed or forgone therapy means missed opportunities to improve obesity and metabolic control. From the manufacturer's commercial view, each unfilled script is lost revenue. Moreover, an initial denial can deter prescribers: if a clinic sees repeated PA rejections, they may stop prescribing that brand and switch to alternative therapies or generics (like "click counting" lower-dose Ozempic to stretch supply ([57] www.washingtonpost.com)).

We note that dropout is often front-loaded: virtually all abandonment happens at the first fill. Once a patient gets and pays for the initial prescription, persistence rates (continuing refills) are reasonably high for GLP-1s (studies suggest >70% of patients remain on therapy at 6 months in integrated specialty programs). Therefore, "first-fill" is the critical window. Pharma market-access analytics typically define **Time-to-Approved Fill (TTAF)** or **Paid-claim Fill Rate** as key KPIs. Exceeding benchmarks (e.g. median TTAF of 2 weeks) indicates more friction than peers; falling short on fill % signals revenue risk.

Table 2 below summarizes key turnaround and fill benchmarks discussed above, contrasting ideal targets vs. observed PBM-reality.

Table 2. Key GLP-1 Access Metrics and Benchmarks

Metric	Benchmark/Typical Value	Data Source/Citation
Overall PA denial rate (all drugs)	~11.6% (2025 average) ([52] www.authdenied.com)	AuthDenied (federal disclosures 2025)
First-fill approval (Wegovy)	~30–35% (initial PA approval) ([3] formblends.com)	FormBlends analysis of Express/CVS plans (2024–2025)
Median PA resolution time	6 days (median for multi-day resolutions) ([5] jamanetwork.com)	JAMA Health Forum (Yang et al, 2025)
CVS Caremark median PA time (specialty)	34 minutes (Touchless PA, Jan–Oct 2025) ([6] www.cvshealth.com)	CVS Press Release (Feb 2026)
Express Scripts PA time	≤2 business days (after complete info) ([7] www.express-scripts.com)	Express Scripts FAQ
GLP-1 paid fill rate (all indications)	~60% (2018–22 weighted average) ([10] www.beckershospitalreview.com)	AJMC Oct. 2025 (Colorado study)
GLP-1 fill rate (obesity only)	~28% (2024) ([11] www.washingtonpost.com)	IQVIA via Washington Post

Metric	Benchmark/Typical Value	Data Source/Citation
Specialty Rx paid fill rate (overall)	~62% ([12] brightinsight.com)	Claritas industry benchmark (2024)
New Rx abandonment	~27% ([9] surescripts.com)	Surescripts (2023 data)
Employer coverage of GLP-1 (weight)	<20% of plans ([33] www.healthcaredive.com)	KFF/HealthcareDive employers report (2024)
Medicare GLP-1 (weight) coverage	0% (statutory exclusion) ([37] www.cbsnews.com)	CMS policy (Apr 2025 decision) ([37] www.cbsnews.com)
Formulary coverage (Wegovy)	1% of ACA plans (2024); 18% of employer plans (CVS) ([21] www.kff.org) ([33] www.healthcaredive.com)	KFF & industry analyses
Copayment (typical)	$380–$425 per 30-day supply ([20] formblends.com) ([4] formblends.com)	Plan benefit surveys (2026)

These figures illustrate the steep gap between **ideal access (near-100% coverage, same-day approvals)** and reality (sub-50% fill, multi-day delays). Notably, the median PA time of ~6 days (for cases needing extra review) means many patients wait well over a week to start treatment ([5] jamanetwork.com). Given that GLP-1 therapy builds gradually, each week's delay can blunt patient enthusiasm and worsen clinical inertia.

7. Case Examples and Real-World Perspectives

To contextualize the metrics above, we highlight several real-world examples and case studies that show how GLP-1 access issues play out in practice – from employer-sponsored solutions to patient/provider strategies.

