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Prescription-Only, Yet Everywhere: Advertising, Tele-Prescription and Enforcement Gaps in India's Post-Patent GLP-1 Market

ABSTRACT

Novo Nordisk's Indian patent on semaglutide expired in India on 20th March 2026, leading dozens of generic brands to enter the market and create cheaper generic medicines from local drug stores. Resulting in a huge price drop, with sales growing up to 235 percent year on year, and a prescription-only injectable began to resemble a mass-market lifestyle product, although only 0.1 per cent of obese Indians are reportedly on treatment. On the other hand, promotional pressure seems to be increasing as the gap between supply and uptake has grown. This article questions whether the Indian drug law is capable of regulating the creation of demand as effectively as the supply of the same. It interrogates the Drugs and Cosmetics Act, 1954, whose schedule lists obesity. The Central Drugs Standard Control Organisation (CDSCO) issued an advisory on 10th March 2026, the Supreme Court's 2024 ruling on endorsers' liability, along with the unfinished regulation on e- pharmacy and tele-prescription. Applying doctrinal analysis, official statements, market data, and a comparison with the United Kingdom's 2026 enforcement against social-media promotion of weight-loss injections, it provides the structural data for those who are answering at each link of the regulatory chain and recognises the three different gaps in it, which are: a manufacturer-facing advisory that does not visibly reach the influencers, various platforms, and clinics; the marketing approval, which is very difficult to verify in the prescribers' condition, following to an evidence gap, as the consequences of inspection, adverse events, and prescribing patterns are unpublished. It argues that the prohibition on advertising is constitutionally defensible but under-enforced, and that restrictions will push price-sensitive patients into grey markets. This suggests intermediary and endorser liability, GLP-1-centred tele-prescribing norms, verifiable electronic prescriptions, enforcement for citizens and pharmacovigilance reporting, and a calibrated access policy, so that affordability does not lead to unsupervised exposure.

KEYWORDS

Advertising Regulation, Drug Regulation, GLP-1, Prescription-Only Medicines, Telemedicine.

1. INTRODUCTION

The Indian patent on semaglutide expired on 20th March 2026; the patent on the molecule behind Ozempic and Wegovy also expired. [1] With the release of one trade report that merely spoke of a fifty-brand race, brands like Dr Reddy's Zydus, Sun Pharma, Alkem and others started launching generics.[2] A medicine which usually ranges from rupees 8,800-10,000 a month was suddenly offered for about rupees 3,400.[3]

The commercial story is well-narrated; however, on the other hand the legal story is not. Semaglutide is a Schedule H drug, sold only on a prescription, and the Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954 prohibits advertising drugs for conditions which are mentioned in its schedule, which also consists of obesity.[4] Yet the popularity of such weight loss injections is created on social media, in marketing for clinics, and on teleconsultation applications, by people who are neither manufacturers nor prescribers. The Central Drugs Standard Control Organisation (CDSCO) issued an advisory on 10th March 2026, just before the patent's expiration, but it was communicated to manufacturers, importers, and marketing authorisation holders.[5]

The article tests whether Indian drug law can regulate demand as well as supply in the post-patent GLP-1 market. Moreover, the research gap is whether the existing writing on these drugs is clinical, commercial, or patent-focused; simultaneously, the sale in areas like advertising governing promotion, tele-prescription, and online sale has charmed little scholarship. The objectives are to (i) map the applicable framework; (ii) identify enforcement gaps using available data; (iii) test the advertising prohibition against constitutional standards; (iv) compare with the United Kingdom; and (v) propose reforms.

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[1] Pearce IP, "Generic Semaglutide Launches in India, including by Dr Reddy's, Zydus, Alkem, Sun Pharma & Glenmark" (21 March 2026), available at: https://www.pearceip.law/2026/03/21/generic-semaglutide-launches-in-india-including-by-dr-reddys-zydus-alkem-sun-pharma-glenmark/ (Last visited on 4 October 2026).

