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TOGETHER, REACHING WEIGHT LOSS GOALS IS POSSIBLE[1,2]

“Tirzepatide, The First*-and-Only† GIP/GLP-1 Dual Agonist for Chronic Weight Management”

*한국 식품의약품안전처 2023년 6월 허가 기준
†2025년 8월 기준

Speaker

인제의대 일산백병원 가정의학과
윤영숙

References 1. Jastreboff AM, Aronne LJ, Ahmad NN, et al. Tirzepatide Once Weekly for the Treatment of Obesity. N Engl J Med . 2022 Jul 21;387(3):205-216. **2.** 식품의약품안전처, 마운자로바이알주(터제파타이드) 허가사항 (accessed on 10-Jul-2025).

Conflict of Interest

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- I have the following financial relationships to disclose
  - Honoraria (Lecture fee) from: Lilly Korea Ltd.
  - Consultation fee from: Lilly Korea Ltd.

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Why obesity management is important?

Biological Adaptations Make it Difficult for Some People Like Andrea to Reduce Weight and Maintain it.[1-4]

Hunger and satiety hormones from the gastrointestinal tract, pancreas and adipose tissue regulate food intake and energy expenditure. However, with weight reduction, this regulation is altered.[1,2]

Changes in hunger and satiety hormones result in increased appetite and **decreased feelings of satiety**[1-3]

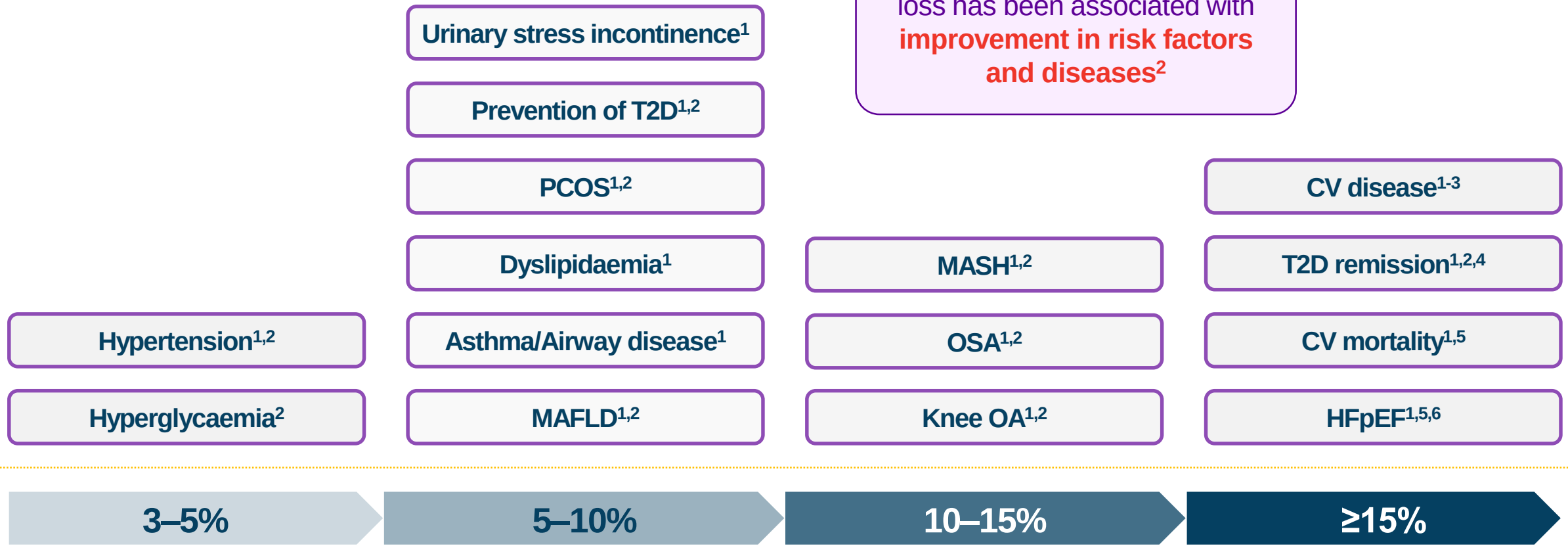
Changes in metabolism are characterized by **decreased energy expenditure**[3]

Lifestyle modifications alone may not be enough to overcome these adaptations.
Unsuccessful weight reduction and weight regain may increase the risk of obesity-related complications.[2-4]

References: 1. Sumithran P, et al. *N Engl J Med*. 2011;365(17):1597-1604. **2.** Apovian CM, et al. *J Clin Endocrinol Metab*. 2015;100(2):342-362. **3.** Hall KD, et al. *Med Clin North Am*. 2018;102(1):183-197. **4.** Fruh SM. *J Am Assoc Nurse Pract*. 2017;29(S1):S3-S14.

Treating obesity may improve or prevent significant obesity-related complications[1-6]

Greater weight loss has been associated with **improvement in risk factors and diseases**[2]



CV=cardiovascular; **HFpEF=**heart failure with preserved ejection fraction; **MAFLD=**metabolic dysfunction-associated fatty liver disease; **OA=**osteoarthritis.

References: 1. Garvey WT, *et al. Endocr Pract.* 2016;22(suppl 3):1-203. **2.** Horn DB, *et al. Postgrad Med*. 2022;134(4):359-375. **3.** Look AHEAD Research Group. *Lancet Diabetes Endocrinol*. 2016;4(11):913-921. **4.** Lean ME, *et al. Lancet*. 2018;391(10120):541-551. **5.** Benraoune F, *et al. Curr Opin Cardiol*. 2011;26(6):555-561. **6.** Sundström J, *et al. Circulatio*n. 2017;135(17):1577-1585.

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What is Mounjaro and why is it different to GLP-1 RAs?

The proposed roles of GIP and GLP-1 in the regulation of metabolism[1–4]*

*Pre-clinical data from animal studies do not necessarily predict clinical studies.

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BRAIN

GIP activity

↓ Reduced food intake

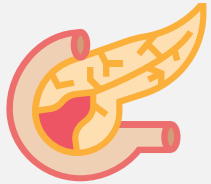
↓ Reduced nausea

GLP-1 activity

↓ Reduced food intake

↑ Increased satiety

PANCREAS



GIP activity

↑ Increased insulin

↑ Increased glucagon in a glucose-dependent way

GLP-1 activity

↑ Increased insulin

↓ Reduced glucagon

SUBCUTANEOUS WHITE ADIPOSE TISSUE

GIP activity

↑ Increased insulin sensitivity

↑ Increased lipid-buffering capacity

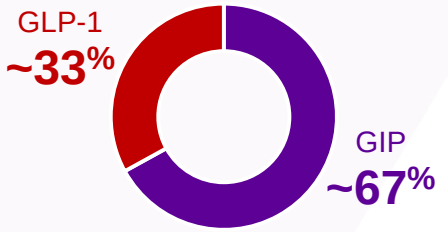
↑ Increased storage capacity

STOMACH

GLP-1 activity

↓ Reduced gastric emptying

GIP is responsible for **~2/3 of the incretin effect** in healthy humans without T2D[5]



References: 1. Samms RJ, *et al. Trends Endocrinol Metab* 2020; 31(6): 410–21. **2.** Roh E, *et al. Int J Mol Sci* 2023; 24(4): 3384. **3.** Borner T, *et al. Diabetes* 2021; 70(11): 2545–53. **4.** Hayes MR, *et al. Diabetes* 2021; 70(9): 1956–61. **5.** Nauck MA, Meier JJ. *Diabetes* 2019; 68(5): 897–900.