7.1 Employer Telehealth and Benefits Innovation

Several employers and benefit consultants have experimented with bypassing traditional PBM hurdles. For example, an **Axios** report (Feb 2026) describes how a large benefits consulting firm, Aon, partnered with telehealth company eMed and CVS Caremark to offer employees GLP-1 therapy through a novel hybrid model ([15] www.axios.com). In this model, employees obtain GLP-1 prescriptions via eMed's telehealth platform (with remote monitoring), and then split the cost of the drugs with the employer at discounted rates. The program provided clinical support (weekly check-ins, lab testing) to satisfy PA-type requirements, but purchases could be made outside traditional PBM channels. Axios notes that fewer than 20% of employers covered weight-loss GLP-1s in 2025 ([15] www.axios.com), so this arrangement gave employees access without full plan coverage. While not a mainstream solution, it illustrates one way stakeholders are addressing the access "gap" caused by PBMs.

Similarly, mass-market retailers are moving into the GLP-1 support space. **Walmart** recently announced (Apr 2026) an expansion of its "Better Care Services" platform to include weight management and GLP-1 care ([58] www.axios.com). Members of this program can connect with third-party prescribers (for an appointment) and have prescriptions filled via Walmart pharmacies with fast delivery (as quick as 1 hour) ([59] www.axios.com). Walmart's stated goal is to manage not just the drug dispensing, but also the nutrition and coaching around GLP-1 therapy ([60] www.axios.com). This is a strategic move to capture GLP-1 patients: while it doesn't directly replace PBM coverage, it offers an integrated alternative for patients who might otherwise face delays. It also illustrates that retail pharmacies (CVS, Walgreens, Walmart) are deepening their roles in patient support, partly in response to the complexities imposed by PBMs.

7.2 Insurer and PBM Policy Shifts

Several PBMs have begun publicly adjusting their policies in response to market changes. As noted earlier, **CVS Caremark** struck a deal with Novo Nordisk in late 2024: Wegovy was made the preferred GLP-1 on CVS's national formulary in exchange for discounts ([61] www.washingtonpost.com). CVS announced that this change "will probably force

thousands of patients to switch from Lilly's Zepbound" (tirzepatide) ([61] www.washingtonpost.com). In effect, CVS used its formulary position to pivot usage from one manufacturer to another, reflecting how PBMs can steer patient volumes via contracting. Meanwhile, some state Blue plans (e.g. Blue Cross of Michigan, BCBSMA, Independence Blue Cross in PA) have outright ended coverage of GLP-1s for obesity ([39] www.washingtonpost.com), formally withdrawing benefits that had earlier been offered. These moves underscore how payers continuously revise GLP-1 coverage, sometimes shifting brand preferences or eliminating benefits entirely as budgets evolve.

UnitedHealthcare's bulletin (Table 1) provides a concrete local example: in Massachusetts and New York One Care plans, UHC made **Zepbound preferred** for weight-loss, removing Wegovy and Saxenda from the preferred list ([49] www.uhcprovider.com). They even encourage switching existing Wegovy/Saxenda patients to Zepbound ([49] www.uhcprovider.com). Such guidance (PDF provider updates) shows how PBMs communicate changes to clinicians, forcing them to re-engage affected patients. (Note: plans typically grandfather active prescriptions until PA expiration, but switch new starts to the preferred drug.)

7.3 Provider and Patient Strategies

From the provider side, clinicians have had to juggle coverage hurdles. As *Dr. Katherine Saunders* (Stanford) noted to the Washington Post, doctors are essentially learning to "navigate health coverage" as a subspecialty for obesity care ([62] www.washingtonpost.com). Many clinics now employ dedicated staff or patient navigators to handle GLP-1 PAs. These teams track each case across PBMs, submit appeals, and sometimes help patients choose specific GLP-1 brands based on their insurance. In some cases, physicians use creative workarounds: e.g. prescribing Ozempic "stacked" dosing (dialing multiple clicks twice weekly) to effectively extend a single vial beyond label recommendations, when PA denial prevents paying for Wegovy ([57] www.washingtonpost.com). While not FDA-sanctioned, such rationing is reported in practice to maintain some therapy continuity in the face of obstacles.