[2] One Goal, 50 Brands", *Outlook Business* (13 April 2026), available at: https://www.outlookbusiness.com/corporate/one-goal-50-brands-inside-the-scramble-for-indias-post-patent-semaglutide-market (Last visited on 4 October 2026).

[3] Supra note 2.

[4] Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954, ss. 3, 7 and Schedule; Drugs and Cosmetics Rules, 1945, r. 65 and Sch. H.

[5] Ministry of Health and Family Welfare, "GLP-1 Drugs Use, Risks, and Regulation" (PIB, April 2026), available at: https://www.pib.gov.in/PressReleasePage.aspx?PRID=2247459&reg=3&lang=1 (Last visited on 4 October 2026).

2. LITERATURE REVIEW

Research on semaglutide in India mainly concerns patent expiry and generic competition, alongside clinical literature on efficacy and safety. The documents on obesity burden were surveyed in public health by the national ICMR-INDIAB, which was placed at 28.6 per cent for generalised and 39.5 per cent for abdominal obesity among adults[6]. The Indian legal commentary has researched surrogate advertising largely in alcohol and tobacco; according to the analysis made in the 2026 advisory, which predicts that regulators will prefer substance over form, on the other hand, practitioners and students have only begun to apply that to pharmaceuticals.[7] Neither of the above-mentioned schedules suggests how a prescription-only drug can travel from approval to patient once price barriers fall. The study that this paper tends to find is how it would look beyond the manufacturers to intermediaries, influencers, clinics, and platforms; integrates tele-prescription and e-pharmacy; derives comparative lessons; and studies enforcement evidence.

3. RESEARCH METHODOLOGY

This exploration is doctrinal and analytical, supplemented by elaborative statistics and a functional comparison. The sources of the research and comparison are the Drugs and Cosmetics Act, 1940 and Rules, the 1954 Act, the Consumer Protection Act, 2019; Supreme Court and High Court decisions; CDSCO and Health Ministry statements; market data reported in the press; the ICMR-INDIAB study; and United Kingdom instruments and regulatory rulings. The scope is the promotion, prescription, and sale of GLP-1 receptor agonists for weight management in India; patent litigation, clinical efficacy, and compounding are excluded.

The limitations discovered are three: firstly, the market figures are commercial evaluates reported through the press. Moreover, the studies and advisory have been cited from renowned secondary citations rather

[6]R .M. Anjana et al., "Metabolic non-communicable disease health report of India: the ICMR-INDIAB national cross-sectional study (ICMR-INDIAB-17)", (2023) 11 *Lancet Diabetes & Endocrinology* 474.

[7] Sanskriti Sharma, "From Whiskey To Weight-Loss Drugs: Rethinking Surrogate Advertising In Pharma", *LiveLaw Law School*, available at: https://www.livelaw.in/lawschool/articles/whiskey-weight-loss-drugs-rethinking-surrogate-advertising-pharma-530392 (Last visited on 4 October 2026); "From Awareness to Advertising: Re-examining the GLP-1 drug boundaries (Part 1)", *Cyril Amarchand Mangaldas Blog* (April 2026), available at: https://corporate.cyrilamarchandblogs.com/2026/04/from-awareness-to-advertising-re-examining-the-glp-1-drug-boundaries-part-1/ (Last visited on 4 October 2026).

than primary documents. No official data has yet been discovered on prescribing patterns or enforcement outcomes. The analytical structure consists of approval, promotion, prescription, dispensing, and surveillance, which together make a regulatory chainwork model where every link has been tested for legal basis and addressee, along with the enforcement evidence, followed by a proportionality review.