Mounjaro Is a Single Molecule Designed to Activate Both the GIP and GLP-1 Receptors[1,2]

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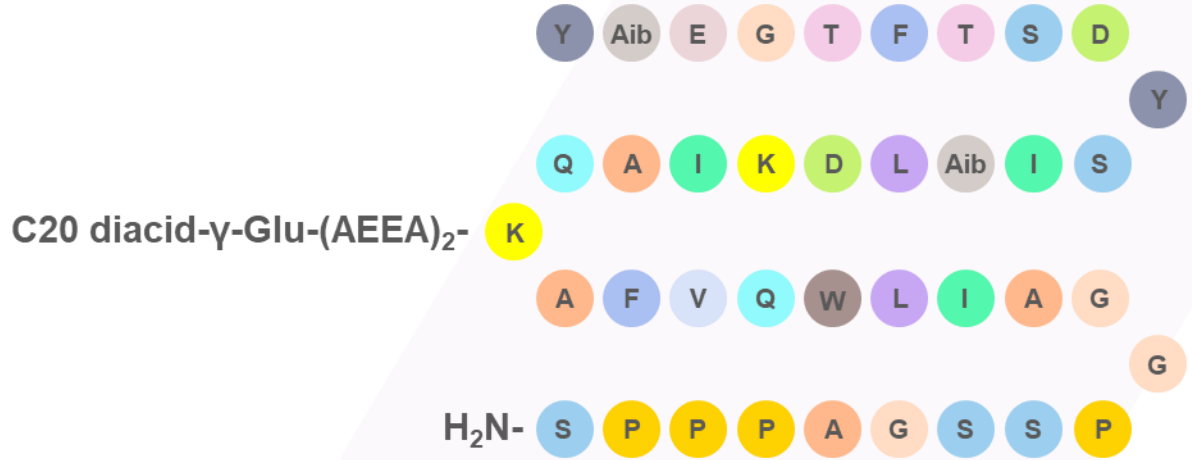
Structure	39-amino-acid modified peptide based on the **native GIP peptide sequence** with a C20 fatty diacid moiety[1,2]
Receptor activity	Activity on the GIP receptor is similar to the native GIP hormone, whereas activity of Mounjaro on the GLP-1 receptor is lower compared to the native GLP-1 hormone[1]
Mean half-life	Approximately **5 days**, enabling once-weekly dosing[1]
Dose adjustment	No dose adjustment of Mounjaro is recommended for patients with renal or hepatic impairment[1]



CHRONIC WEIGHT MANAGEMENT

References: 1. 마운자로 식약처 허가사항(의약품안전나라의약품통합정보시스템(https://nedrug.mfds.go.kr)) [revised on 30 Jul 2024]. **2.** Willard FS, et al. JCI Insight. 2020;5(17):e140532.

Potential Mechanism of Action of Mounjaro

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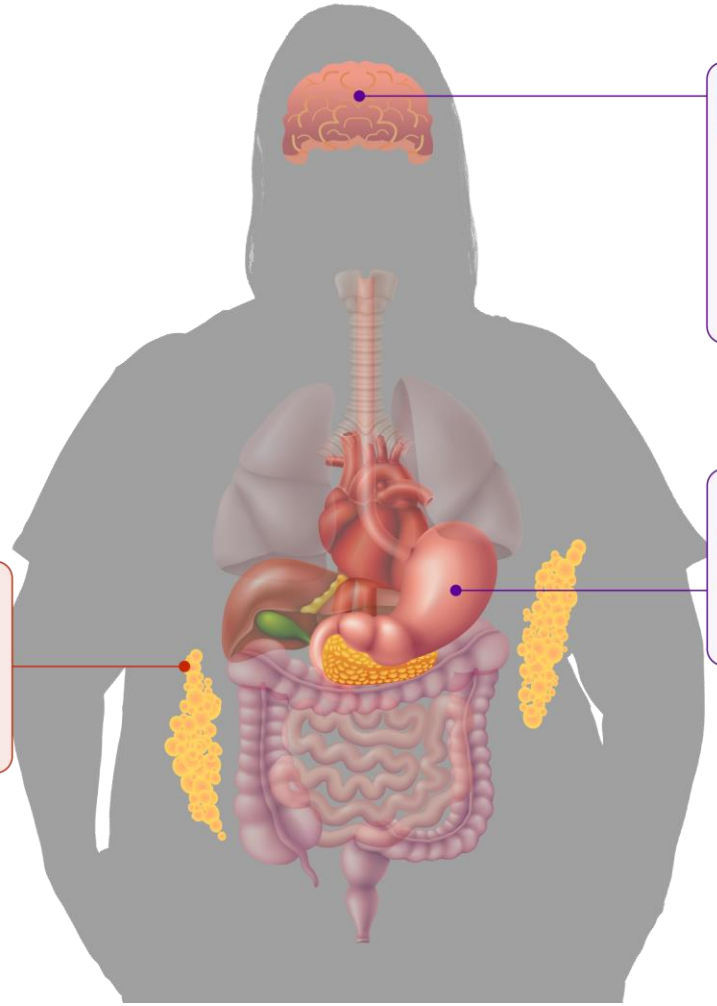

Regulates appetite and feelings of satiety[2]

Both **GIP** and **GLP-1** receptors are found in areas of the brain important for appetite regulation.[2*]

Regulates gastric emptying[2,3]

GLP-1 receptors regulate gastric emptying.[3*]

Regulates fat storage[1,2]

GIP receptors are present in adipose tissue.[2†]

*Pre-clinical data from animal studies do not necessarily predict the results of clinical studies.
†Areas of the body such as the pancreatic α and ß endocrine cells, heart, vasculature, immune cells (leukocytes), gut, and kidney.[1]

Detailed mechanism of action includes information not covered in the Tirzepatide label.
Data presented in the figure come from human and animal studies.

GIP=glucose-dependent insulinotropic polypeptide; **GLP-1**=glucagon-like peptide-1.

References: 1. Jastreboff AM, et al. Tirzepatide Once Weekly for the Treatment of Obesity. N Engl J Med. 2022;387(3):205-216. **2.** Samms RJ, *et al. Trends Endocrinol Metab* 2020; 31(6): 410–21. **3.** Krieger JP. *Peptides* 2020; 131: 170342.

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What is Mounjaro's efficacy and safety profile for people living with chronic weight management issues?

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SURMOUNT-1

Mounjaro 5 mg, 10 mg, and 15 mg vs placebo in adults with overweight or obesity with complications, excluding T2D[1,2]

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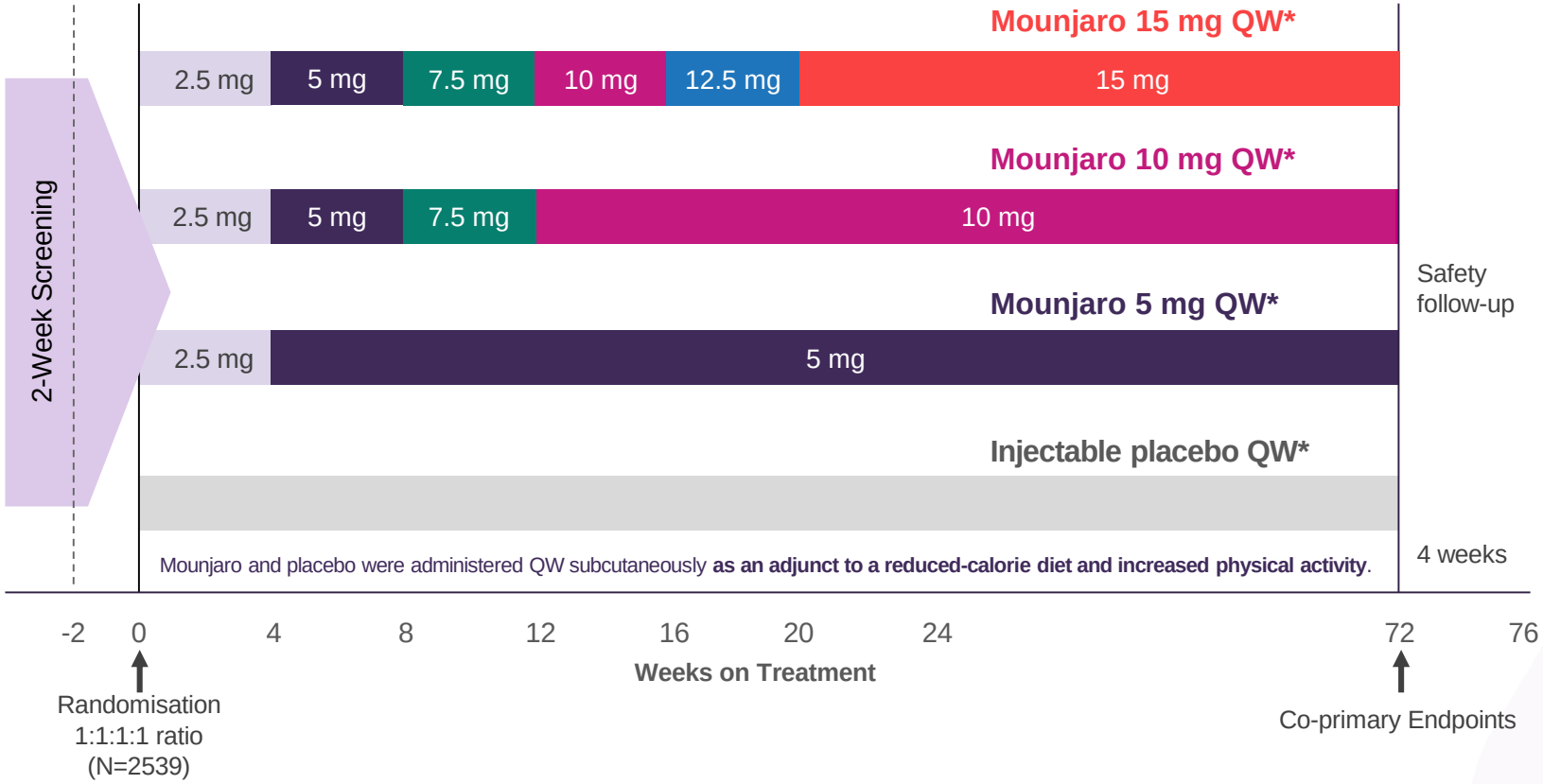

