Health Affairs Scholar, 2026, 4, 1–6
https://doi.org/10.1093/haschl/qxag284
Published: 15 October 2026
Brief Report

Health Affairs Scholar OXFORD
EMERGING & GLOBAL HEALTH POLICY

Prescription denials for GLP-1 receptor agonists across commercial, Medicare, and Medicaid coverage, 2018-2024

Miaoqing Jia [1]*, Joseph F. Levy [2], Emma E. McGinty[1], Sri Lekha Tummalapalli [3,4], Yongkang Zhang [1]

[1]Division of Health Policy and Economics, Department of Population Health Sciences, Weill Cornell Medical College, New York, NY 10022, USA
[2]Department of Health Policy and Management, Johns Hopkins School of Public Health, Baltimore, MD 21205, USA
[3]Division of Healthcare Delivery Science & Innovation, Department of Population Health Sciences, Weill Cornell Medicine, New York, NY 10022, USA
[4]Cornell Health Policy Center, New York, NY 10065, USA
*Corresponding author: Department of Population Health Sciences, Weill Cornell Medicine, 575 Lexington Avenue, New York, NY 10022, USA.
Email: mij4018@med.cornell.edu

Abstract

Introduction **Access to GLP-1 receptor agonists (GLP-1 RAs) remains strongly shaped by payer coverage and utilization management. Patient-level evidence on GLP-1 RA denial across payer types is limited.**

Methods **Using a national multi-payer claims database capturing adjudication status of pharmacy claims, we examined GLP-1 RA prescription denial and whether individuals with an index denial subsequently obtained a paid fill from 2018 to 2024. The index claim was defined as each individual's first observed GLP-1 RA claim. We estimated multivariable logistic regressions to examine factors associated with index-claim denial and the likelihood of receiving a paid fill within 90 days among individuals with a denied index claim.**

Results **Overall, 7.9% of individuals had a denied index GLP-1 RA claim, increasing from 4.0% (2018) to 9.6% (2022) before declining to 6.6% (2024). Denial was higher in Medicaid than in commercial coverage (12.6% vs 5.6%) and for obesity-indicated than diabetes-indicated brands (16.8% vs 6.3%). Among individuals with a denied index claim, 34.1% obtained a paid fill within 90 days, declining from 45.9% (2018) to 24.8% (2024).**

Conclusion **Denial was concentrated in Medicaid and obesity-indicated products, and most individuals with a denied index claim did not obtain a paid fill within 90 days.**

Keywords: GLP-1 receptor agonists, prior authorization, prescription denial, Medicaid, Medicare, prescription drug coverage, formulary exclusion, utilization management

Key Points

- GLP-1 RA index-claim denial increased from 4.0% in 2018 to 9.6% in 2022 before declining to 6.6% in 2024, and was more than twice as high in Medicaid as in commercial coverage.
- Only one-third of individuals with a denied index claim obtained a paid fill within 90 days; this share fell from 45.9% in 2018 to 24.8% in 2024 and was lower for obesity-indicated brands (21.0% vs 40.2%).
- Denial was higher for Wegovy than Ozempic (16.5% vs 6.3%) and for Saxenda than Victoza (21.2% vs 4.6%), but similar for Zepbound and Mounjaro (13.2% vs 14.1%).

Introduction

GLP-1 receptor agonists (GLP-1 RAs) are transforming obesity and type 2 diabetes (T2D) management, with trials and real-world evidence demonstrating substantial reductions in body weight and major adverse cardiovascular events.[1,2] Use and spending have grown rapidly. Among adults with T2D in the United States, GLP-1 RA use more than doubled, increasing from 7.6% in 2018 to 19.4% in 2022,[3] while national spending on GLP-1 RA increased

Received: August 26, 2026. **Revised:** October 6, 2026. **Accepted:** October 8, 2026
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from $13.7 billion in 2018 to $71.7 billion in 2023.[4] Given the high and rapidly growing costs of these therapies, coverage and access have become important policy priorities.