4. DISCUSSION AND ANALYSIS

4.1 A market shock

The total number of GLP-1 marketed at the price of rupees 1,906 crore in just twelve months to May 2026, up to 237 percent as per the data revealed by Pharmarack, including tirzepaitde (Mounjaro) accounted for ₹1,207 crore and semaglutide ₹589 crore.[8] By the month of July, the figure rose to rupees 2,215 crore. [9] However, while launching, the prices of such generics varied from about rupees 2,200 a month(Zydus) to about rupees 4,200(Dr Reddy's).[10] In March, Mounjaro logged its initial monthly sales decline, from rupees 135 crore to rupees 114 crore, as semaglutide sales hiked up from 48 crore to 59 crore, a downfall of about 16 percent against a rise of about 23 percent.[11] Monthly expansion then decreased sharply, from 58.4 per cent in April to 12.1 per cent in May and 2.3 percent in June.[12] The below mentioned table places this against the disease burden.

[8]"Why is India's obesity drug market thinning despite the GLP-1 rush?", *BusinessToday* (10 June 2026), available at: https://www.businesstoday.in/industry/pharma/story/why-is-indias-obesity-drug-market-thinning-despite-the-glp-1-rush-536151-2026-06-10 (Last visited on 4 October 2026).

[9] Just scratching the surface': How Ozempic maker Novo Nordisk sees India's GLP-1 market growing", *ThePrint* (August 2026), available at: https://theprint.in/health/just-scratching-the-surface-how-ozempic-maker-novo-nordisk-sees-indias-glp-1-market-growing/3019448/ (Last visited on 4 October 2026).

[10] Supra note 1.

[11] Mounjaro's sales dip: How cheap generics are redrawing India's GLP-1 market", *Forbes India*, available at: https://www.forbesindia.com/article/news/deep-dive/mounjaros-sales-dip-how-cheap-generics-are-redrawing-indias-glp-1-market/2993063/1 (Last visited on 4 October 2026).

[12] India Fat-Loss Drug Sales Slow After Early Spike From Generics", *Bloomberg* (8 July 2026), available at: https://www.bloomberg.com/news/articles/2026-07-08/india-fat-loss-drug-sales-slow-after-early-spike-from-generics (Last visited on 4 October 2026).

Table 1: The post-patent GLP-1 market in context

Indicator	**Figure**
Generalised obesity among adults (2021 estimate)	28.6%, about 254 million people
Abdominal obesity among adults	39.5%
Semaglutide patent expiry	20 March 2026
Monthly cost: branded v. generic	₹8,800–10,000 v. from about ₹3,400
GLP-1 market, 12 months to May 2026	₹1,906 crore (up 237%)
GLP-1 market, 12 months to July 2026	₹2,215 crore (up 235%)
Monthly sales growth: April, May, June 2026	58.4%; 12.1%; 2.3%
Obese Indians on GLP-1 (Novo India estimate)	About 0.1%
Entities inspected by regulators, March 2026	49

Sources: notes 6, 2, 8–12 and 13.

There are a total of three inferences: firstly, demand is price-sensitive, so lower prices widen the pool of buyers beyond closely supervised metropolitan patients. Secondly, we have the penetration is small relative to the need: 0.1 percent of 254 million people implies roughly around 2.5 lakh patients, the incentives through commercials to find new patients will persist. Thirdly, the June slowdown suggests an initial surge of pent-up demand rather than a plateau, and as firms will compete for remainder so will the promotional pressure will as it keeps on rising.

4.2 The legal chain on paper

The drug was approved on the basis that it will be prescribed by

endocrinologists and internal medicine specialists, for a few indications, as well as cardiologists.[13] Whereas Schedule H drugs are only supposed to be supplied on a registered practitioner's prescription.[14] As stated in Section 3 of the 1954 Act, it forbids 'any person' from taking part in advertising a drug for a schedule condition, including obesity; nevertheless, its penalties are modest by modern standards.[15] The CDSCO advisory suggests five prohibited forms, which are: promotion to the public, downplaying the lifestyle ways, and involving demand for drug therapy. It uses 'awareness' campaigns and influencer engagement that produce brand recall as surrogate advertising.[16] An advisory's force derives from the Act and Rules, which are interpreted as not being delegated legislation, although the 2022 CCPA Guidelines, which bar surrogate advertisements for goods whose advertisement is itself prohibited.[17]

Moreover, in *Indian Medical Association v. Union of India (2024),* the Supreme Court ruled that advertisers and endorsers are equally responsible for misrepresenting and misleading advertisements plus that the right to health includes the consumer's right to be informed.[18] As per the guidelines provided in the Consumer Protection Act, 2019, and the 2022 CCPA, sources penalties and endorsement norms.[19] On paper, therefore, the string is closed.

