Primary Care
Women's Health Society

Further reading

Injectable weight loss drugs, contraception and HRT

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This resource has been produced on behalf of the PCWHS. It is for guidance only; healthcare professionals should use their own judgment when applying it to patient care.

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Background

- Private prescribing of semaglutide (Ozempic®) and tirzepatide (Mounjaro®) is common, often with no face-to-face interaction between prescriber and patient.
- The BMA, medical defence organisations and LMCs have raised concerns about the potential for significant unresourced work and medicolegal risk related to the private provision of GLP-1 agonists[1].
- Concerns fall into two categories:
    - Interactions with contraception and HRT.
    - Whether the GP has a duty of care to check the notes for contraindications if informed that a patient of theirs is taking such a drug. It is unclear whether a failure to do so would result in medicolegal liability.

Guidance

- FSRH, January 2025[2]:
    - All women taking GLP-1 agonists should use contraception.
    - Those taking tirzepatide (but not semaglutide) should switch to a non-oral method, or add a barrier method, for four weeks after initiation and four weeks after each dose increase.
    - Those using oral contraception who experience vomiting or severe diarrhoea as a side-effect should follow existing FSRH recommendations[3,4].
    - There is no data regarding interactions with emergency contraception (EC) – recommend a copper intrauterine device, but if this is refused, follow usual guidance regarding weight and an increased dose of levonorgestrel EC[5].

- BMS, April 2025[6]:
    - Transdermal oestrogen is preferred in women with obesity and in those using GLP-1 agonists. This is because of risks resulting from the obesity and the lack of interaction if this route is used.
    - There is very little data on the interaction between GLP-1 agonists and progestogens used in HRT; transdermal or vaginal routes are unlikely to interact, but GLP-1 agonists delay gastric emptying and may therefore reduce absorption of oral progestogens.
    - Extrapolating from data derived from combined oral contraception containing ethinylestradiol and given that GLP-1 dose increases are

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frequent, pragmatic advice is that switching to a non-oral progestogen (combined patch or levonorgestrel intrauterine device (LNG-IUD)) would be preferable while the GLP-1 agonist is being used.
- If an oral progestogen is preferred by the patient, the dose of progestogen should be increased for four weeks after starting and after each dose increase of the GLP-1 agonist.
- This document suggests that this applies to both semaglutide and tirzepatide, in contrast to FSRH guidance which only recommends changes for those taking tirzepatide.
- The BMS does not specify the amount of any dose increase.
- Current guidance on unscheduled bleeding[7] considers risk factors to determine the appropriate referral pathway. A possible lower threshold should be considered for women using oral progestogens and a GLP-1 agonist.

PCWHS primary care action plan

We would suggest the following plan, to keep your patients safe and protect you from any adverse medicolegal outcomes. Example templates are in the resources section, or you may prefer to write your own. This is our pragmatic interpretation of the guidelines – you retain responsibility for your own decisions.

1) On receipt of information that a patient of yours is taking a GLP-1 agonist, send a template letter back to the provider.
2) If the patient is a woman aged <55, also send her a template text about contraception. Those on semaglutide sometimes move to tirzepatide at a later date, so we would recommend sending this for both medications.
3) Add the GLP-1 to the medication screen as 'other or hospital issue', to ensure that the interaction is automatically flagged if she is started on an oral contraceptive/progestogen in the future.
4) In response to the new BMS guidance, do a search for all women who are taking an oral progestogen, check their notes for GLP-1 letters and contact those who are taking a GLP-1 to arrange a review. Consider sending all of this cohort a text to advise that if they are taking a GLP-1 agonist but have not informed the practice, that they should come for an HRT review.
5) At the review, do the following:
    a. Suggest changing to a non-oral method (LNG-IUD/combined patch).
    b. If she insists on staying on an oral progestogen, increase the dose and share the uncertainty about what the correct dose increase might be and whether increasing the dose is enough to ensure safety.
    c. Remind her to promptly report any unscheduled bleeding.
6) Care should be taken to assess for all factors affecting endometrial risk.
7) In the absence of a BMS suggested dose increase for those who wish to continue with an oral progestogen, we would pragmatically suggest that those on a standard dose of oestrogen increase their progestogen to the dose which is suggested by the BMS for those taking a high dose of oestrogen (but not taking a GLP-1 agonist), as shown in the table below. Individual clinical

judgment should be used for women who are already taking a higher dose of progestogen (due to a higher oestrogen dose) who then start taking a GLP-1 agonist. The most robust endometrial protection is provided by a 52mg LNG-IUD.

Type of progestogen	Sequential or continuous	Suggested dose
Micronised progesterone	Sequential	300 mg
	Continuous	200 mg
Medroxyprogesterone	Sequential	20 mg
	Continuous	10 mg
Norethisterone	Sequential	5 mg*
	Continuous	5 mg*

*This does not represent an increase from the usual dose, however the 5mg dose is used because there is no 1mg preparation; a 1mg dose would be sufficient for use in HRT in the absence of a GLP-1 agonist[8].

Resources

Template letter to private providers of GLP-1 agonists

To Whom It May Concern
(patient demographics)
Thank you for letting us know that you are prescribing a GLP-1 agonist to the patient named above. This is a standard letter that we send in response to all such notifications, some of which ask us to review the medical history for contraindications.
The practice is under substantial pressure to provide NHS care and is not resourced to review notes on behalf of private providers. If you would like a report about the patient's medical history, please let us know – the fee for this will be £(insert own fee) and work on the report will start after the funds have been received by BACS. Alternatively, the patient can access their notes online/via the NHS app, and you can go through these yourself.
For the avoidance of doubt, the medicolegal liability for ensuring that there are no contraindications to your prescribing lies entirely with you, and you should not assume that the lack of a positive reply from us means that no contraindications exist.
Yours faithfully

Template text to women aged <55 taking GLP-1 agonists

We have been informed by your private prescriber that you are taking weight loss injections. Tirzepatide (Mounjaro) may mean that your contraception pills do not work effectively. If you are using the contraceptive pill, please use condoms for four weeks after each dose change, to avoid an unwanted pregnancy. This does not apply to semaglutide (Ozempic). Please contact the practice if you want to discuss your contraception.

Template text to women taking GLP1 agonists and using oral progestogens (alone, or in combined oral HRT)

We have been informed by your private provider that you are using weight loss injections. These may have an impact on the effectiveness of your HRT to adequately protect your endometrium (womb lining). Please do contact the practice for a review so that we can discuss potential alternatives.

References

1) Mahase E. Weight loss drugs: New online pharmacy checks have "significant" GP workload implications *BMJ* 2025; 388 :r295
2) FSRH. Glucagon-like peptide-1 (GLP-1) agonists and oral contraception. Jan 2025.
3) FSRH. Progestogen only pills. Aug 2022.
4) FSRH. Combined hormonal contraception. Oct 2023.
5) FSRH. Emergency contraception. July 2023.
6) BMS. Use of incretin-based therapies in women using hormone replacement therapy (HRT). Apr 2025.
7) BMS. Management of unscheduled bleeding on hormone replacement therapy (HRT). Apr 2024.
8) BMS. HRT preparations and equivalent alternatives. Mar 2022.

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