OBESITY CARE ADVOCACY NETWORK

NEW PROGRAM STARTS JULY 1, 2026

Medicare GLP-1 BRIDGE

QUESTIONS & ANSWERS

for Patients, Providers, Pharmacies, and Advocates

PROGRAM STARTS JULY 1, 2026

A program giving Medicare members access to obesity treatments at a flat **$50/month.**

Understanding the Bridge Program

Q: What is the GLP-1 Bridge Program?

A: The Medicare GLP-1 Bridge program will provide eligible Medicare beneficiaries with access to obesity medications starting July 1, 2026. The program will operate outside the Medicare Part D payment system and will be administered through a central processor.

Q: When does the GLP-1 Bridge program start?

A: Starting July 1, 2026, providers can send prescriptions for GLP-1s to pharmacies for eligible Medicare beneficiaries.

Why do we need the GLP-1 Bridge program?

For decades, Medicare Part D has been statutorily prohibited from covering weight-loss medications, meaning older adults living with obesity have not been able to access obesity medications. The Bridge program is the Centers for Medicare & Medicaid Services (CMS)'s mechanism for opening that door immediately to Medicare beneficiaries to have coverage for medications for obesity.

Q: How will the Bridge program be run?

A: The Bridge program will be run by CMS, under the 402 authority, outside the standard Medicare Part D benefit.

For medical conditions like type 2 diabetes, moderate-to-severe sleep apnea, or metabolic dysfunction-associated steatohepatitis (MASH), beneficiaries will continue to receive their medications through their Part D plan. Understanding the distinction will help providers avoid the common mistake of submitting prescriptions to the wrong place and will help advocates push back when patients encounter unnecessary barriers to access.

3 ELIGIBILITY & CLINICAL CRITERIA

Who Qualifies?

Q: Who is eligible for the GLP-1 Bridge program?

A: If you are a Medicare Part D enrollee in a standalone prescription drug plan (PDP), Medicare Advantage prescription drug (MA-PD) plan, Special Needs Plans (SNP), or dual-eligible beneficiary, you are eligible for the Bridge program.

Patients in private, fee-for-service plans, section 1876 cost contract plans, fallback plans, and religious fraternal benefit plans, are excluded unless they also hold a standalone PDP.

PACE enrollees are excluded entirely because PACE is a fully integrated care model that wraps all Medicare and Medicaid benefits into a single program. PACE participants cannot simultaneously hold a standalone PDP and therefore have no pathway to Bridge eligibility.

Q: What clinical criteria must be met for eligibility?

A: To receive a prescription for a GLP-1 under the Bridge program, a provider must attest via prior authorization (PA) that the patient meets one of three clinical pathways based on body mass index (BMI) and health status at the time GLP-1 therapy is initiated. The thresholds are:

- BMI 35 or above for weight management alone,
- BMI 30 AND a diagnosis of one or more of the following: (A) heart failure with preserved ejection fraction, (B) uncontrolled hypertension (defined as systolic blood pressure above 140 mm Hg or diastolic blood pressure above 90 mm Hg, despite concurrent treatment with two antihypertensive medications), or (C) chronic kidney disease stage 3a or above,
- BMI 27 AND a diagnosis of one or more of the following: (A) pre-diabetes (B) previous myocardial infarction, (C) previous stroke, or (D) symptomatic peripheral artery disease.

Q: How should providers approach eligibility for patients who are already on GLP-1 therapy?

A: Eligibility is anchored to the patient's clinical status at the time GLP-1 therapy is initiated, not at the time of the prior approval request. For example, a patient who began therapy with a BMI of 37 and is now at 32 because the medication is working still qualifies; that is precisely the intended outcome. Providers must document the baseline BMI clearly in the medical record so that when the PA is submitted, they can attest accurately to the initiation criteria.

How Prescribing Works

Q: What is the prescribing process under the Bridge, and how should practices prepare before July 1?

A: Humana is serving as the CMS central processor for the Bridge, managing all prior authorization (PA) review and claims adjudication.

The provider must submit a prescription for one of the eligible GLP-1 medications to the beneficiary's pharmacy using your standard process. In the submission, the provider should direct the pharmacist to send the claim directly to Medicare GLP-1 Bridge by including an obesity diagnosis code (the E66 family) and indicating "SEND TO BRIDGE FOR WEIGHT MANAGEMENT" on the prescription in the "Note" field if electronic, or as an annotation if non-electronic.

Note: If the pharmacist doesn't get that direction, they might send the claim to the beneficiary's Part D plan who will reject the claim.

Q: What happens if a provider submits the PA to the Part D plan instead of through the central processor, Humana?

A: CMS has directed Part D plans to redirect pharmacists to send the central processor rather than issue a denial. Patient appeal rights under Part D remain fully intact for any indications that are separately coverable; a protection that advocates and providers should be prepared to cite as needed.

Q: What is the prior authorization process under the Bridge?

A: Once the pharmacy transmits a claim to the central processor, Medicare will confirm the patient's eligibility. If the claim is denied at this step, the pharmacy will get instructions on how to resubmit the claim.