Figure modified from Jastreboff AM, *et al.* 2022.[2]

Brief Study Design[2]

2539 participants

- BMI of ≥30 kg/m² or ≥27 kg/m² to <30 kg/m² and ≥1 weight-related complication†, excluding T2D
- Received instructions for a reduced-calorie diet and increased physical activity*

Co-Primary Endpoints (10 mg and/or 15 mg)[2]

- % change in body weight (baseline to week 72)
- % of participants with weight reduction ≥5% at week 72

Key Secondary Endpoints[2]

Change from baseline to week 72

- Waist circumference (10 mg and/or 15 mg)
- Percentage change in body weight (5 mg)
- Systolic blood pressure, fasting insulin, and lipid levels (all doses combined)

Measured at week 72

- percentage of population with weight reduction of ≥5% at (5 mg)
- percentage of population with weight reduction of ≥10%, ≥15%, and ≥20% (10 mg and/or 15 mg)

Selected Baseline Demographics[1,2]

Mean across treatment conditions (N=2539)

Age	BMI	Waist circumference
44.9 years	38.0 kg/m²	114.1 cm

*Included counselling by a dietitian or qualified healthcare professional, a deficit of 500 calories per day, and at least 150 minutes of physical activity per week.[2] †"Obesity-related complications" is used as synonymic to "weight-related complications and/or comorbidities".[1]

BMI=body mass index; **QW=**once weekly; **T2D=**type 2 diabetes

References: 1. Jastreboff AM, et al. N Engl J Med 2022; 387(3): 205–16. **2**. Jastreboff AM, *et al. N Engl J Med* 2022; 387(3): 205–16 (supplementary appendix).

Results seen at 20 weeks* and continued through 72 weeks with Mounjaro[1,2†‡]

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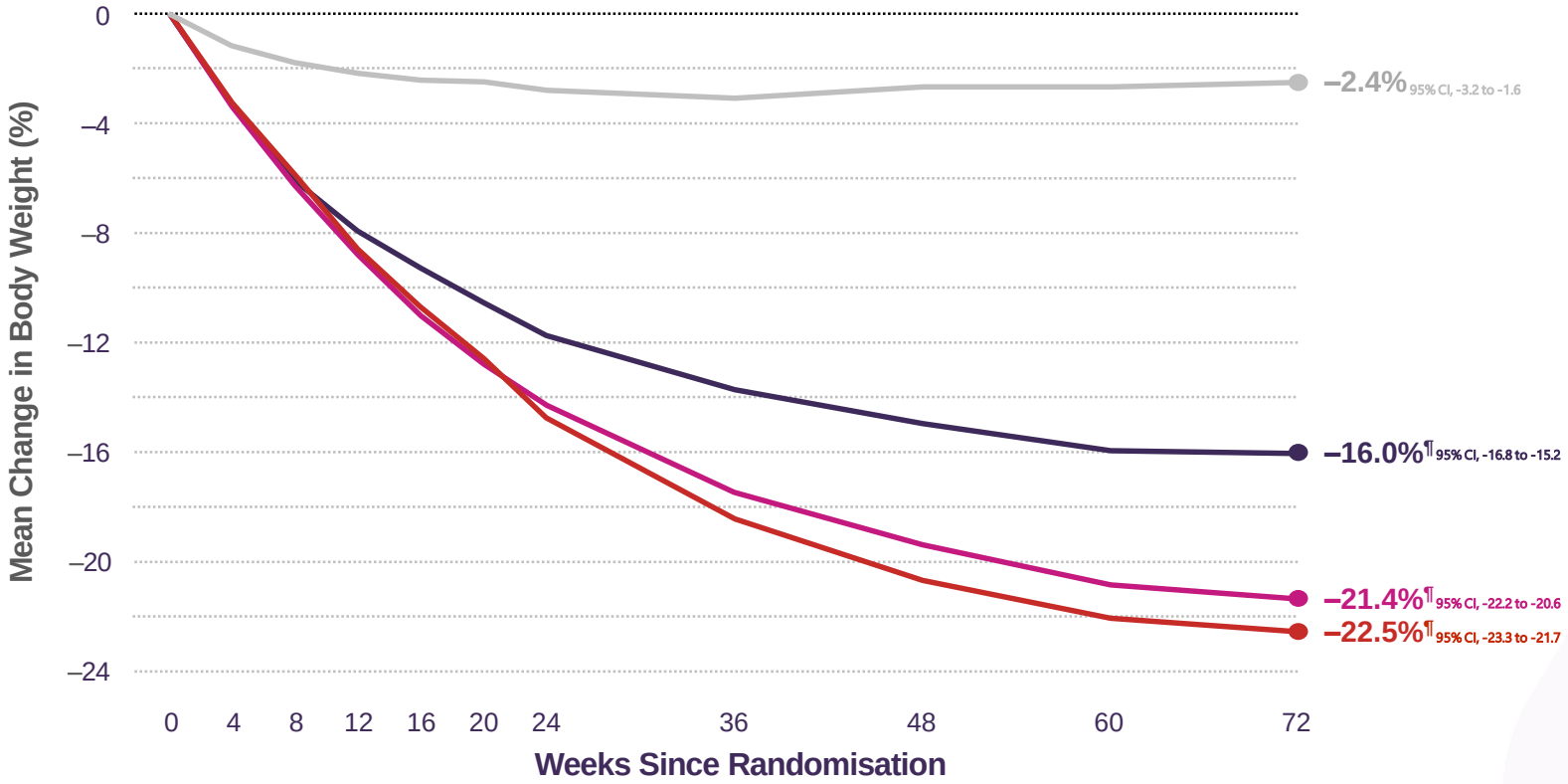
*Estimated treatment difference of pooled Mounjaro from placebo in change from baseline to week 20 in body weight (kg): 95% CI, -10.1(-10.7 to -9.6).[2] †Mounjaro 5 mg, 10 mg or 15 mg vs placebo p<0.001 (co-primary endpoint; secondary endpoint for 5 mg).[1,2] ‡Studied in adults with obesity (BMI of ≥30 kg/m^2) or with overweight (BMI of ≥27 kg/m^2 to >30kg/m^2) with at least 1 obesity-related complication#, excluding type 2 diabetes.[1,2] All participants received lifestyle intervention, including a reduced-calorie diet and increased physical activity.[2]

Percentage change in body weight over time from baseline to Week 72[2‡§]

Mean baseline weight=104.8 kg



–22.5%
mean reduction in body weight
with Mounjaro 15 mg at 72 weeks[1¶]

Figure modified from Jastreboff AM, *et al.* 2022.[2]

§Efficacy estimand, MMRM analysis, mITT population (efficacy analysis set).[2] ¶p<0.001 for percentage difference from placebo (–13.5%, –18.9%, and –20.1%, respectively), adjusted for multiplicity. Efficacy estimand, MMRM analysis, mITT population (efficacy analysis set).[1,2] #"Obesity-related complications" is used as synonymic to "weight-related complications and/or comorbidities."[1]
BMI=body mass index; **mITT=**modified intent-to-treat; **MMRM=**mixed model for repeated measures.
References: 1. Jastreboff AM, et al. N Engl J Med 2022; 387(3): 205–16. **2**. Jastreboff AM, *et al. N Engl J Med* 2022; 387(3): 205–16 (supplementary appendix).