Access to GLP-1 RAs remains uneven and continues to depend heavily on payer coverage and utilization management policies.[5-7] Unlike most branded drugs, GLP-1 RAs span a covered indication (T2D) and an often-excluded indication (obesity) within the same therapeutic class. Between 2018 and 2024, Medicare Part D statutorily excluded GLP-1 RAs used solely for weight loss, and most state Medicaid programs did not cover GLP-1 RAs for obesity.[8,9] Even for covered indications, insurers increasingly use utilization management tools such as prior authorization (PA), which requires documentation of a covered diagnosis or clinical eligibility before treatment. Among Medicare Part D plans covering these therapies, PA requirements increased from below 25% in 2023 to approximately 83% by late 2024.[10,11] Most state Medicaid programs covering GLP-1 RAs for obesity also require PA, with criteria varying widely across states.[9] Beginning July 1, 2026, the Medicare GLP-1 Bridge program expanded access to selected weight-management GLP-1 therapies for eligible Part D beneficiaries through standardized eligibility criteria and a centralized PA process that permits electronic submission, through December 31, 2027.[12]

Coverage exclusions and PA requirements may result in denials of GLP-1 RA prescriptions, potentially delaying or preventing treatment. Prior research has characterized formulary level PA policies,[9,11] medication fill rates,[13] prescribing disparities,[14] and off-label use among individuals without diabetes.[15] Recent work found that formulary based rejections of single-source branded drugs increased from 24.3% in 2018 to 40.7% in 2024, with substantial variation across therapeutic classes.[16] As coverage expands while PA remains a central tool for managing access and utilization, evidence on the frequency and distribution of prescription denials is needed to establish a baseline and identify where access barriers are concentrated.

Using a national, multi-payer claims database that captures the adjudication status of pharmacy claims, we described GLP-1 RA denial rates and trends across commercial insurance, Medicare, and Medicaid coverage from 2018 to 2024, examined whether individuals with a denial subsequently received a paid fill, and identified patient-level factors associated with denial and receipt of a paid fill.

Study data and methods

Data and sample

We used Inovalon Real-World Data, a national closed-claims, multi-payer claims database with pharmacy and medical claims and linked monthly enrollment information for more than 200 million beneficiaries in Medicare Advantage, managed Medicaid, and commercial insurance across all 50 states, allowing individuals to be followed across their enrollment periods.[17] We included adults with at least one paid or denied GLP-1 RA prescription claim for semaglutide, tirzepatide, liraglutide, dulaglutide, exenatide, or lixisenatide during 2018-2024, identified using National Drug Codes (NDC). We restricted the analysis to 2018 onward, the first year after FDA approval of injectable semaglutide. We excluded individuals under 21 as Medicaid medication coverage policies differ for this population, as well as those with missing age, unknown payer for the index claim, missing state, unknown sex, or an unclassified index brand. We required 6 months of continuous enrollment before the index claim so that diagnoses and comorbidities could be observed for all individuals.

Outcomes

For each individual, we defined their index claim as their first observed GLP-1 RA prescription claim in 2018-2024 and classified that claim as paid or denied based on adjudication status. Each individual contributed one observation. The primary outcome was a binary indicator of whether the index claim was denied, identified using the pharmacy claim status code. Among individuals with a denied index claim, we examined whether they received a paid GLP-1 RA fill within 90 days following the denial. This analysis additionally required continuous enrollment in a pharmacy benefit during the follow-up period.

Covariates

We defined index claim brand as the product submitted on the index claim and classified it according to FDA-approved indication as obesity-indicated (Wegovy, Saxenda, Zepbound) or diabetes-indicated. Payer type of the index claim was defined as commercial, Medicare, or Medicaid, using enrollment information for the index-claim month; 97.4% of individuals had claims under a single payer category during the study period. We identified T2D, obesity, and comorbidities (hypertension, cardiovascular disease, chronic kidney disease, hyperlipidemia, depression, and sleep apnea) using ICD-10-CM codes in the 6 months preceding the index claim. Prior GLP-1 RA use was defined as any observed paid GLP-1 RA fill during 2013-2017. Age, sex, and race by index claim were obtained from the enrollment record; race was classified as White, Black, Asian, Other, or Unknown. Full code lists are in Appendix Table AS1; cohort characteristics are in Appendix Table AS2.