Patients also face tough choices. Many turn to **manufacturer assistance programs** when insurance fails. Both Novo Nordisk and Lilly offer copay savings cards (capping monthly cost ~$35) for eligible patients ([63] www.washingtonpost.com). However, these often still require PA approval as a prerequisite. Financially strained patients increasingly pay cash: IQVIA reported half of GLP-1 fills were cash-paid (2024) ([11] www.washingtonpost.com). Some patients use compounding pharmacies to obtain cheaper semaglutide formulations, but a 2025 FDA mandate largely shut down the bulk compounding of GLP-1s ([18] apnews.com) ([64] www.washingtonpost.com). (Small-scale compounding with prescriber-signed Rx is still technically allowed under Section 503A, but few physicians risk it.)

7.4 Impact on GLP-1 Brands

The combined effect of these barriers is that **brand uptake data often fall short of forecasts**. For example, internal models predicted rapid penetration of Wegovy beyond a few million users, but actual claims suggest a flatter growth curve as of early 2026. Sales forces and market analysts have noted that inventory of prescription fills is constrained by PBM edits as much as by raw demand.

Anecdotally, manufacturers are responding by bolstering patient support. Most GLP-1 brands now have robust "hub services" that assist with PA submission (filling forms, obtaining authorizations), training on self-injection, and affordability programs (discounts, financial aid). Some even offer telehealth coaching (e.g. Novo's "CNN Healthforeignly Pepperroot)** to enhance outcomes. These initiatives aim to counter PBM friction, but their ROI depends on metrics: manufacturers track fill rates and PA successes among patients enrolled in such programs to gauge effectiveness.

8. Discussion and Future Directions

The data and examples above highlight a **market access paradox**: despite strong clinical demand, payer access remains **uneven and bureaucratic**. From a strategic standpoint, this has several implications for commercial pharma

teams:

- **Data-driven access management.** Constantly measuring PBM metrics (denial rates, turnaround, fill success) is no longer optional. The metrics in Tables 1–2 provide benchmarks, but each brand must collect their own. Digital platforms (ePA trackers, payer-claims analytics) can flag which PBMs or plans are underperforming. A higher-than-expected denial rate at a major PBM may warrant a targeted engagement (e.g. re-educating on updated criteria, or negotiating a special arrangement). Time-to-fill data can signal whether PA paperwork is a bottleneck. By integrating these data into dashboards, teams can identify "holes" in coverage and allocate resources (like appeal teams or physician education) accordingly.

- **Segmented support programs.** Given the tiered coverage by indication and payer type, patient assistance/savings programs should be tailored. For diabetes patients, many clinical workflows exist (insulin assistance, etc.), but for obesity patients the playbook is newer. Commercial teams should map out which PBMs/plan sponsors cover GLP-1s for obesity at all, and ensure that for those who don't, employees/physicians know how to use cash-pay co-pay cards or delays. Patient support calls should emphasize the appeals process: many coverage denials can be overturned if additional medical justification is provided. Equally, clinical liaisons should be aware of restrictions (e.g. step therapy requirements) so they help physicians preempt rejections by submitting the requisite documentation.

- **Collaboration with PBMs and providers.** Some PBMs are receptive to input. For example, CVS Caremark has "account teams" that will help large employers design weight-loss coverage bundles ([40] business.caremark.com). Pharmaceutical teams can work through these channels to create mutually agreeable criteria – for instance, by providing real-world evidence that skipping older steps does not adversely impact outcomes, thereby advocating for reduced step requirements. Training programs on PA submissions (even webinars for providers) can improve first-pass approval rates. Also, some PBMs now publish their PA forms online (e.g. Express Scripts, OptumRx portals), which can be used to prepare comprehensive submissions quickly.

- **Legislative and regulatory avenues.** The federal government's recent decisions create uncertainty. On one hand, Congress (via the Inflation Reduction Act) will impose rebates on Medicaid GLP-1s starting 2024, which could constrain Medicaid coverage further. On the other hand, calls for treating obesity as a disease have led some states to mandate weight-loss medication coverage (e.g. state laws or CMS pilot programs). Pharma may invest in advocacy for anti-hunger/disease arguments. The current administration's reluctance to expand Medicare coverage (Apr 2025) demonstrates political pushback on broad coverage. It is plausible that incremental changes (e.g. allowing coverage under certain obesity execptions for MA) could occur, but this is far from guaranteed. Companies should therefore not rely on immediate policy fixes for the GLP-1 access gap.

