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PATIENT GUIDE · MEDICARE

Could the Medicare GLP-1 Bridge work for me?

A plain-language look at who may qualify, what it really costs, and what happens when the program ends.

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Care that believes you.

For most of my career, the answer to this question was simply no.

If you are on Medicare and you have been carrying extra weight for years, you already know the drill. You bring it up. Someone tells you to try harder. Nobody offers you anything that works.

I want to name something first, because I think it matters more than the policy details. Medicare has never covered a medication prescribed to treat obesity. Not once. Not because the medicine failed, and not because your doctor did not ask. Because the law that built Medicare's drug benefit specifically excluded weight-loss drugs from day one.

So when a woman on Medicare sat across from me and asked whether she could get a GLP-1, I had to tell her the truth. Yes, this medication could help you. And no, your insurance will not pay for a single milligram of it. Some of my patients paid cash until they could not anymore. Most just stopped asking.

I think about my own mother when I write sentences like that. She spent years being told her symptoms were nothing, being handed a smaller version of the care she actually needed. She is the reason I do this work the way I do it.

On July 1, 2026, that answer changed. Medicare now covers certain GLP-1 medications for weight, at a flat fifty dollars a month, through a temporary program called the Medicare GLP-1 Bridge. It is not permanent, it is not for everyone, and it comes with real trade-offs I am going to walk you through honestly.

But it is real. And after twenty years of telling women no, I am not going to let this one pass by quietly because the paperwork looked complicated.

WHAT THIS GUIDE WILL AND WILL NOT DO

This guide will not tell you that you qualify. It will tell you exactly how to find out, what it costs, and what to ask for.

A temporary program. A permanent-feeling difference.

Six things worth understanding before you read anything else about it.

1 It is a demonstration, not a new Medicare benefit

CMS built the Bridge using its demonstration authority. That is a legal workaround, not a change to the law. The statutory ban on Medicare covering weight-loss drugs is still on the books.

2 It runs July 1, 2026 through December 31, 2027

It was originally scheduled to end in December 2026. In April 2026, CMS extended it through the end of 2027 after the larger follow-on program stalled.

3 It sits outside your Part D plan

Your plan does not have to opt in, and your plan sponsor carries none of the cost. This is why access is broad. It is also the source of every trade-off on page 6.

4 It is nationwide

All fifty states and the U.S. territories. There is no state-by-state lottery here, which is unusual and genuinely good news.

5 You pay a flat $50 per monthly supply

One month is 28 or 30 days depending on the drug. The $50 does not change based on where you are in your Part D year.

6 It only covers GLP-1s used for weight

If you are already getting a GLP-1 through Part D for another reason, you stay where you are. More on that on page 5.

SCALE

A KFF analysis of Part D enrollment data estimated roughly 3.8 million Medicare beneficiaries could be eligible. If that is close to accurate, this is the largest single expansion of obesity care access in Medicare's history.

Three doors in. You only need to fit through one.

First, two things have to be true for everyone.

You are 18 or older

The Bridge is not limited to people 65 and up. Anyone on Medicare drug coverage may qualify, including people who reached Medicare through disability.

You have Medicare drug coverage

A standalone Part D plan, a Medicare Advantage plan with drug coverage, a Special Needs Plan, an employer or union group waiver plan, or LI NET.

Then you need to meet **one** of these three clinical paths when you start therapy.

35+

BMI

Nothing else required

A BMI of 35 or higher qualifies on its own, with no additional diagnosis needed.

30+

BMI

Plus at least one of

- Diastolic heart failure, also called heart failure with preserved ejection fraction
- Uncontrolled high blood pressure
- Chronic kidney disease, stage 3a or higher

27+

BMI

Plus at least one of

- Prediabetes
- A previous heart attack or stroke
- Peripheral artery disease with symptoms, meaning blocked arteries in the legs or arms

WHY I WANT YOU TO NOTICE THE THIRD DOOR

A BMI of 27 with prediabetes is a wider gate than most commercial insurance plans open. If you have ever been told your A1C was "a little high" and sent home with nothing, that sentence may be the thing that qualifies you. Ask for the number. Ask when it was last checked.

BEFORE YOUR APPOINTMENT

Know your current BMI and bring your most recent A1C, blood pressure readings, and kidney function results if you have them. Your provider has to attest to a specific diagnosis. Walking in with the documentation makes that a five-minute conversation instead of a second visit.

Two of these three "no" answers are actually better news.

Being turned away from the Bridge does not always mean being turned away from treatment. It usually means you belong in a different lane.

1 **You already get a GLP-1 covered by your Part D plan**

You are not eligible for the Bridge, and you do not need it. Keep getting your medication through your current plan. That coverage counts toward your deductible and your out-of-pocket maximum, which the Bridge does not. You are in the better lane already.

2 **You have type 2 diabetes, moderate-to-severe sleep apnea, or fatty liver disease**

These are conditions Medicare already allows Part D plans to cover GLP-1s for. So the Bridge excludes you, and points you back to your plan instead. If nobody has ever prescribed one to you for those diagnoses, that is a conversation worth having this month. Ask your provider directly whether a GLP-1 is appropriate for the condition you actually have.