Maintenance dose of Mounjaro 5 mg achieved significant weight reduction compared to placebo[1,2*†]

*Mounjaro 5 mg vs placebo p<0.001 (secondary endpoint).[1,2] † Studied in adults with obesity (BMI of ≥30 kg/m^2) or with overweight (BMI of ≥27 kg/m^2 to >30kg/m^2) with at least 1 obesity-related complication[#], excluding type 2 diabetes.[1,2] All participants received lifestyle intervention, including a reduced-calorie diet and increased physical activity.[2]

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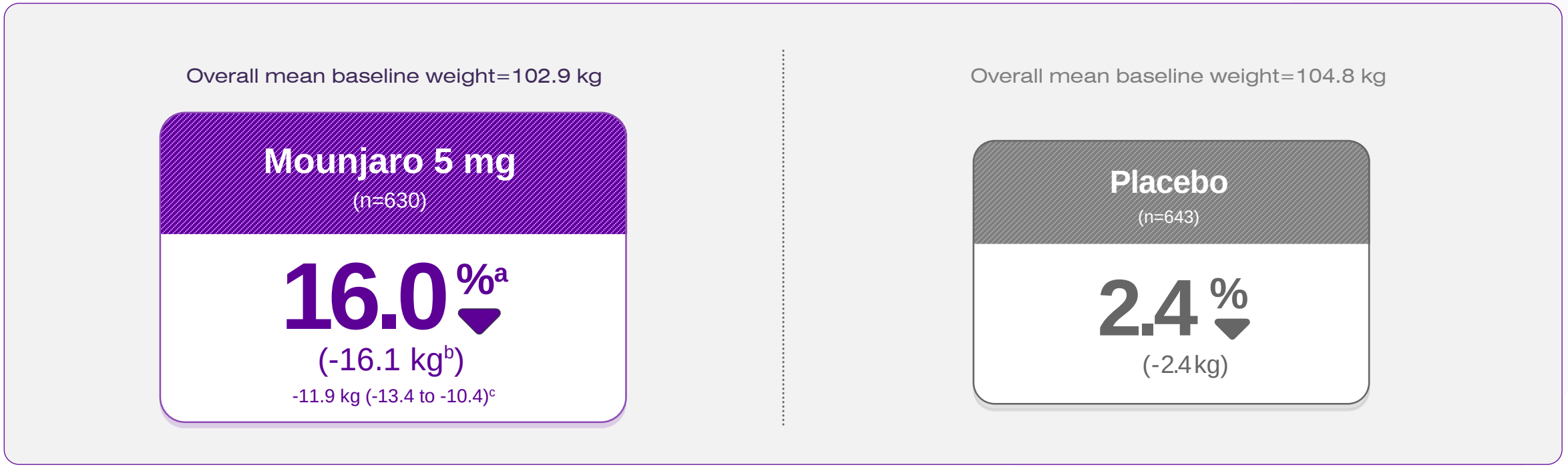
Percentage change in body weight over time from baseline to Week 72[1]



[a] p<0.001 vvs placebo, adjusted for multiplicity.[1]
[b] p<0.001 vs placebo, not adjusted for multiplicity.[1]
[c] Difference from placebo in percentage change in body weight — percentage points .[1]
Efficacy estimand, MMRM analysis, mITT population (efficacy analysis set).[1]
Studied in adults with obesity (BMI of ≥30 kg/m^2) or with overweight (BMI of ≥27 kg/m^2) with at least 1weight-related complication, excluding type 2 diabetes.[1]
All participants received lifestyle intervention, including a reduced-calorie diet and increased physical activity.[1]

References: 1. Jastreboff AM, et al. N Engl J Med 2022; 387(3): 205–16. **2**. Jastreboff AM, *et al. N Engl J Med* 2022; 387(3): 205–16 (supplementary appendix).

SIGNIFICANT reductions in body weight with Mounjaro compared to placebo[1,2*†]

*p<0.001 vs placebo, adjusted for multiplicity (5 mg ≥10% and ≥20% not adjusted for multiplicity).[1,2]

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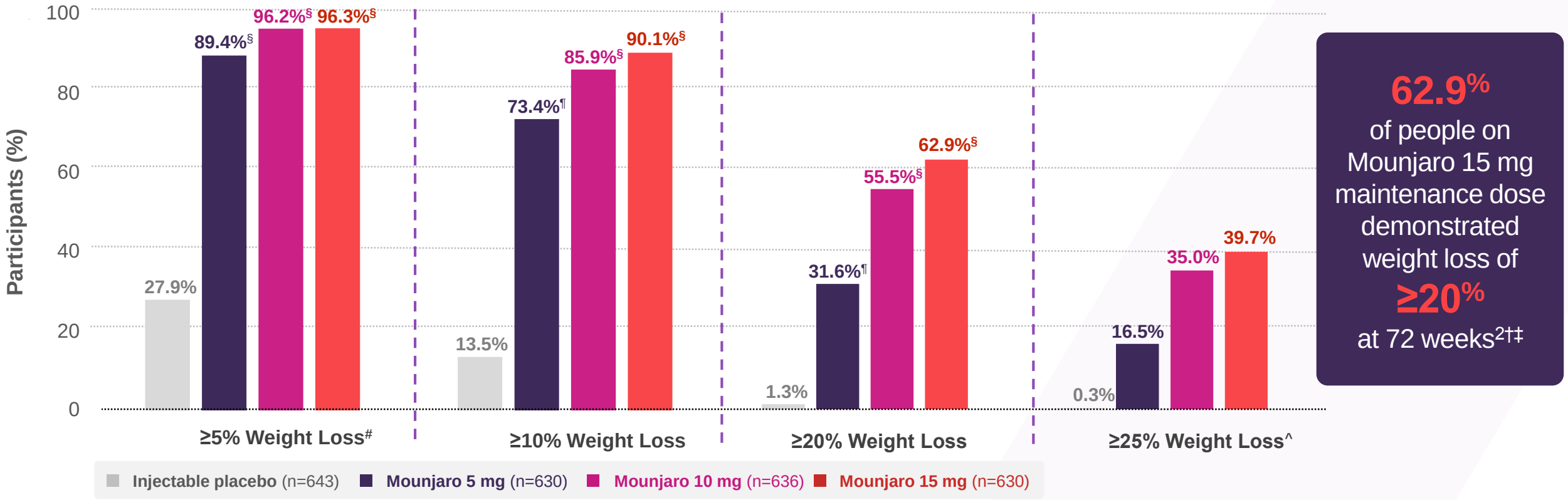
Percentage of participants who achieved ≥5%, ≥10%, ≥20% and ≥25% weight reduction at 72 Weeks[1,2†‡]

Mean baseline weight=104.8 kg



62.9% of people on Mounjaro 15 mg maintenance dose demonstrated weight loss of **≥20%** at 72 weeks[2†‡]

Figure modified from Jastreboff AM, *et al.* 2022.[2]

†Studied in adults with obesity (BMI of ≥30 kg/m²) or with overweight (BMI of ≥27 kg/m² to <30 kg/m²) with at least 1 obesity-related complication¥, excluding type 2 diabetes.[1,2] All participants received lifestyle intervention, including a reduced-calorie diet and increased physical activity.[2] ‡Efficacy estimand, logistic regression analysis.[1,2] §p<0.001 vs placebo, key secondary endpoint (≥5% for 5 mg was an additional secondary endpoint), adjusted for multiplicity.[1,2] ¶p<0.001 vs placebo, not adjusted for multiplicity.[1] #Co-primary endpoint.[2] ^Exploratory endpoint; hypothesis testing was not conducted.[2] ¥Obesity-related complications" is used as synonymic to "weight-related complications and/or comorbidities".[1]

BMI=body mass index.

References: 1. Jastreboff AM, et al. N Engl J Med 2022; 387(3): 205–16. **2**. Jastreboff AM, *et al. N Engl J Med* 2022; 387(3): 205–16 (supplementary appendix).

SURMOUNT-1 safety profile[1,2*]

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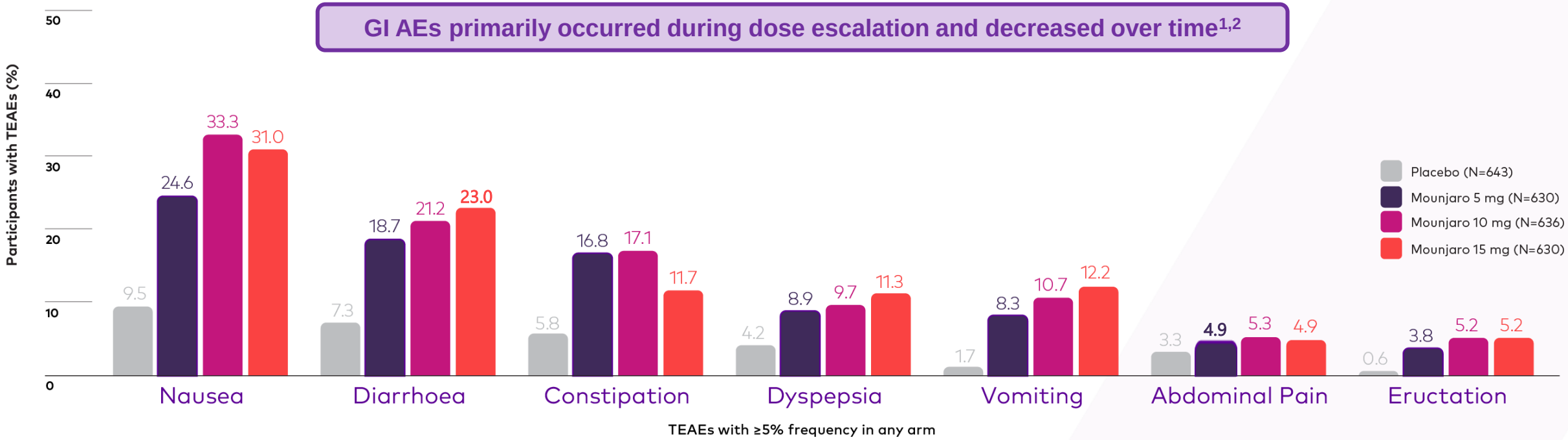
Gastrointestinal-related treatment emergent adverse events[1,2*]