- **Market evolution.** The GLP-1 franchise is about to get new entrants. Oral GLP-1s (Lilly's paltusotine-orforglipron, etc.) are expected in late 2025/2026, and might be covered differently (some plans treat orals less restrictively than injectables). GLP-1 combination therapies or follow-ons may also arrive. These new drugs will face their own PA/CD rules. The success of injection-based GLP-1s in changing metabolic care may push some PBMs to ease access over time (if they see long-term healthcare savings). But for at least the near term, we expect continued tight management. Pharma teams should constantly update access intelligence as new agents launch.

- **Technology and analytics.** The trend toward e-prescribing and automated PA (like CVS/Surescripts) offers hope for lower turnaround times. If adopted broadly, this could improve approvals for patients meeting criteria. Commercial teams could incentivize providers to use these tools by offering bonus programs or faster co-pay assistance. On the analytics side, integrated platforms (like Paintor, CoverMyMeds, ClaritasRx) can correlate PBM metrics with prescribing behavior. For example, if one formulary has a 4-week PA delay, a brand might choose to promote alternative access channels there (e.g. targeted hub clinic projects).

Summary of Table 2 Benchmarks

The metrics in Table 2 serve as **benchmarks for performance**: e.g., an average specialty fill rate of 62% ([12] brightinsight.com) or a first-pass GLP-1 approval of ~30% ([3] formblends.com). Teams should seek to exceed these in areas they control. In particular, improving **first-submission approval** by even 10 percentage points (say, via better PA documentation) can have large downstream impact on prescription volume. Similarly, cutting PA resolution days will improve patient satisfaction: one Goldman Sachs report estimated a 20% drop in fill rate for every additional week of waiting time ([8] www.claritasrx.com).

9. Conclusions

The market access landscape for GLP-1 therapies in mid-2026 is characterized by extremely high demand but severely constrained distribution through insurer and PBM systems. Prior authorization rules, step therapies, and formulary

exclusions are the norm rather than the exception for these high-cost drugs. The data examined in this report show that most commercial patients face significant hurdles: large denial rates (often two-thirds of requests), multi-day delays (median ~6 days if not instant-approve), and high first-fill abandonment (fill rates commonly ≤60%). These obstacles exist despite broad recognition of GLP-1 efficacy; they are driven by payer cost-containment priorities.

For pharmaceutical commercial teams, these realities demand a metrics-driven, multi-pronged strategy. Teams must continuously gather PBM-specific access data (denial rates, turnaround, fill rates) to identify bottlenecks. They should fortify patient-access support (hub programs, financial assistance, ePA facilitation) targeted at the most restrictive payers. Collaboration with PBMs and payers (to refine criteria) remains important, as does advocacy (insurance benefits and legislative). Tools like electronic PA integration offer hope to shrink delays over time, but cannot alone solve coverage denials.

In the near term, the GLP-1 market will continue to evolve rapidly: new agents, shifting policy, and creative distribution models (e.g. telehealth GLP-1 benefits) will change the landscape. Future trends to watch include how value-based contracting (rebates/tie-ins from IRA) might alter PBM incentives, whether new guidelines broaden obesity indications, and how consumer affordability programs adapt to PBM pressures. Throughout, pharma teams should heed the fundamental lesson here: *availability of a life-changing therapy is no guarantee of patient access, unless the complex machinery of insurance coverage is navigated successfully*.

In summary: this report has provided an exhaustive examination of GLP-1 access via PBMs as of 2026, with data-backed insights into denial rates, timelines, and fill outcomes. We conclude that maximizing patient access and brand success in this class requires intensive focus on these barriers – from executive strategy and data analysis to front-line provider education and patient assistance – all underpinned by the metrics detailed above. Going forward, pharma teams that proactively adapt their market-access playbook to this constrained environment will be best positioned to capture the opportunity of the GLP-1 revolution while serving patient needs.

External Sources

[1] https://www.eurekalert.org/news-releases/1053255#:~:About...

[2] https://www.aporesearch.com/news/pharma-healthcare/glp-1-a-global-therapeutic-trend-moving-from-50-billion-to-500-billion#:~:Accor...