4.3 Who answers at each link?

Table 2 maps the chain from approval to surveillance.

[13] All India Radio, "India Tightens Surveillance on GLP-1 Weight Loss Drug Sales" (24 March 2026), available at: https://www.newsonair.gov.in/india-tightens-surveillance-on-glp-1-weight-loss-drug-sales (Last visited on 4 October 2026).

[14] Supra note 4.

[15] Supra note 4.

[16] No Surrogate Ads for Weight-loss Drugs: CDSCO Cracks down on GLP-1 'Awareness' Ads", *Moneylife*, available at:https://www.moneylife.in/article/no-surrogate-ads-for-weightloss-drugs-cdsco-cracks-down-on-glp1-awareness-ads/79917.html (Last visited on 4 October 2026).

[17] Supra note 7.

[18] *Indian Medical Association v. Union of India*, 2024 LiveLaw (SC) 381 (order dated 7 May 2024); *Consumer Education & Research Centre v. Union of India*, (1995) 3 SCC 42.

[19] Consumer Protection Act, 2019, s. 21; Guidelines for Prevention of Misleading Advertisements and Endorsements for Misleading Advertisements, 2022.

Table 2: Accountability along the regulatory chain

Link	Actor	Principal rule	Public enforcement evidence
Approval	CDSCO	Drugs and Cosmetics Act, 1940; prescriber condition	Condition reported; 2025 petition disposed
Promotion	Manufacturer	Advisory of 10 March 2026; 1954 Act, s. 3	Advisory only
Promotion	Influencer, clinic	1954 Act, s. 3; CPA 2019, s. 21; IMA (2024)	None located
Prescription	Doctor, tele-platform	Telemedicine guidelines, 2020	None located
Dispensing	Pharmacy, e-pharmacy	Drugs Rules, r. 65, Sch. H; no final e-pharmacy rules	49 inspections; outcomes undisclosed
Surveillance	CDSCO, IPC	Committee recommendations (2026)	No public review

Source: author's compilation from the sources cited in this section.

As we know, every link has an addressee, and almost none has public proof of enforcement. When a patient is hurt, there are definite ways or remedies fragmented: negligence standards govern prescribers, consumer complaints lie against sellers and clinics, and the liability chapter of the 2019 Act extends to the manufacturers and sellers[20] But no mechanism bridges adverse event reporting to compensation.

4.4 Three enforcement gaps

The advisory helps in binding the manufacturers, importers, and

[20] *Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1; Consumer Protection Act, 2019, ch. VI (ss. 82–87).

marketing authorisation holders. An influencer who is getting paid through referral codes, be it via a clinic or tele-pharmacy, is none of these. Getting to her depends on Section 3 of a 1954 statute or on CCPA action, and the author found no recorded prosecution or CCPA order against GLP-1 promotion by influencers. The Drugs Consultative Committee, at its 68th meeting (reported in April 2026), whereas the states were asked to keep a vigil on marketing authorisation holders, again a manufacturer-facing formula.[21]

The channel gap. The prescriber condition only works properly if the prescription trail is in line. Ministry itself recognised a high demand for availability; however, they decided not to name or report the outcomes upon discovery. The retail was made through pharmacies, online platforms, wholesalers, and wellness clinics, and reported inspections of 49 entities, including online pharmacy warehouses and slimming clinics.[22] The channels where the draft rules were published in August 2018 and 2026 trade reporting still state as functional in a legal grey zone, proving that the online channels are not being revised.[23] After the emergence of the 2020 guidelines, the tele-prescription GLP-1 became widely available in the mass market.[24]