Statistical analysis

We first described annual GLP-1 RA denial rates and subsequent fill rates by payer and brand. Because denial was measured at the index claim, annual rates reflect the proportion of individuals with a denied index claim in each year and are not influenced by differences in follow-up. We then estimated individual-level multivariable logistic regressions to examine patient characteristics associated with index-claim denial and the likelihood of receiving a paid fill within 90 days among individuals with a denied index claim, adjusting for index claim year. Standard errors were clustered at the state level to account for within-state correlation in denial. As a secondary analysis, we estimated payer-stratified denial models to assess whether racial differences varied across payers. This study was approved by the Institutional Review Board at [institution omitted].

Study results

Among 2 520 208 individuals with an index GLP-1 RA claim from 2018 to 2024, 199 819 (7.9%) experienced a denial. The annual

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denial rate increased from 4.0% in 2018 to 9.6% in 2022, then declined to 6.6% in 2024 (Figure 1). Medicaid beneficiaries had higher denial rates than commercial and Medicare beneficiaries across all years (12.6%, 5.6%, and 3.0% overall, respectively). Medicare denial declined from 2.7% in 2018 to 2.0% in 2021, then increased to 5.3% in 2024, coinciding with the expansion of Part D PA over the same period.[10] Denial was higher for obesity-indicated than diabetes-indicated brands (16.8% vs 6.3%; Figure 1), including Wegovy vs Ozempic (16.5% vs 6.3%) and Saxenda vs Victoza (21.2% vs 4.6%), but not Zepbound vs Mounjaro (13.2% vs 14.1%).

Among individuals whose index claim was denied, 34.1% obtained a paid GLP-1 RA fill within 90 days. This share declined from 45.9% in 2018 to 24.8% in 2024 (Figure 1). It was highest among Medicare beneficiaries (46.7%), followed by Medicaid (37.9%) and commercial (26.8%) enrollees. A paid fill after denial was less common for obesity-indicated than diabetes-indicated brands (21.0% vs 40.2%).

In multivariable analysis (Table 1; Appendix Table AS3), Medicaid coverage was associated with higher odds of denial than commercial coverage (adjusted odds ratio [AOR], 3.42; 95% confidence interval [CI], 1.28-9.11), as was Black compared with White individuals (AOR, 1.71; 95% CI, 1.22-2.40). A documented T2D diagnosis was associated with lower odds of denial (AOR, 0.52; 95% CI, 0.43-0.64), whereas a documented obesity diagnosis was not significantly associated with denial (AOR, 0.97; 95% CI, 0.85-1.11). Relative to dulaglutide, odds of denial were higher for Zepbound (AOR, 7.29; 95% CI, 3.52-15.09), Mounjaro (AOR, 6.96; 95% CI, 4.78-10.13), Wegovy (AOR, 4.90; 95% CI, 2.28-10.54), and Saxenda (AOR, 4.14; 95% CI, 2.16-7.95). In payer-stratified models, Black individuals had higher odds of denial than White individuals under commercial (AOR, 1.60; 95% CI, 1.27-2.02) and Medicaid (AOR, 1.63; 95% CI, 1.16-2.28) coverage but not under Medicare (Appendix Table AS4).

Factors associated with subsequently obtaining a paid fill differed from those associated with index-claim denial (Table 1).