If the patient is eligible, the central processor will still deny the claim but will instruct the pharmacy that a prior authorization is necessary, and the pharmacy will send the prior authorization request form the provider, typically within 24-72 hours.

Providers must wait to get the request from the pharmacy electronically or by fax for beneficiaries to be covered under Bridge.

The PA form is available on the CMS site for reference; starting on July 1st, once the provider receives the request, the PA form will need to be submitted to the central processor.

Q: Which medications are covered under the Bridge, and what should prescribers and pharmacists know about formulary boundaries?

A: As of spring 2026, three products are covered for weight management: Wegovy, Zepbound,and Foundayo. Only the KwikPen formulation of Zepbound qualifies; the single-dose vial and pen are excluded. All doses of the Wegovy pens and the Wegovy pill are covered.
Ozempic and Mounjaro are not covered under the Bridge. Prescribers and pharmacists should also be aware that when these same drugs are prescribed for a separately coverable Part D indication, such as type 2 diabetes, moderate-to-severe sleep apnea, or metabolic dysfunction-associated steatohepatitis (MASH) , those claims route through the Part D plan as usual, not through the Bridge.

5 PHARMACY & DISPENSING

Pharmacy Operations

Q: What operational changes should pharmacies implement ahead of the July 1 launch?

A: No opt-in is required for pharmacies to participate in the Bridge program. The most critical change is knowing which Bank Identification Number (BIN) and Processor Control Number (PCN) to use. Bridge claims must be routed using BIN 028918 and PCN MEDDGLP1BR, not to the patient's Part D plan. Claims submitted to the plan will result in a rejection. Pharmacies should be aware that while Humana serves as the overall program administrator, pharmacy claims are processed by SS&C Health and routed through RelayHealth; it is the RelayHealth network that pharmacies will encounter in their dispensing systems, not Humana directly.

CMS will be conducting outreach ahead of launch, but pharmacies should not wait to update their internal workflows and train dispensing staff before July 1.

Q: How should pharmacists counsel patients on the cost structure?

A: Patients pay a flat $50 per monthly supply at the pharmacy counter, regardless of their Part D benefit. Medicare Low-Income Subsidies (LIS) do not apply to Bridge claims. Providers and pharmacists should proactively ensure patients understand that their $50 copay does not count toward their Part D out-of-pocket maximum or deductible, a distinction that can catch patients off guard at year-end, particularly those carefully tracking their true out-of-pocket costs. Clear counseling prevents downstream frustration and supports adherence.

IMPORTANT PHARMACY INFORMATION

BIN
028918

PCN
MEDDGLP1BR

ROUTING
RelayHealth
Do not submit claims to the patient's Part D plan.

WHAT PATIENTS PAY

$50
PER MONTH
per 30-day supply

- Flat monthly cost
- Does not count toward Part D out-of-pocket maximum
- Your Part D plan is not billed

Helping Patients Navigate Access

Q: What has the coverage landscape looked like for patients living with obesity under Medicare, and why is the Bridge a meaningful shift?

A: For patients living with obesity, the road to treatment through Medicare has been defined by exclusion. Unlike virtually every other chronic disease, obesity has been treated differently, and the statutory exclusion of obesity medications from Part D has reinforced that stigma at a systemic level. The GLP-1 Bridge program represents the first time Medicare has meaningfully opened the door to pharmacological treatment for obesity as a disease. For advocacy organizations, this moment calls for urgent action to ensure patients know their access has changed.

Q: What are the priority actions for advocacy leaders when it comes to the Bridge program?

A: Three areas demand immediate focus: awareness, navigation, and equity. On awareness, many patients and providers do not yet know this coverage is coming. OCAN's survey of older Americans demonstrated that upwards of 82 percent of the Medicare population was unaware that a new program will be available soon, even though more than a quarter have been medically cleared for obesity treatment. On navigation, advocacy organizations should develop plain-language guidance on how the Bridge process works, what the $50 copay means in practice, and what to do if something goes wrong at the pharmacy. On equity, dual-eligible and low-income populations face the greatest risk of falling through the cracks, both because of the copay burden and plan type exclusions.

Q: How does the Bridge program relate to the BALANCE model?

A: They are related but distinct. CMS has said that the Bridge program will run through the end of 2027 and is deliberately simple; one central processor, one flat copay, no Part D plan opt-in required. BALANCE is a full Center for Medicare and Medicaid Innovation (CMMI) demonstration model that will eventually be woven into the Part D structure with outcome-based accountability and more robust lifestyle support components. At this time, the earlies the BALANCE program will be ready to launch in Medicare will be January 1, 2028.

OBESITY CARE ADVOCACY NETWORK

RESOURCES

- Prescriber Fact Sheet
- Pharmacy Fact Sheet
- Prior Auth Fact Sheet
- CMS Payer Sheet

Visit **obesitycareadvocacynetwork.com** to learn more.

Submit technical questions to the Medicare GLP-1 Bridge mailbox at **glp1demo@cms.hhs.gov**.

If you are a person with Medicare and have questions about Medicare coverage, please contact **1-800-MEDICARE** for assistance. Beneficiaries in need of coverage should contact **1-800-MEDICARE** or their local State Health Insurance Assistance Program (SHIP).