The evidence gap. During a hearing in the Delhi High Court, a petition alleged limited India-specific data and weak pharmacovigilance in July 2025; it was directed to CDSCO to make a decision on who will represent the petitioner, while giving a period of three months to dispose of the matter.[25]

Since then, the Indian Pharmacopoeia was instructed to create adverse-event reviews.[26]

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[21] Obesity Drugs", *Medical Dialogues* (18 April 2026), available at: https://medicaldialogues.in/news/industry/pharma/cdsco/no-ads-for-prescription-drugs-panel-flags-surrogate-advertising-misleading-promotions-of-glp-1-obesity-drugs-168927 (Last visited on 4 October 2026).

[22] Supra note 5.

[23] 'E-pharmacy in India 2026: Top Apps for Medicine Delivery", *India Pharma Outlook*, available at: https://www.indiapharmaoutlook.com/in-depth/epharmacy-in-india-2026-top-apps-for-medicine-delivery-nwid-5311.html (Last visited on 4 October 2026).

[24] Board of Governors in supersession of the Medical Council of India, *Telemedicine Practice Guidelines* (2020).

[25] *Jitendra Chouksey v. Union of India*, (Del HC, 2 July 2025), reported at: https://assamtribune.com/health-and-fitness/decide-within-3-months-delhi-hc-tells-cdsco-on-plea-against-use-of-diabetes-drugs-in-weight-management-1583273 (Last visited on 4 October 2026).

[26] Supra note 6.

4.5 Constitutional analysis

In *Hamdard Dawakhana,* the Supreme Court upheld the 1954 Act, suggesting that advertisement of drugs should be treated as a part of trade rather than protected speech; however, commercial speech within Article 19(1)(a) was brought by *Tata Press,* later excluded as false, misleading and unfair advertising.[27] A ban on advertising drugs to the public is likely to be upheld as a reasonable limit that protects public health. IMA adds an Article 21 dimension.

Under the proportionality test the goal is legitimate. [28]The ban is logically linked to it. For prescription drugs the ban is probably necessary because consumers cannot judge the product.

Balancing presents the challenge. A total ban on 'awareness' communication could dampen public-health messages about a condition that affects about 254 million adults.[29] A tighter rule that bans named-drug, outcome and incentive claims but allows unbranded awareness messages, from governments and professional societies would limit expression less while still achieving the goal. More importantly, prohibition without access policy has a second-order cost: with most patients paying out of pocket[30] and penetration near 0.1 per cent, over-restriction may push price-sensitive patients towards unlicensed sellers, where quality and safety are least assured.

4.6 Comparative perspective: the United Kingdom

UK law bans advertising prescription-only medicines to the public. In February 2026 the Advertising Standards Authority issued its first rulings against members of the public whose Instagram, TikTok and Facebook posts used discount codes and referral links to promote weight-loss injections for online pharmacies, holding that public posts were advertisements for which the posters were responsible.[31] The MHRA, ASA and GPhC issued a joint warning in June 2026, extended to

[27] *Hamdard Dawakhana v. Union of India*, AIR 1960 SC 554; *Tata Press Ltd. v. MTNL*, (1995) 5 SCC 139.

[28] *Modern Dental College & Research Centre v. State of M.P.*, (2016) 7 SCC 353; *K.S. Puttaswamy v. Union of India*, (2017) 10 SCC 1.

[29] Supra note 6.

[30] "Lilly, Novo lock horns in India's obesity drug race", *Reuters*, available at: https://www.marketscreener.com/news/lilly-novo-lock-horns-in-india-s-obesity-drug-race-ce7e59dad98af027 (Last visited on 4 October 2026).