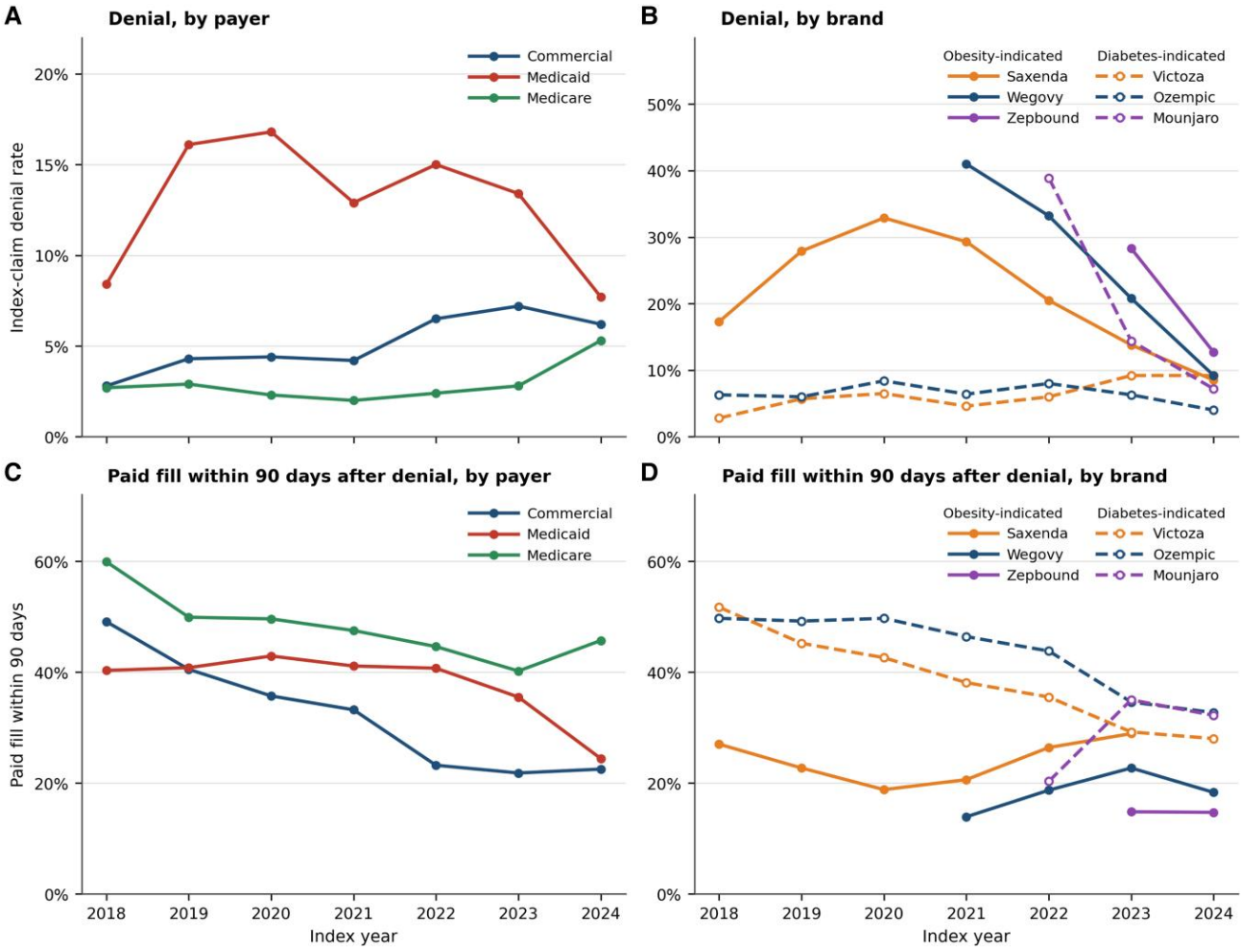


Figure 1. GLP-1 receptor agonist index-claim denial and subsequent paid fill, by payer and brand, 2018-2024. Panels (A) and (B) show the percentage of individuals whose index GLP-1 RA claim was denied. Panels (C) and (D) show the percentage of individuals with a denied index claim who obtained a paid GLP-1 RA fill within 90 days, among individuals with 90 days of continuous enrollment after the index claim. Solid lines indicate obesity-indicated brands and dashed lines diabetes-indicated brands of the same molecule; dulaglutide, exenatide, and lixisenatide, which have no obesity-indicated counterpart, are not shown. Lines begin at each brand's market entry (Wegovy 2021, Mounjaro 2022, Zepbound 2023); Mounjaro cells before 2022 are suppressed as pre-approval. Cells with fewer than 200 individuals are suppressed (Saxenda 2024, Panel D).

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Table 1. Factors associated with GLP-1 receptor agonist index-claim denial and with a subsequent paid fill after denial, 2018-2024.