[3] https://formblends.com/articles/glp1-hub/does-express-scripts-cover-wegovy#:~:,citi...

[4] https://formblends.com/articles/comparison-hub/does-cvs-caremark-cover-wegovy#:~:CVS%2...

[5] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2847566?guestAccessKey=3c6568f2-39d3-46ff-a724-6df8e542c5b8#:~:patie...

[6] https://www.cvshealth.com/news/pbm/cvs-caremark-advances-prior-authorization-to-get-specialty-medications-to-patients-faster.html?cid=sm_li_prior_authorization_announcement#:~:broad...

[7] https://www.express-scripts.com/frequently-asked-questions/how-long-does-it-take-complete-coverage-review-prior-authorization#:~:Nearl...

[8] https://www.claritasrx.com/thought-leadership/benchmarking-market-access/#:~:Time,...

[9] https://surescripts.com/what-we-do/first-fill-abandonment#:~:27...

[10] https://www.beckershospitalreview.com/pharmacy/40-of-glp-1-prescriptions-go-unfilled-study-finds/#:~:1.%20...

[11] https://www.washingtonpost.com/business/2025/05/24/weight-loss-drugs-insurance-coverage/#:~:Patie...

[12] https://brightinsight.com/resources/brightinsight-claritas-rx-abandonment-and-discontinuation-variation-in-specialty-drugs#:~:Fill%...

[13] https://www.uhcprovider.com/content/provider/en/resource-library/news/2025/ma-medicaid-zepbound-phentermine.html#:~:Prior...

[14] https://www.uhcprovider.com/content/provider/en/resource-library/news/2025/ma-medicaid-zepbound-phentermine.html#:~:,requ...

[15] https://www.axios.com/2026/02/17/employers-new-option-workers-glp-1-demand#:~:Emplo...

[16] https://www.axios.com/2026/04/16/walmart-glp1-care-platform#:~:presi...

[17] https://apnews.com/article/a5f94b1dd7449e15a17922f5503354d6#:~:Short...

[18] https://apnews.com/article/a5f94b1dd7449e15a17922f5503354d6#:~:The%2...

[19] https://www.axios.com/2025/02/24/glp1-copycat-crackdown-fda-lifts-shortage-status#:~:Maker...

[20] https://formblends.com/articles/glp1-hub/does-express-scripts-cover-wegovy#:~:,CVD%...

[21] https://www.kff.org/affordable-care-act/costly-glp-1-drugs-are-rarely-covered-for-weight-loss-by-marketplace-plans/#:~:Affor...

[22] https://www.aporesearch.com/news/pharma-healthcare/glp-1-a-global-therapeutic-trend-moving-from-50-billion-to-500-billion#:~:By%20...

[23] https://www.aporesearch.com/news/pharma-healthcare/glp-1-a-global-therapeutic-trend-moving-from-50-billion-to-500-billion#:~:US%24...

[24] https://www.aporesearch.com/news/pharma-healthcare/glp-1-a-global-therapeutic-trend-moving-from-50-billion-to-500-billion#:~:Regio...

[25] https://www.aporesearch.com/news/pharma-healthcare/glp-1-a-global-therapeutic-trend-moving-from-50-billion-to-500-billion#:~:milli...

[26] https://www.drugtopics.com/view/icer-finds-insurers-struggled-to-provide-fair-access-to-obesity-drugs#:~:Revie...

[27] https://www.drugtopics.com/view/icer-finds-insurers-struggled-to-provide-fair-access-to-obesity-drugs#:~:type%...

[28] https://www.eurekalert.org/news-releases/1053255#:~:follo...

[29] https://www.beckershospitalreview.com/glp-1s/weight-loss-drug-fill-rates-by-state.html#:~:Weigh...

[30] https://www.beckershospitalreview.com/pharmacy/40-of-glp-1-prescriptions-go-unfilled-study-finds/#:~:1.%20...

[31] https://www.beckershospitalreview.com/pharmacy/40-of-glp-1-prescriptions-go-unfilled-study-finds/#:~:fill%...

[32] https://www.kff.org/affordable-care-act/costly-glp-1-drugs-are-rarely-covered-for-weight-loss-by-marketplace-plans/#:~:When%...

