



## NHS BSW Prescribing guidance for switching Tirzepatide (Mounjaro®) to Semaglutide (Ozempic®) in *well controlled* adult patients being treated for Type 2 diabetes.

### Background:

- NICE have recently published the medicines update of [NG28](#)<sup>1</sup>. Within this, there are recommendations to initiate medications earlier than previously used and widening access to GLP1s & GLP1/GIP molecules for various cohorts of patients with T2DM.
- In order for the ICB to get the best value for money out of the use of these medications and to be able to offer them as recommended by NICE in an equitable manner, NHS BSW ICB in conjunction with the BSW diabetes steering group, recommend the use of semaglutide as the 1<sup>st</sup> line GLP1 for ALL patients living with T2DM (ahead of Tirzepatide (GLP1/GIP)).
- This will allow us to treat more patients as semaglutide is cheaper than tirzepatide. The Number Needed to Treat (NNT) for semaglutide in preventing major cardiovascular events (MACE) is 125 for the 3P-MACE endpoint.<sup>2</sup>
- For patients that are well controlled on tirzepatide, they can be considered for a switch to a less potent treatment. Semaglutide could be used instead without deleterious effects on their control or outcomes.
- Head-to-head data published in 2024 have not shown significant differences in serious adverse events between the two medicines.<sup>3</sup>
- Switching between such agents requires careful consideration. There is little high-quality guidance on this, while interclass differences (i.e. dual vs mono-agonism) complicate assumptions about equivalency<sup>4</sup>. There is no guidance on this from NICE or the MHRA currently.
- Therefore, we propose practical approaches for safe, effective switching and where direct data is absent, it draws on analogous guidance from other GLP-1 receptor agonist transitions, fundamental pharmacological principles<sup>3</sup> and advice from our BSW Diabetes

### Criteria for switching:

#### **Only switch patients as follows:**

- HbA1C threshold of: 48mmol/mol or below and have achieved *stable glycaemic control* over the last 6-12 months.
- Patients who have not had recent loss of glycaemic control or dose escalation within the last 3–6 months

#### **Practices should start with the patients that have the most well controlled/low HbA1C.**

It should be recognised that there might be a modest rise in HbA1c and plateau of weight loss following the switch.

#### **EXCLUSION CRITERIA:**

- Patients being treated for obesity with Mounjaro via specialist weight clinics
- Patients who previously had significant side effects to semaglutide

Individualised, well-documented clinical judgment remains best practice. Ultimately, prescribing decisions should always be based on what is clinically appropriate for each individual patient.

In some cases, after a period of using semaglutide, switching back to tirzepatide might be appropriate if they have a sustained trend towards weight gain (e.g. 3-5kg) or HbA1c has risen above their individualised target.

## Delivery model:

Switching from tirzepatide to semaglutide should be undertaken following individual clinical review by an appropriate clinician and a shared decision-making discussion with the patient rather than a blanket or administrative switch. It requires consideration of indication, prior response, tolerability and dosing with clear counselling and documentation to ensure safety and adherence. Appropriate follow-up should be arranged to monitor tolerability, side-effects, and response to treatment. While this guidance recommends a patient-centred, clinically led approach, GP practices may determine the most appropriate delivery model locally, using their professional judgement and existing consultation processes.

## Titration schedule<sup>4</sup>:

- Obtain informed consent from the patient and document the switch in the medical notes.
- Ensure patients are counselled about the switch, titration schedule, potential side-effects & how to manage them and receive appropriate patient information leaflets.

There is no validated dose equivalence between the two agents owing to their differing receptor profiles.

Given their long half-lives (i.e. five to seven days) and overlapping incretin activity, concurrent administration of tirzepatide and semaglutide could heighten side effects. However, prolonged discontinuation may compromise glycaemic control and cause rebound appetite. The safest approach is to restart semaglutide at its lowest available dose (i.e. 0.25mg weekly), then titrate gradually per standard schedule, regardless of the previous tirzepatide dose.

**Example:** *A patient on tirzepatide 10mg weekly should start semaglutide 0.25mg once weekly (on the day they are due a dose) for four weeks then increase to 0.5mg and higher as tolerated.*

This “start-low-go-slow” approach balances efficacy with minimised GI side effects and improves adherence during the transition period.

**A short washout period (up to 1–2 weeks) may be considered in patients with significant gastrointestinal side effects, at the clinician’s discretion.**

Prescribers should refer to the SPC for semaglutide (Ozempic®) for full prescribing information, contraindications, cautions and adverse effects:

<https://www.medicines.org.uk/emc/product/9748/smpc>

## Monitoring and review:

The frequency of monitoring/follow up will depend on individual patients — but as the switch is aimed at patients that are well controlled, it is not envisaged that there will need to be frequent follow-ups. Assess the following:

- HbA1c (six monthly) and fasting glucose daily;
- Weight and BMI (baseline and 4-8 weekly)
- Side-effects/GI symptom severity tracking; (e.g. nausea, vomiting, diarrhoea, constipation and abdominal pain)

- Renal and hepatic function;
- Adherence and injection technique, which is assessed at the beginning of treatment.

### Advice to be given to patients:

- Patients should be made aware that there might be a modest rise in HbA1c and plateau of weight loss following the switch. If they have any concerns, they should contact their diabetes nurse/doctor to discuss.
- Patients might wish to contact the NHS BSW ICB PALs team if they have any concerns: [Compliments and complaints - Bath and North East Somerset, Swindon and Wiltshire ICB](#)  
Email: [scwcsu.palscomplaints@nhs.net](mailto:scwcsu.palscomplaints@nhs.net) or by phone **0300 561 0250**

### Cost (Drug Tariff April 26):

Strength	Cost (£)
<b>Semaglutide (Ozempic®)</b>	
0.25 mg	73.25
0.5 mg	73.25
1 mg	73.25
<b>Tirzepatide (Mounjaro®)</b>	
2.5 mg	133.00
5 mg	180.00
7.5 mg	255.00
10 mg	255.00
12.5 mg	330.00
15 mg	330.00

### References:

1. NICE Type 2 diabetes in adults: management. [NG28](#) Updated 18/2/2026. Accessed 25/3/26.
2. Krüger, N., Schneeweiss, S., Desai, R.J. *et al.* Cardiovascular outcomes of semaglutide and tirzepatide for patients with type 2 diabetes in clinical practice. *Nat Med* **32**, 342–352 (2026). <https://doi.org/10.1038/s41591-025-04102-x>
3. Frías JP, Davies MJ, Rosenstock J, et al. Tirzepatide versus Semaglutide Once Weekly in Patients with Type 2 Diabetes. *N Engl J Med.* 2021;385(6):503-515.doi: 10.1056/nejmoa2107519
4. Shahid, S. [Switching between weight-loss medications - The Pharmaceutical Journal](#), PJ December 2025, Vol 315, No 8004;317(8004):DOI:10.1211/PJ.2025.1.389743