Variable	Index claim denied AOR (95% CI)	Paid fill within 90 days after denial AOR (95% CI)
Prior observed GLP-1 RA use, 2013-2017 (ref: none)		
Any prior use	0.32 (0.21-0.49)	1.79 (1.31-2.45)
Payer type (ref: commercial)		
Medicaid	3.42 (1.28-9.11)	1.29 (0.64-2.59)
Medicare	0.85 (0.46-1.55)	1.67 (1.03-2.73)
Documented diagnosis (ref: none)		
Documented T2D diagnosis	0.52 (0.43-0.64)	3.28 (2.72-3.94)
Documented obesity diagnosis	0.97 (0.85-1.11)	1.11 (1.03-1.20)
Product brand (ref: dulaglutide)		
Exenatide	1.84 (1.28-2.66)	0.86 (0.69-1.07)
Lixisenatide	3.09 (2.16-4.42)	0.61 (0.47-0.80)
Liraglutide, diabetes (Victoza)	0.92 (0.62-1.35)	0.97 (0.84-1.12)
Liraglutide, obesity (Saxenda)	4.14 (2.16-7.95)	0.85 (0.56-1.30)
Semaglutide, diabetes (Ozempic)	1.71 (1.20-2.46)	1.08 (0.87-1.35)
Semaglutide, obesity (Wegovy)	4.90 (2.28-10.54)	0.81 (0.49-1.33)
Tirzepatide, diabetes (Mounjaro)	6.96 (4.78-10.13)	0.83 (0.58-1.20)
Tirzepatide, obesity (Zepbound)	7.29 (3.52-15.09)	0.66 (0.35-1.23)
Race (ref: White)		
Black	1.71 (1.22-2.40)	0.94 (0.83-1.08)
Asian	0.56 (0.33-0.93)	1.02 (0.88-1.20)
Other	1.16 (0.42-3.19)	0.93 (0.66-1.30)
Unknown	1.63 (0.63-4.25)	1.19 (0.87-1.63)
Sex (ref: female)		
Male	0.99 (0.91-1.07)	0.91 (0.85-0.98)
Other covariates		
Age, per year	1.00 (1.00-1.01)	0.99 (0.98-1.00)
Cardiovascular disease	1.19 (1.05-1.36)	0.97 (0.88-1.06)
Sleep apnea	1.00 (0.89-1.12)	1.13 (1.09-1.18)
Depression	0.99 (0.85-1.14)	1.10 (1.06-1.14)
Hypertension	0.98 (0.87-1.10)	1.09 (1.02-1.16)
Observations	2 520 208	173 782
Pseudo R^2	0.114	0.085

Adjusted odds ratios from person-level multivariable logistic regression. The first column models denial of the index claim among all individuals; the second models receipt of a paid GLP-1 RA fill within 90 days among individuals whose index claim was denied and who had at least 90 days of post-index enrollment. Both models include prior observed use, payer type, documented T2D and obesity diagnoses, product brand, age, sex, race, comorbidities (hypertension, cardiovascular disease, chronic kidney disease, hyperlipidemia, depression, and sleep apnea), and index year (fixed effects). Standard errors clustered at the state level. Chronic kidney disease, hyperlipidemia, and index-year estimates are adjusted for but not displayed.
Source: Inovalon Real-World Data, 2018-2024.
Abbreviations: AOR, adjusted odds ratio; CI, confidence interval; GLP-1 RA, GLP-1 receptor agonist; T2D, type 2 diabetes.

Prior GLP-1 RA use (AOR, 1.79; 95% CI, 1.31-2.45), Medicare coverage (AOR, 1.67; 95% CI, 1.03-2.73), and a documented T2D diagnosis (AOR, 3.28; 95% CI, 2.72-3.94) were associated with higher odds of obtaining a paid fill. After accounting for other factors, including a documented T2D diagnosis, estimates for obesity-indicated brands did not differ significantly from dulaglutide, and race was not associated with obtaining a paid fill. Results using a 180-day window were similar (Appendix Table AS5).