[33] https://www.healthcaredive.com/news/employer-sponsored-health-insurance-premiums-rise-weight-loss-drugs/729519/#:~:Fewer...

[34] https://business.caremark.com/insights/glp1-management-strategies.html#:~:How%2...

[35] https://business.caremark.com/insights/glp1-management-strategies.html#:~:weigh...

[36] https://www.cbsnews.com/news/medicare-and-medicaid-will-not-cover-weight-loss-drugs-trump-administration-decides/#:~:The%2...

[37] https://www.cbsnews.com/news/medicare-and-medicaid-will-not-cover-weight-loss-drugs-trump-administration-decides/#:~:But%2...

[38] https://formblends.com/articles/glp1-hub/does-express-scripts-cover-wegovy#:~:rangi...

[39] https://www.washingtonpost.com/business/2025/05/24/weight-loss-drugs-insurance-coverage/#:~:Blue%...

[40] https://business.caremark.com/insights/glp1-management-strategies.html#:~:Our%2...

[41] https://business.caremark.com/insights/glp1-management-strategies.html#:~:Formu...

[42] https://business.caremark.com/insights/glp1-management-strategies.html#:~:How%2...

[43] https://www.uhcprovider.com/content/provider/en/resource-library/news/2025/ma-medicaid-zepbound-phentermine.html#:~:,requ...

[44] https://www.uhcprovider.com/content/provider/en/resource-library/news/2025/ma-medicaid-zepbound-phentermine.html#:~:Step%...

[45] https://business.caremark.com/insights/glp1-management-strategies.html#:~:CVS%2...

[46] https://formblends.com/articles/glp1-hub/does-express-scripts-cover-wegovy#:~:Direc...

[47] https://formblends.com/articles/glp1-hub/does-express-scripts-cover-wegovy#:~:weigh...

[48] https://formblends.com/articles/glp1-hub/does-express-scripts-cover-wegovy#:~:1,D%2...

[49] https://www.uhcprovider.com/content/provider/en/resource-library/news/2025/ma-medicaid-zepbound-phentermine.html#:~:Cover...

[50] https://www.authdenied.com/#:~:69...

[51] https://www.authdenied.com/#:~:Prior...

[52] https://www.authdenied.com/#:~:PA%20...

[53] https://www.healthcaredive.com/news/cms-final-prior-authorization-rule-payer-deadline/704721/#:~:Healt...

[54] https://www.cvshealth.com/news/pbm/cvs-caremark-advances-prior-authorization-to-get-specialty-medications-to-patients-faster.html?cid=sm_li_prior_authorization_announcement#:~:autho...

[55] https://www.cvshealth.com/news/pbm/cvs-caremark-advances-prior-authorization-to-get-specialty-medications-to-patients-faster.html?cid=sm_li_prior_authorization_announcement#:~:When%...

[56] https://www.beckershospitalreview.com/pharmacy/40-of-glp-1-prescriptions-go-unfilled-study-finds/#:~:fill%...

[57] https://www.washingtonpost.com/business/2025/05/24/weight-loss-drugs-insurance-coverage/#:~:Davis...

[58] https://www.axios.com/2026/04/16/walmart-glp1-care-platform#:~:Walma...

[59] https://www.axios.com/2026/04/16/walmart-glp1-care-platform#:~:presi...

[60] https://www.axios.com/2026/04/16/walmart-glp1-care-platform#:~:store...

[61] https://www.washingtonpost.com/business/2025/05/24/weight-loss-drugs-insurance-coverage/#:~:CVS%2...

[62] https://www.washingtonpost.com/business/2025/05/24/weight-loss-drugs-insurance-coverage/#:~:%E2%8...

[63] https://www.washingtonpost.com/business/2025/05/24/weight-loss-drugs-insurance-coverage/#:~:Docto...

[64] https://www.washingtonpost.com/business/2025/05/24/weight-loss-drugs-insurance-coverage/#:~:Many%...

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AI Consulting & Training: Comprehensive AI strategy development, team training programs, and implementation guidance for pharmaceutical organizations adopting AI technologies.

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