GI AEs primarily occurred during dose escalation and decreased over time[1,2]



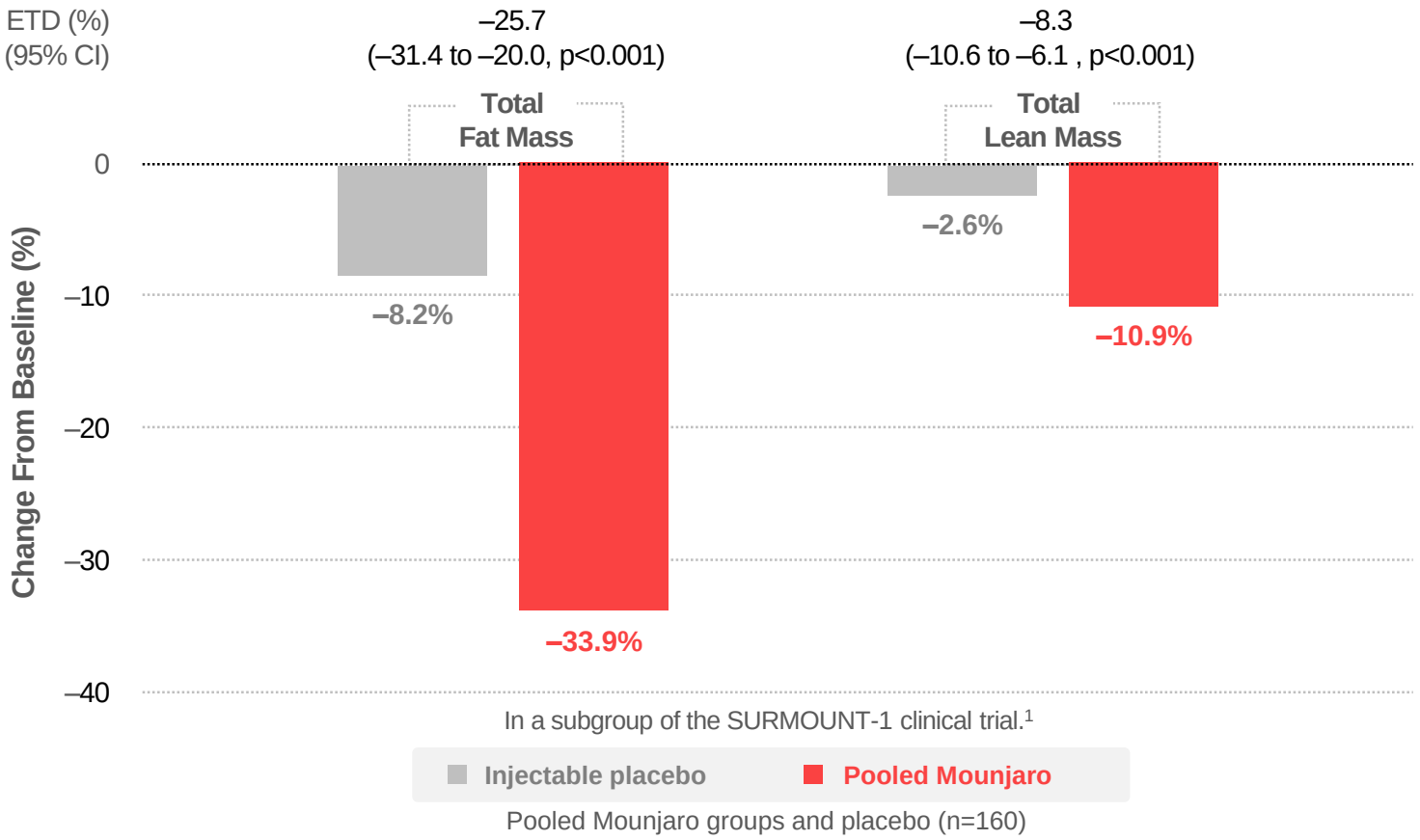
The most frequently reported gastrointestinal-related adverse events were nausea, diarrhoea, and constipation, which occurred in more participants in the Mounjaro groups than placebo[1,2]

†Studied in adults with obesity (BMI of ≥30 kg/m^2) or with overweight (BMI of ≥27 kg/m^2 to <30 kg/m^2) with at least 1 obesity-related complication‡, excluding type 2 diabetes.[1,2] All participants received lifestyle intervention, including a reduced-calorie diet and increased physical activity.[1] ‡"Obesity-related complications" is used as synonymic to "weight-related complications and/or comorbidities".[2]
AE=adverse event; **BMI=**body mass index; **GI=**gastrointestinal; **TEAE=**treatment-emergent adverse event.
References: 1. Jastreboff AM, et al. N Engl J Med 2022; 387(3): 205–16. **2**. Jastreboff AM, *et al. N Engl J Med* 2022; 387(3): 205–16 (supplementary appendix).

People taking Mounjaro experienced improvements in body composition[1*†]

*Subgroup analysis of 160 participants with baseline and week 72 dual energy x-ray absorptiometry (DXA) data.[1]

Percentage change in total fat mass and total lean mass from baseline to Week 72[1†]



In a subgroup of the SURMOUNT-1 clinical trial.[1]

Pooled Mounjaro groups and placebo (n=160)

Reduction in total fat mass was accompanied by a **reduction in visceral fat[1‡]**

"Pooled Mounjaro" refers to pooled Mounjaro 5 mg, 10 mg, and 15 mg groups.

The percentage change in total body fat mass from baseline to week 72 was assessed in a subset of participants who underwent DXA (n=255 enrolled; n=160 completers with both baseline and week 72 DXA data).[1]

†Studied in adults with obesity (BMI of ≥30 kg/m^2) or with overweight (BMI of ≥27 kg/m^2 to <30 kg/m^2) with at least 1 obesity-related complication[§], excluding type 2 diabetes.[1] All participants received lifestyle intervention, including a reduced-calorie diet and increased physical activity.[1] ‡Visceral fat and its accumulation are risk factors for metabolic diseases.[2] §"Obesity-related complications" is used as synonymic to "weight-related complications and/or comorbidities".

BMI=body mass index; **CI=**confidence interval; **DXA=**dual x-ray absorptiometry; **ETD=**estimated treatment difference.

References: 1. Look M, Dunn JP, Kushner RF, et al. Body composition changes during weight reduction with tirzepatide in the SURMOUNT-1 study of adults with obesity or overweight. Diabetes Obes Metab. 2025 May;27(5):2720-2729. **2**. Samms RJ, *et al. Trends Endocrinol Metab* 2020; 31(6): 410–21.

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How does Mounjaro compare to other obesity management medication?

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SURMOUNT-5

The efficacy and safety of Mounjaro was compared to Semaglutide in a Phase 3b trial for 72 weeks[1]