3 **You have Medicare but no drug coverage**

This is the one that is genuinely a closed door for now. The Bridge only runs through Part D enrollment. You may be able to join a drug plan during a valid enrollment period, and that would open the door for you. It is worth checking your dates rather than assuming.

SAY THIS OUT LOUD AT YOUR NEXT VISIT

"I want to know whether I qualify for the Medicare GLP-1 Bridge. And if I do not, I want to know what I do qualify for."

You are allowed to ask both halves of that question. A good answer names the next step, not just the obstacle.

ONE MORE THING

Eligibility is determined by CMS and its contracted reviewer, not by Body Good and not by your prescriber. We can help you assemble a complete, accurate request. No one can promise you an approval.

The medications on the list

Wegovy	Semaglutide. Both the injection and the tablet form are covered.
Foundayo	Orforglipron. A daily tablet, no injection required.
Zepbound	Tirzepatide, **KwikPen formulation only.** Single-dose vials and single-dose pens are not covered by this program. If your prescription is written for the wrong form, it will not go through.

Which medication is right for you is a clinical decision, not a preference. Product names are listed here for identification only.

The honest math

Fifty dollars is the number everyone repeats. Here is what sits underneath it.

- Your $50 **does not count** toward your Part D deductible or your annual out-of-pocket maximum. It is a separate program, so the spending lives outside your plan entirely.
- It **will not appear** on your Part D Explanation of Benefits or your Medicare Summary Notice. Do not panic when you cannot find it.
- **Extra Help cannot lower it.** If you rely on the Low-Income Subsidy, that subsidy does not reach into this program. Fifty dollars is fifty dollars.
- You **cannot spread it** across months using the Medicare Prescription Payment Plan.
- The $50 **stays $50** in every phase of your Part D year. That cuts both ways. It never spikes, and it never drops to zero after you hit your cap.

WHO THIS TRADE-OFF HURTS

If you have Extra Help, or if you reliably hit your out-of-pocket maximum because of other medications, run the numbers before you enroll. There are situations where $600 a year outside the cap is a worse deal than it first appears. I would rather you know that from me now than discover it in November.

Five steps, in the order they really happen.

1 Your provider sends the prescription to your pharmacy

Nothing starts until a prescription for a covered drug exists. The prescription itself is what triggers the rest of the process.

2 Your provider completes a prior authorization

They certify which clinical criteria you meet, and that the medication is being prescribed as part of a lifestyle program focused on diet and exercise. That second piece is a real requirement, not a formality. CMS contracted Humana to process these approvals.

3 You get a letter confirming coverage

Confirmation arrives by mail. Your pharmacy may also ask for your Medicare number or the last four digits of your Social Security number to process the claim.

4 You pay $50 at the counter

The pharmacy handles the rest of the claim with CMS. Nothing is billed to your Part D plan.

5 Your approval carries through 2027

Once approved, your prior authorization is valid through December 31, 2027, including refills and dose changes. It only has to be redone if you switch to a different GLP-1. Titrating your dose upward does not restart the paperwork.

A ROLLOUT NOTE, FROM THE FIELD

In the first weeks, some prescriptions were mistakenly submitted to Part D plans and came back denied, when they should have been routed to the Bridge. If you get a denial letter from your plan, do not treat it as the final answer. Call and ask specifically whether the request was submitted through the Medicare GLP-1 Bridge. This is a routing problem, and routing problems are fixable.

What happens when it ends? Nobody can tell you yet.

I am not going to soften this part, because you deserve to plan around the truth rather than a hopeful version of it.

The Bridge was always meant to be temporary. It was built to hold the gap until a bigger, longer-term program called the BALANCE Model took over Medicare coverage in 2027. That was the plan.

It did not happen. Part D plan sponsors were required to opt in, CMS needed a large share of them to participate, and not enough did. In April 2026, CMS announced it would not move forward with BALANCE in Medicare for 2027, and extended the Bridge through the end of 2027 instead.

So as of today, there is no confirmed coverage pathway for Medicare beneficiaries taking a GLP-1 for weight after December 31, 2027. It may be extended again. BALANCE may be restarted or redesigned. Congress may lift the statutory ban. None of that is decided.

HOW I WOULD THINK ABOUT IT

Eighteen months of treatment you can afford is still eighteen months of treatment you can afford.

That is not me telling you to ignore the cliff. It is me telling you not to skip real care today because of an uncertain 2028. What I want instead is a plan that accounts for it: know your options before the deadline, not after.

Three things to do now, so 2028 is not a surprise

- Track your response. Weight, blood pressure, A1C, how you actually feel. Documented benefit is the strongest argument you will have for continued coverage under whatever comes next.
- Understand your self-pay options before you need them, including manufacturer direct programs and cash-price comparison tools. Knowing the real number now removes the panic later.
- Talk with your clinician about what maintenance looks like, and what happens if access changes. This is a chronic condition. The plan should be built like one.

