Claims about GLP-1 medicines are everywhere—from online marketplaces and social media channels to clinics and conversations with friends. Some claims are supported by strong research; others stretch the evidence, omit important conditions, or promote products that are not the medicines studied in clinical trials. Knowing the difference matters when a treatment can affect your health, finances, and long-term approach to weight management.

"Evidence-based" does not mean that a medicine works for every person or has no risks. It means that decisions are informed by the best available research, interpreted in context, and considered alongside a person's health, preferences, and circumstances. For GLP-1 receptor agonists, that means looking beyond dramatic before-and-after photos to randomized controlled trials (RCTs), clinical guidance, and real-world monitoring.

What are GLP-1 medicines, and how do they work?

GLP-1 stands for glucagon-like peptide-1, a hormone involved in blood sugar regulation and appetite. GLP-1 receptor agonists act on receptors for this hormone. Depending on the medicine and dose, they can help the body release insulin when blood sugar is high, reduce glucagon release, slow stomach emptying, and increase feelings of fullness. These effects may help people eat less and lose weight.

Semaglutide is one GLP-1 receptor agonist. Ozempic and Wegovy are brand names for semaglutide products, but they are not interchangeable labels for the same treatment plan. Products can differ in their approved purpose, dose, and prescribing instructions. Ozempic is primarily used to treat type 2 diabetes, while Wegovy is approved for chronic weight management in eligible patients in the US. Approval and access rules vary by country, so a product's name alone does not tell you whether it is appropriate for weight loss.

GLP-1 medicines are not "fat burners," and they do not replace nutrition, movement, sleep, or support for the factors that influence weight. They may make changes in eating patterns more achievable, but responses vary. Weight can also increase after stopping treatment, so a responsible plan considers what ongoing care may look like—not just the first few months.

What do the STEP trials tell us?

The STEP program included large RCTs studying semaglutide for weight management. In a randomized controlled trial, participants are assigned to different treatment groups by chance. This helps researchers compare outcomes while reducing the influence of factors that could otherwise distort the results. Many STEP studies compared semaglutide with placebo, with both groups receiving lifestyle support.

Study What it examined Headline result What to keep in mind STEP 1 Semaglutide 2.4 mg in adults with overweight or obesity, without diabetes At 68 weeks, average body-weight change was about −14.9% with semaglutide and −2.4% with placebo. Participants also received lifestyle intervention; an average is not a guarantee for an individual. STEP 2 Adults with overweight or obesity and type 2 diabetes At 68 weeks, average weight change was about −9.6% with semaglutide 2.4 mg and −3.4% with placebo. Results in people with diabetes may differ from results in people without diabetes. STEP 4 Continuing semaglutide versus switching to placebo after an initial treatment period People who continued treatment generally lost more weight, while those switched to placebo regained weight on average. This highlights the importance of planning for treatment duration and follow-up. STEP 5 Longer-term treatment over two years Average weight loss was maintained with continued semaglutide treatment. Trial results describe a study population, not every person's likely experience.

These results are clinically meaningful, but a headline percentage is not the whole story. Trial participants met specific criteria, received structured follow-up, and were monitored under research conditions. Some participants stopped treatment, and some experienced side effects. Trials also have limits: their participants may not reflect everyone who might seek treatment, and a study may not answer every question about long-term use, affordability, or access.

RCTs are a strong way to test whether a treatment can work under controlled conditions. They do not prove that every online claim is true, nor do they tell a clinician everything needed to prescribe safely to one person. Good evidence includes the trial result, its limitations, the quality of follow-up, and how the findings fit an individual's situation.

How to assess a weight-loss claim

When you see a claim on social media channels, in an advertisement, or through online marketplaces, ask what evidence supports it. A credible claim should be traceable to a named medicine, dose, population, and study—not just a testimonial or a "clinically proven" badge.

- **Look for RCTs and published results.** Ask whether the claim refers to a randomized controlled trial, a smaller observational study, or a personal story.
- **Check the comparison.** Was the medicine compared with placebo, another treatment, or no treatment? Did both groups receive lifestyle support?
- **Check the time frame and dose.** Results after a year or more at a studied dose cannot automatically be applied to a different dose or a short course.
- **Look at the full outcome.** Average weight loss is useful, but it does not show how many people stopped treatment, experienced side effects, or regained weight after stopping.
- **Be cautious with guarantees.** Claims such as "lose a specific amount in a month" or "no side effects" are warning signs.
- **Verify the supply and prescriber.** A marketplace listing or social media post is not evidence that a product is authentic, legally supplied, or suitable for you.

Observational studies and real-world data can add useful information about how treatments perform outside trials. However, they can be affected by differences between people who do and do not receive a medicine. They complement RCTs; they do not automatically replace them.

NICE guidance and eligibility

In the UK, the National Institute for Health and Care Excellence (NICE) assesses treatments and publishes recommendations for the NHS. NICE guidance is not the same as a universal rule for every country, and eligibility can depend on the specific medicine, indication, local service, and the latest guidance. In the US, prescribing and coverage decisions follow different regulatory and insurance systems.