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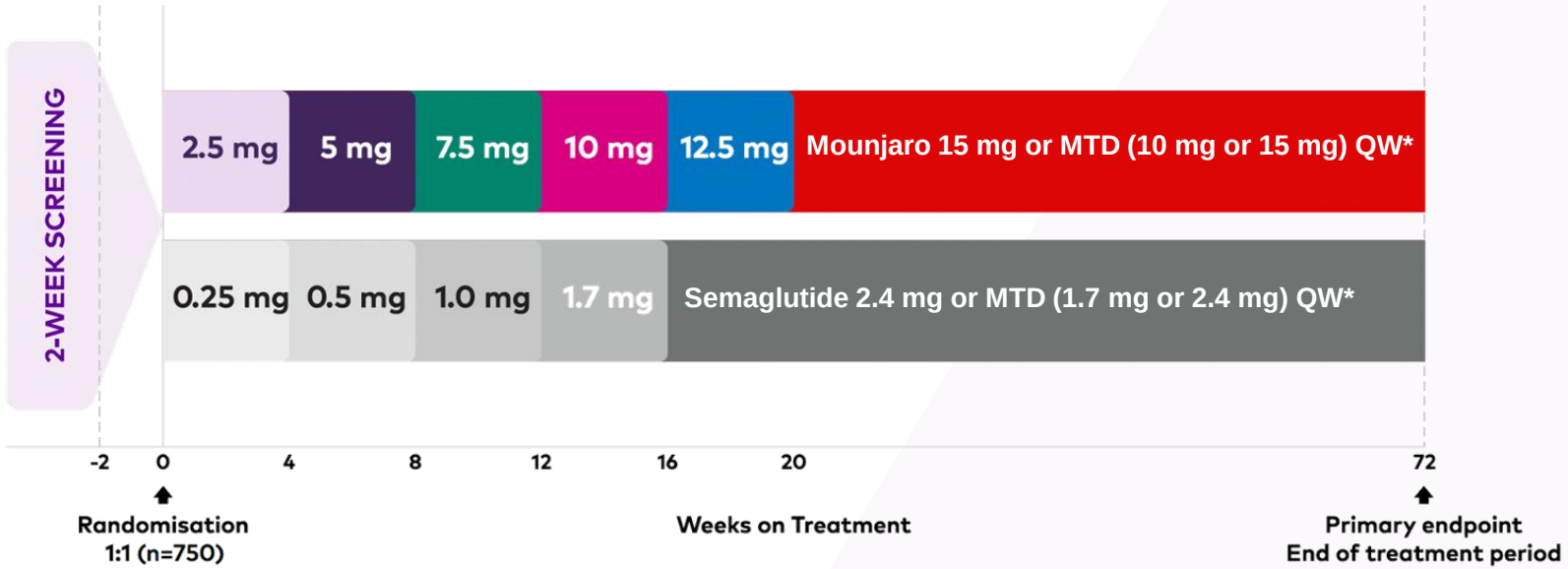
SURMOUNT-5 TRIAL DESIGN

- SURMOUNT-5 was a Phase 3b, head-to-head, open-label clinical trial which assessed the safety and efficacy of Mounjaro vs Semaglutide[1]
- This study included 750 adults living with obesity (BMI of ≥30 kg/m^2) or overweight (BMI of ≥27 kg/m^2) and ≥1 weight-related complication, excluding type 2 diabetes[1]
- Participants in all arms also received instructions for a reduced-calorie diet and increased physical activity[1]*



PRIMARY ENDPOINTS[1‡]

- Mean percentage change in body weight from baseline to 72 weeks

SECONDARY ENDPOINTS[1‡]

- Body weight reductions of ≥10%, ≥15%, ≥20%, and ≥25% from baseline to 72 weeks
- Change in waist circumference (cm) from baseline to 72 weeks

Adapted from Aronne LJ *et al.* 2025.[1]

*Included counselling by a dietitian or qualified healthcare professional, a deficit of 500 kcal per day, and at least 150 minutes of physical activity per week.[1]
†Mounjaro and Semaglutide were administered QW subcutaneously as an adjunct to a reduced-calorie diet and increased physical activity.[1]
‡Primary and key secondary endpoints were adjusted for multiplicity.[1]
BMI=body mass index; **MTD**=maximum tolerated dose; **QW**=once weekly.
Reference: 1. Aronne LJ, et al. N Engl J Med. 2025 Jul 3;393(1):26-36 (including supplement and protocol)..

Demographic and clinical characteristics were similar across treatment groups[1]

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SURMOUNT-5 mean baseline characteristics[1]

	Mounjaro MTD (10 mg or 15 mg) (n=374)	Semaglutide MTD (1.7 mg or 2.4 mg) (n=376)	Total (n=750)
Age (years)	45.0	44.4	44.7
Female sex (%)	64.7	64.6	64.7
Prediabetes at randomisation (%)	57.5	55.9	56.7
Duration of obesity (years)	16.4	14.7	15.6
Body weight (kg)	112.7	113.4	113.0
BMI (kg/m^2)	39.4	39.4	39.4
<35 kg/m^2 (%)	30.7	31.4	31.1
≥35 kg/m^2 (%)	69.3	68.6	68.9
Waist circumference (cm)	117.7	118.8	118.3
Participants with multiple obesity-related complications (%)*	50.0	50.3	50.1

Adapted from Aronne LJ *et al.* 2025.[1]

*Participants were considered to have multiple obesity-related complications if they had two or more complications related to obesity, including a history of conditions reported at screening.[1]
BMI=body mass index; **MTD**=maximum tolerated dose; **QW**=once weekly.
Reference: 1. Aronne LJ, et al. N Engl J Med. 2025 Jul 3;393(1):26-36 (including supplement and protocol)..

SUPERIOR body weight reduction with Mounjaro vs Semaglutide[1]*

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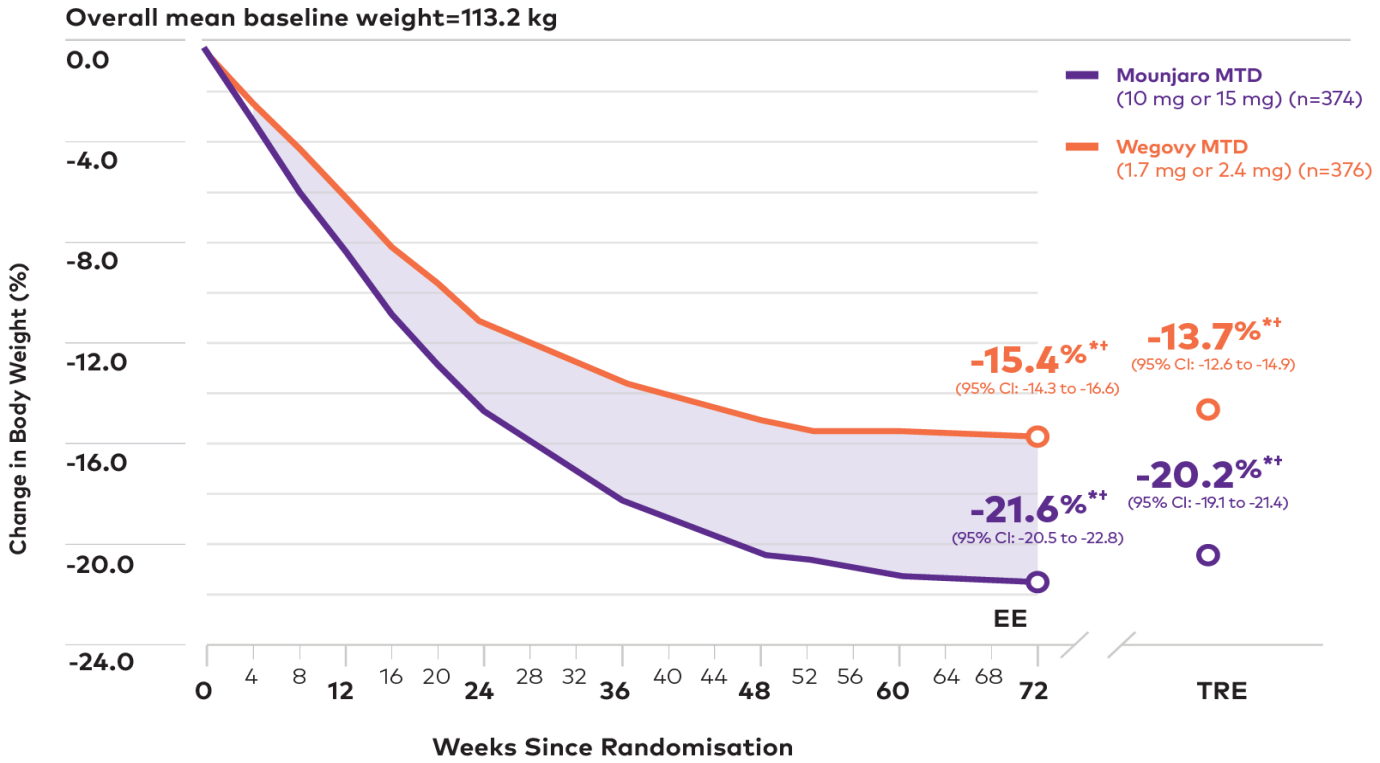
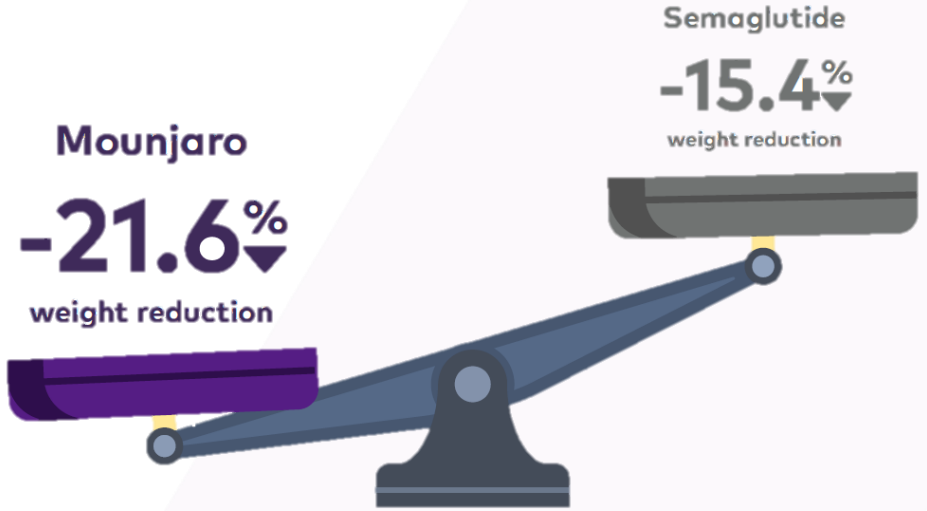
*At 72 weeks, patients taking Mounjaro MTD (maximum tolerated dose; 10 mg or 15 mg) experienced superior mean percentage body weight reduction from baseline of -20.2% vs -13.7% in those taking Semaglutide MTD (1.7 mg or 2.4 mg) using the modified treatment-regimen estimand (47% relative reduction), or -21.6% vs -15.4%, respectively, using the efficacy estimand (40% relative reduction), p<0.001 for both, adjusted for multiplicity, mITT population.[1]