You can do all of this without us. Some people would rather not.

Your own doctor can prescribe and submit the prior authorization for the Bridge. If you have a provider who knows you and will do the paperwork properly, use them. That is the honest answer, and I am not going to pretend otherwise.

What we offer is for the woman who has already asked twice and gotten nowhere, or whose provider is not set up to move quickly on this. Our Medicare PA Concierge exists to assemble the clinical documentation, submit the request correctly the first time, and follow it until there is an answer.

What you would pay, separated out

COST	WHAT IT IS	AMOUNT
Body Good program fee One-time, at enrollment	Clinical review and prior authorization submission	**$79**
Ongoing care management Recurring, billed monthly	Follow-up, dose management, refills, and support	**$39 / mo**
Medication at the pharmacy Set by CMS, not by Body Good	Your Bridge copay for a monthly supply, if approved	**$50 / mo**
Labs, if ordered Variable	Billed separately by the laboratory or your plan	**Varies**

Our fees pay for clinical work and coverage support. They are separate from your medication cost and are charged whether or not CMS approves your request. We cannot guarantee eligibility, approval, or a specific medication.

Your next step, whichever route you take

- [ ] Confirm you have Medicare drug coverage, and know which type
- [ ] Find your current BMI, and your most recent A1C and blood pressure
- [ ] Check yourself against the three doors on page 4
- [ ] Ask your provider to send a prescription and complete the Bridge prior authorization
- [ ] If you get a denial from your Part D plan, confirm it was routed through the Bridge

QUESTIONS ABOUT YOUR OWN ELIGIBILITY

You can call 1-800-MEDICARE (1-800-633-4227) to ask about eligibility or check the status of a prior authorization. TTY users can call 1-877-486-2048. Medicare also publishes a short eligibility questionnaire at medicare.gov/coverage/weight-loss-drugs.

Where this came from

Every eligibility rule, medication, date, and dollar figure in this guide traces to one of the sources below. Program rules can change. Check the primary sources before you make a decision.

1. **Medicare.gov · Weight loss drugs.** Official eligibility criteria, covered medications, provider requirements, and cost rules for the Medicare GLP-1 Bridge. Includes an interactive eligibility questionnaire.
medicare.gov/coverage/weight-loss-drugs

2. **Centers for Medicare & Medicaid Services.** "Coming Soon: CMS to Provide $50 Monthly Access to GLP-1 Medications for Medicare Beneficiaries." Program announcement, dates, and structure.
cms.gov/newsroom/press-releases/coming-soon-cms-provide-50-monthly-access-glp-1-medications-medicare-beneficiaries

3. **KFF.** Freed M, Cubanski J, Williams E. "What to Know About the BALANCE Model for GLP-1s in Medicare and Medicaid and the Medicare GLP-1 Bridge." Updated May 11, 2026. Source for the Part D statutory exclusion, the $245 negotiated net price, the Low-Income Subsidy exclusion, the BALANCE Model delay, and the post-2027 coverage uncertainty.
kff.org/medicare/what-to-know-about-the-balance-model-for-glp-1s-in-medicare-and-medicaid

4. **AARP.** "Medicare Starts Offering $50 GLP-1 Doses in July." Source for the estimate that approximately 3.8 million beneficiaries could be eligible, based on KFF analysis of 2023 Part D enrollment data.
aarp.org/medicare/glp1-weight-loss-copay-program

5. **CNBC.** "Medicare obesity drug GLP-1 coverage starting July 1," June 30, 2026. Source for the prior authorization workflow and CMS's contract with Humana to process Bridge approvals.
cnbc.com/2026/06/30/medicare-obesity-drug-glp-1-coverage-starting-july-1.html

6. **NPR.** "Some Medicare beneficiaries can now get popular obesity drugs for $50 a month," updated July 1, 2026. Source for program framing and the covered formulation list.
npr.org/2026/05/06/nx-s1-5812662/medicare-bridge-glp1-drugs-copay

7. **Medicare Rights Center.** "GLP-1 Weight-Loss Drug Demonstration Begins July 2026." Source for beneficiary-facing trade-offs, including deductible, out-of-pocket limit, and Extra Help exclusions.
medicarerights.org/medicare-watch/2026/06/04/glp-1-weight-loss-drug-demonstration-begins-july-2026

MEDICAL DISCLAIMER

This guide is general education about a Medicare program. It is not medical advice, a diagnosis, or a treatment recommendation, and it does not establish a patient relationship. GLP-1 medications are not appropriate for everyone and carry real risks that should be discussed with a qualified clinician who knows your history. Eligibility for the Medicare GLP-1 Bridge is determined by CMS and its contracted reviewer. Body Good does not determine coverage and cannot guarantee approval.

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You do not have to prove you deserve to be treated.

For the first time, Medicare will help pay for this. If you think one of the three doors might be yours, ask. The worst possible outcome is a no you already have.

With care,
Dr. Linda Moleon