Discussion

We found that less than 10% of individuals had a denied index GLP-1 RA claim between 2018 and 2024. Denial rates increased through 2022 and were highest among Medicaid enrollees and for obesity-indicated brands. Among individuals with a denied index claim, only about one-third obtained a paid fill within 90 days, and this share fell by nearly half over the study period. To our knowledge, this is the first national, patient-level characterization of GLP-1 RA prescription denials across commercial, Medicare, and Medicaid coverage. By linking claims to enrollment records, we identified which individuals experienced denials, characterized payer-specific trends in denial rates, and determined which individuals subsequently received a paid fill.

This low share obtaining a paid fill after denial is consistent with prior evidence that formulary rejections and authorization restrictions often result in no subsequent treatment.[16,18] The decline is not explained by shorter follow-up. From a coverage

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perspective, the decline may partly reflect which products were denied. Among individuals included in the paid-fill analysis, obesity-indicated brands accounted for 16% of denied index claims in 2018 and 51% in 2024. In prior work, rejections for weight-management products more often reflected formulary exclusion, which was less often followed by a fill of the original drug.[16] The share obtaining a paid fill also declined for diabetes-indicated brands, consistent with the broader expansion of utilization management over this period.[10,16]

Our denial rate of 7.9% is lower than the rejection rates reported for incretin products in prior work.[16] Differences in the definition of the index claim, same-day classification, and product composition explained little of this difference (Appendix Table AS6). Prior studies have largely relied on pharmacy transaction data, which capture each prescription submission in detail but may include multiple submissions, reversals, and resubmissions within the same prescription episode. Our closed-claims data instead link prescription claims to enrollment records. In our data, paid and denied claims on the same date were rare (0.1% of individuals), suggesting that rejections resolved within the same pharmacy visit are less often captured. Our estimate therefore reflects denial recorded on each individual's first observed paid or denied claim rather than all rejection events. The same database has been used to study claim denials, as many participating plans report claim adjudication status and multiple submissions over time.[19]

The high denial rate among Medicaid beneficiaries is consistent with more restrictive PA criteria and broader obesity-coverage exclusions in state Medicaid programs compared with commercial plans.[8,9] We also found higher odds of denial among Black individuals within both commercial and Medicaid coverage, consistent with prior studies reporting larger claim-denial burdens among patients from historically disadvantaged racial and ethnic groups.[20]

This analysis had several limitations. The data did not include National Council for Prescription Drug Programs reject-reason codes, so we could not distinguish PA, formulary exclusion, and step therapy from other rejections. We could not determine whether a subsequent paid fill represented resolution of the index denial through resubmission or appeal, a new prescription, or a switch to a different GLP-1 RA product. Covariates and payer were defined at the index claim and may not reflect subsequent changes. Plan-level identifiers and formulary information were unavailable, precluding direct estimation of formulary effects. Finally, the continuous enrollment requirement may limit generalizability to individuals with less stable coverage.

Conclusion

GLP-1 RA index-claim denial increased through 2022 and was concentrated among Medicaid enrollees and obesity-indicated products. Most individuals with a denied index claim did not obtain a paid fill within 90 days. Policies such as the Medicare GLP-1 Bridge may reduce affordability barriers through defined eligibility criteria and fixed monthly copayments.[12] Coverage expansion may improve access while shifting the principal barrier from whether a therapy is covered to whether patients and clinicians can successfully navigate the authorization process.

Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

M.J. declares no conflicts to disclose. J.F.L. declares no conflicts to disclose. E.E.M. reports grants from the National Institute on Drug Abuse, National Institute of Mental Health, and Centers for Disease Control and Prevention to her institution; research funding from the Novartis Foundation (funds to institution); consulting fees from Washington University in St. Louis Implementation Research Institute and the University of California, Los Angeles; a lecture honorarium from New York University; and personal fees from the Agency for Healthcare Research and Quality National Integration Academy. None of these relationships are related to the current manuscript. S.L.T. reports research funding from the Novartis Foundation and SAIGroup (funds to institution) and personal fees from the National Kidney Foundation as Associate Editor of Kidney Medicine and Peterson Health Technology Institute. None of these relationships are related to the current manuscript. Y.Z. declares no conflicts to disclose.

Data availability

The data used in this study were obtained under license from Inovalon Insights, LLC. The terms of the license agreement do not permit the authors to share the data. Researchers may request access to data from Inovalon Insights, LLC, subject to its licensing terms.

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