Percentage change in body weight over time from baseline to week 72[1,2]*

Mean baseline weight=113.2 kg





Adapted from Aronne LJ *et al.* 2025[1] and Horn DB *et al.* Presentation at ECO 2025.[2]

†Graph data derived from a MMRM analysis for the efficacy estimand (EE; left side) plus the 72-week estimates for the modified treatment-regimen estimand (TRE; right side).[1]
Limitations of an open-label study may be related to a bias in evaluation of the outcomes, efficacy and/or safety, and analysis was not tested against a placebo-controlled comparison group. However, the consistency of the current findings with those from previous blinded studies support their generalisability.[1]
TRE: Evaluated the treatment effect regardless of premature discontinuation of the trial drug or initiation of other medications for obesity management.[1] EE: Evaluated the treatment effect among participants who had stayed on treatment and not taken other anti-obesity therapies.[1]
mITT=modified intent-to-treat.
References: 1. Aronne LJ, et al. N Engl J Med. 2025 Jul 3;393(1):26-36 (including supplement and protocol).. **2**. Horn DB *et al.* Presentation at the 32nd European Congress on Obesity (ECO), Malaga, Spain, 11–14 May 2025. AD06.02.

~1 in 2 patients taking Mounjaro achieved a body weight reduction target of ≥20%[1]*

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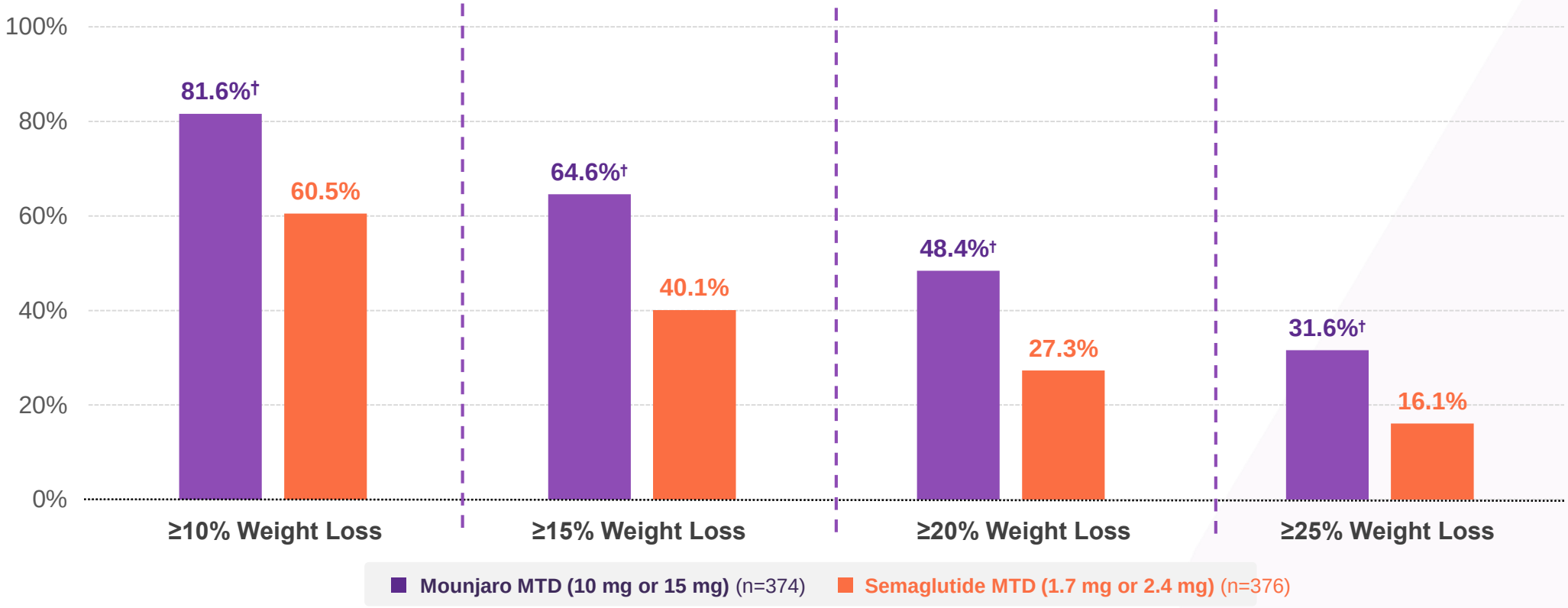
*At 72 weeks, a body weight reduction target of ≥20% from baseline was achieved by 48.4% of patients taking Mounjaro MTD (10 mg or 15 mg) vs 27.3% in those taking Semaglutide MTD (1.7 mg or 2.4 mg), p<0.001, modified treatment-regimen estimand, imputed data, adjusted for multiplicity.[1]

Percentage of participants who achieved weight reduction targets at week 72[1†]

Mean baseline weight=113.0 kg



Adapted from Aronne LJ *et al.* 2025.[1]

†Key secondary endpoint: p<0.001 vs Semaglutide MTD, modified treatment-regimen estimand, imputed data, adjusted for multiplicity.[1]
Limitations of an open-label study may be related to a bias in evaluation of the outcomes, efficacy and/or safety, and analysis was not tested against a placebo-controlled comparison group. However, the consistency of the current findings with those from previous blinded studies support their generalisability.[1]
TRE: Evaluated the treatment effect regardless of premature discontinuation of the trial drug or initiation of other medications for obesity management.[1]
MTD=maximum tolerated dose; **TRE=**treatment-regimen estimand.

Reference: 1. Aronne LJ, et al. N Engl J Med. 2025 Jul 3;393(1):26-36 (including supplement and protocol)..

The overall safety profile of Mounjaro in SURMOUNT-5 was similar to previously reported SURMOUNT trials[1]*

*The study was not powered to compare the safety and tolerability of Mounjaro and the safety and tolerability of Semaglutide.[1]

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The most common adverse events (AEs) with Mounjaro and Semaglutide were **gastrointestinal (GI) in nature** and included nausea, constipation, diarrhoea, and vomiting[1]

These AEs were generally **mild to moderate** in severity[1]

Discontinuation rate and GI AEs
with Mounjaro vs Semaglutide†‡

	Mounjaro MTD (10 mg or 15 mg) (n=374)	Semaglutide MTD (1.7 mg or 2.4 mg) (n=376)
Discontinuation from study treatment due to GI AEs§	**2.7%**	**5.6%**
Discontinuation from study treatment due to AEs	**6.1%**	**8.0%**
Discontinuation from study due to AEs	**1.6%**	**1.6%**
Severe or serious GI AEs	**4.5%**	**3.7%**
GI AEs occurring in ≥10% of participants in both treatment groups[1§]		
Nausea	**43.6%**	**44.4%**
Constipation	**27.0%**	**28.5%**
Diarrhoea	**23.5%**	**23.4%**
Vomiting	**15.0%**	**21.3%**

Adapted from Aronne LJ *et al.* 2025.[1]

†The study was not powered to compare the safety and tolerability of Mounjaro and the safety and tolerability of Semaglutide.[1]
‡Discontinuation rates were not endpoints for SURMOUNT-5. Significance not assessed.[1]
§Gastrointestinal adverse events included nausea, constipation, diarrhoea, and vomiting.[1]
Limitations of an open-label study may be related to a bias in evaluation of the outcomes, efficacy and/or safety, and analysis was not tested against a placebo-controlled comparison group. However, the consistency of the current findings with those from previous blinded studies support their generalisability.[1]
AE=adverse event; **GI=**gastrointestinal; **MTD=**maximum tolerated dose.
References: 1. Aronne LJ, et al. N Engl J Med. 2025 Jul 3;393(1):26-36 (including supplement and protocol)..