NICE technology appraisal TA875 recommends semaglutide for weight management only in defined circumstances. Its published criteria include adults with at least one weight-related comorbidity and an initial body mass index (BMI) of 35 kg/m^2 or higher, with a lower BMI threshold of 2.5 kg/m^2 for some people from certain ethnic backgrounds. Treatment is recommended alongside a reduced-calorie diet and increased physical activity, within a specialist weight management service. NICE also specifies a maximum treatment duration of two years under this recommendation. Guidance and service arrangements can change, so patients and clinicians should check current NICE and local NHS information.

Eligibility is not simply a matter of reaching a particular weight or obtaining a prescription online. A clinician may review health conditions, current medicines, prior treatment, potential benefits and risks, and whether specialist support is available. BMI is one tool, not a complete measure of health or an individual's worth. It should be interpreted in context.

Side effects and real-world monitoring

Evidence-based care includes discussion of harms as well as benefits. Nausea, diarrhea, vomiting, constipation, and abdominal discomfort are common, particularly during dose escalation. For many people these symptoms improve, but persistent or severe symptoms deserve medical attention. Vomiting or diarrhea can lead to dehydration, which may be especially concerning for people with kidney problems or those taking medicines affected by fluid loss.

Less common but important risks include gallbladder problems and pancreatitis. People with diabetes may need careful blood sugar monitoring, especially if they also use insulin or a sulfonylurea, because the risk of low blood sugar can increase when treatments are combined. In some people with diabetes, rapid improvement in blood sugar can affect existing diabetic eye disease. A prescriber should review relevant medical history and other medicines before treatment.

Semaglutide is generally not used during pregnancy for weight loss. Anyone who is pregnant, planning pregnancy, or breastfeeding should discuss treatment with a qualified clinician. A clinician may also advise stopping before a planned pregnancy; the timing should follow the product information and individualized medical advice.



Real-world monitoring means more than checking the number on a scale. A care team may review dose changes, side effects, hydration, nutrition, physical activity, blood pressure, relevant laboratory results, blood sugar in people with diabetes, and changes in other health conditions. Follow-up also helps assess whether the medicine is providing meaningful benefit and whether the plan remains semaglutide for weight loss safe and sustainable.

Useful questions to ask a clinician

- Which product and indication are being considered, and why is it appropriate for me?
- What benefits are realistic for someone with my health history?
- What side effects should prompt a call or urgent medical care?

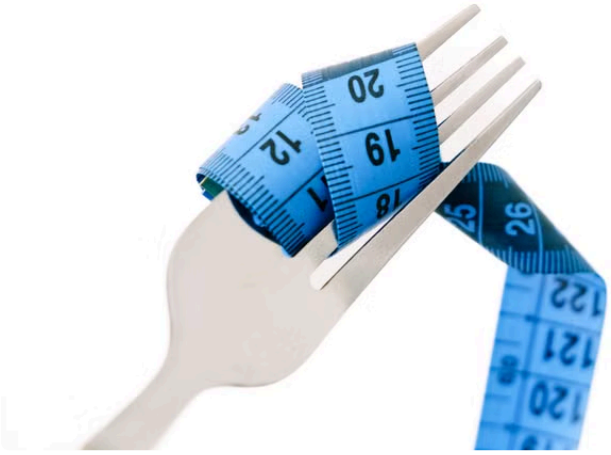
- How will my other medicines and health conditions be monitored?
- What is the plan if the medicine is ineffective, unavailable, or needs to be stopped?
- What nutrition, activity, and behavioral support will accompany treatment?

What “evidence-based” should mean in practice

For GLP-1 weight-loss claims, evidence-based means using reliable research without turning an average trial result into a promise. It means distinguishing Wegovy’s weight-management use from Ozempic’s diabetes indication, checking current local guidance, and discussing both benefits and potential harms with an appropriate prescriber. It also means recognizing that a medicine can be effective in clinical settings while still requiring careful real-world monitoring.

Online marketplaces and social media channels can make access and information feel immediate, but neither replaces a clinical assessment. Be skeptical of unverified products, pressure to buy quickly, and claims that promise effortless or guaranteed results. A qualified clinician or pharmacist can help verify legitimate supply and explain whether treatment fits your needs.

GLP-1 medicines can be valuable tools for some people. The strongest approach combines credible evidence, individualized prescribing, ongoing monitoring, and practical support for health behaviors. That is a more useful standard than any single testimonial, viral post, or headline percentage.



Selected evidence and guidance

- Wilding JPH et al. “Once-Weekly Semaglutide in Adults with Overweight or Obesity.” *New England Journal of Medicine*. 2021;384:989–1002 (STEP 1).
- Davies M et al. “Semaglutide 2·4 mg once a week in adults with overweight or obesity, and type 2 diabetes (STEP 2).” *The Lancet*. 2021;397:971–984.
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- National Institute for Health and Care Excellence (NICE). Technology appraisal TA875, *Semaglutide for managing overweight and obesity*. Check NICE for current recommendations and local service details.