Adverse events in SURMOUNT-5[1]

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AEs occurring in ≥5% of participants in either treatment groups[1]

Adverse event, %	Mounjaro MTD (10 mg or 15 mg) (n=374)	Semaglutide MTD (1.7 mg or 2.4 mg) (n=376)
Nausea	43.6	44.4
Constipation	27.0	28.5
Diarrhoea	23.5	23.4
Vomiting	15.0	21.3
Coronavirus disease 2019	13.6	12.5
Fatigue	10.4	12.2
Eructation	9.9	7.7
Injection-site reaction	8.6	0.3
Upper respiratory tract infection	8.6	11.4
Hair loss	8.3	6.1
Abdominal distension	7.2	6.4
Headache	7.2	7.2
Abdominal pain	6.4	6.9
Dizziness	6.4	4.8
Gastro-oesophageal reflux disease	6.1	10.6
Dyspepsia	5.9	7.4
Decreased appetite	4.5	5.1
Nasopharyngitis	4.5	6.1
Sinusitis	2.9	5.6

Adapted from Aronne LJ *et al.* 2025.[1]

Limitations of an open-label study may be related to a bias in evaluation of the outcomes, efficacy and/or safety, and analysis was not tested against a placebo-controlled comparison group. However, the consistency of the current findings with those from previous blinded studies support their generalisability.[1]

AE=adverse event; **GI=**gastrointestinal; **MTD=**maximum tolerated dose.

References: 1. Aronne LJ, et al. N Engl J Med. 2025 Jul 3;393(1):26-36 (including supplement and protocol)..

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Who is indicated for Mounjaro?

Mounjaro is available for 2 different indications

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Chronic weight management*
in adults with an initial body mass index (BMI) of:

≥30 kg/m^2

OR

≥27 to <30 kg/m^2

+

≥1 weight-related comorbid condition†

In adults with **T2D** as an adjunct to diet and exercise to improve glycemic control:

As monotherapy

OR

As combination therapy

*As an adjunct to a reduced-calorie diet and increased physical activity. Chronic Weight Management includes weight loss and weight maintenance.[1]
†For example, hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, or type 2 diabetes mellitus.[1]

References: 1. 식품의약품안전처, 마운자로프리필드펜주(터제파타이드) 허가사항 (accessed on 10-Jul-2025)

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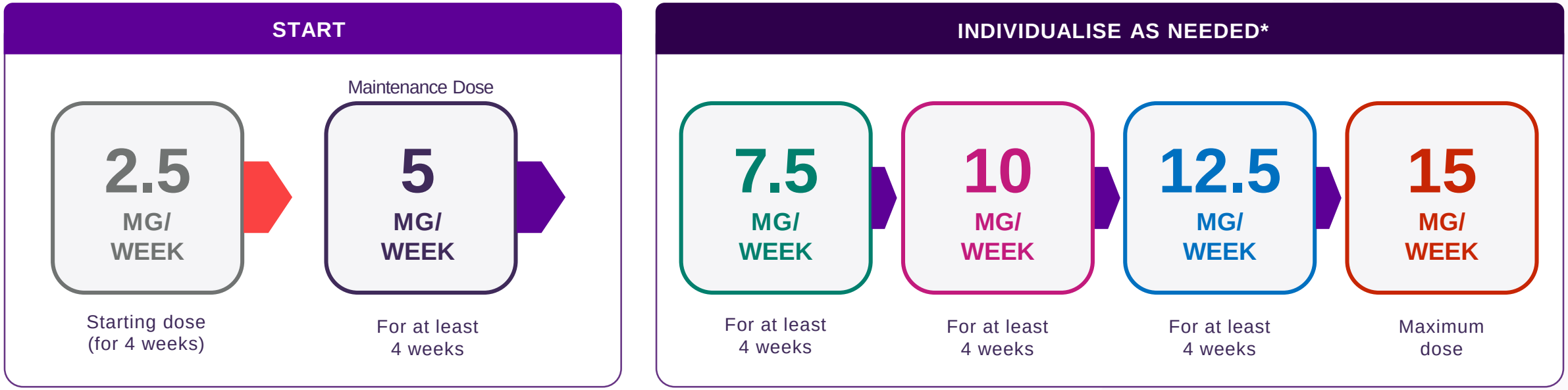
Start and Continue With Confidence: Once-Weekly Mounjaro[1,*]



1. Initiate with the 2.5-mg starting dose
2. After 4 weeks on the 2.5-mg dose, increase to the 5-mg dose

- **If needed to achieve individual treatment goals**, you can continue to increase the dose by 2.5 mg after at least 4 weeks at the current dose to a maximum dose of 15 mg weekly
- Recommended maintenance doses are 5 mg, 10 mg and 15 mg (maximum dose)
- Mounjaro comes in a disposable multidose, prefilled pen, a single-dose prefilled pen and a vial*

*Subject to country and availability.

References: 1. 식품의약품안전처, 마운자로프리필드펜주(터제파타이드) 허가사항 (accessed on 10-Jul-2025)

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Summary

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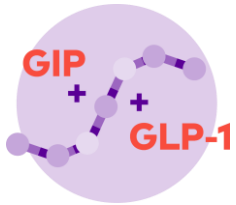
Key Takeaways



Mounjaro has a **unique** mechanism of action, as a **first-in-class agent** that activates both **GIP** and **GLP-1** receptors to target obesity[1,2*]

A **consistent safety profile** across multiple clinical trials that is similar to that of other incretin-based therapies[3-7†]

SUBSTANTIAL weight loss

- Over 72 weeks, **Mounjaro 15 mg** resulted in a significant average **weight reduction of 22.5%** compared to placebo.[4‡]
- Maintenance dose of **Mounjaro 5 mg achieved significant weight reduction (-16.0%)** in obesity and overweight patients compared to placebo over 72 weeks.[4‡]
- **Superior weight loss efficacy with Mounjaro MTD compared to Semaglutide MTD**[3§]

*한국 식품의약품안전처 2023년 6월 허가 기준[1] †In patient groups indicated for chronic weight management, type 2 diabetes treatment, or treatment of moderate to severe OSA with obesity.[1,3-7] ‡SURMOUNT-1: Change in body weight from baseline to week 72 (coprimary endpoint; secondary endpoint for 5 mg) with Mounjaro 5 mg, 10 mg or 15 mg vs placebo (difference from placebo: -13.5%, -18.9%, and -20.1%), p<0.001 , adjusted for multiplicity.[1,4] §At 72 weeks, patients taking Mounjaro MTD (maximum tolerated dose; 10 mg or 15 mg) experienced superior mean percentage body weight reduction from baseline of -20.2% vs -13.7% in those taking Semaglutide MTD (1.7 mg or 2.4 mg) using the modified treatment-regimen estimand (47% relative reduction), or -21.6% vs -15.4%, respectively, using the efficacy estimand (40% relative reduction), p<0.001 for both, adjusted for multiplicity, mITT population.[3]
GIP=glucose-dependent insulinotropic polypeptide; **GLP-1=**glucagon-like peptide-1; **mITT=**modified intent-to-treat; **MTD=**maximum tolerated dose; **OSA=**obstructive sleep apnoea.

References: 1. 식품의약품안전처, 마운자로프리필드펜주(터제파타이드) 허가사항 (accessed on 10-Jul-2025). **2.** Willard FS, *et al. JCI Insight* 2020; 5(17): e140532. **3.** Aronne LJ, et al. N Engl J Med. 2025 Jul 3;393(1):26-36 (including supplement and protocol).. **4.** Jastreboff AM, *et al. N Engl J Med* 2022; 387(3): 205–16 (and supplementary appendix). **5.** Malhotra A, *et al. N Engl J Med*. 2024; 391: 1193–205. **6.** Frías JP, *et al. N Engl J Med* 2021; 385(6): 503–15. **7.** Jastreboff AM, *et al. N Engl J Med* 2025; 392(10): 958–71.

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Thank You

마운자로프리필드펜주 2.5밀리그램/0.5밀리리터 (터제파타이드)

마운자로프리필드펜주 5밀리그램/0.5밀리리터 (터제파타이드)

마운자로프리필드펜주 7.5밀리그램/0.5밀리리터 (터제파타이드)

마운자로프리필드펜주 10밀리그램/0.5밀리리터 (터제파타이드)

마운자로프리필드펜주 12.5밀리그램/0.5밀리리터 (터제파타이드)

마운자로프리필드펜주 15밀리그램/0.5밀리리터 (터제파타이드)

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