[31] Human Medicines Regulations 2012 (UK), reg. 284(1); CAP Code (UK), r. 12.12; "Social media ads for prescription-only weight-loss medicines banned", *Express & Star* (11 February 2026), available at: https://www.expressandstar.com/uk-news/2026/02/11/social-media-ads-for-prescription-only-weight-loss-medicines-banned/ (Last visited on 4 October 2026).

unlicensed 'pipeline' products and advertised waiting lists.[32] The GPhC reported that 17 per cent (222) of concerns raised between January 2024 and December 2025 related to advertising of weight-loss services, including pharmacies paying influencers via discount codes.[33]

Table 3: Regulating promotion of weight-loss medicines

Feature	India	United Kingdom
Legal basis	DMR Act 1954, s. 3; Drugs Rules; CDSCO advisory	Human Medicines Regulations 2012, reg. 284(1); CAP Code r. 12.12
Addressed	Manufacturers, importers, MAHs (advisory); 'any person' (1954 Act)	Advertisers, pharmacies, affiliates and members of the public
Influencers	Equal responsibility in principle (2024); no GLP-1 ruling located	ASA rulings on public posts (February 2026)
Enforcers	CDSCO; State Drug Controllers; CCPA	MHRA, ASA and GPhC jointly
Public data	Inspection count only (49)	GPhC review: 17% (222) of concerns

Source: notes 4, 16, 18, 21, 31–33.

Three lessons emerge: liability attaches to the function of the post rather than the status of the poster; regulators act jointly; and enforcement data

[32] MHRA, "Warning on promoting newly licensed prescription-only medicines and unlicensed medicines for weight management" (18 June 2026), available at: https://www.gov.uk/government/news/warning-on-promoting-newly-licensed-prescription-only-medicines-and-unlicensed-medicines-for-weight-management (Last visited on 4 October 2026).

[33] "Pharmacy regulator warns against promotion of prescription weight-loss medicines", *The Pharmaceutical Journal* (June 2026), available at: https://pharmaceutical-journal.com/article/news/pharmacy-regulator-warns-against-promotion-of-prescription-weight-loss-medicines (Last visited on 4 October 2026).

are published.

5. FINDINGS

(1) The market has expanded rapidly (₹2,215 crore; up 235 per cent) but growth slowed to 2.3 per cent in June, while penetration remains near 0.1 per cent, so promotional pressure is likely to persist.

(2) India's rules are comprehensive on paper (Schedule H, section 3 of the 1954 Act, the advisory, *IMA*) but are addressed mainly to manufacturers; influencers, clinics and platforms are reached only through older or general laws.

(3) Every link in the chain has an addressee, but almost none has public evidence of enforcement, and remedies for patient harm are fragmented.

(4) The prescriber condition and the online channel are weakly verifiable: no final e-pharmacy rules exist and tele-prescribing guidelines pre-date mass GLP-1 use.

(5) Enforcement and safety evidence is unpublished: 49 inspections without disclosed outcomes, no public adverse-event review, and a 2025 judicial intervention that ended with a direction to decide.

(6) The advertising prohibition is constitutionally defensible, but a prohibition-only strategy risks neglecting access.

6. RECOMMENDATIONS

(1) *Intermediary and endorser liability.* Parliament or the CCPA should state expressly that paid or incentivised posts, referral codes and 'waiting list' pages referring to prescription-only drugs are advertisements, attaching liability to advertisers, endorsers and, after notice, platforms. The 1954 Act's penalties should be modernised.

(2) *GLP-1 tele-prescribing norms.* The National Medical Commission should require documented body-mass index and comorbidity assessment, baseline tests and an initial consultation mode, and bar bundled drug-plus-consultation pricing.

(3) *E-pharmacy rules.* The 2018 draft should be finalised with pharmacist verification of electronic prescriptions and a bar on influencer incentives.

(4) *Auditable prescriptions.* For approval-conditioned drugs, electronic prescriptions should record prescriber qualification, enabling State Drug Controllers to audit compliance.

(5) *Transparency.* CDSCO should publish quarterly inspection, notice and licence-cancellation data, together with adverse-event reviews.

(6) *Harm and redress.* Adverse-event reports should feed a defined pathway to compensation and licence action, and the Drugs Consultative Committee should adopt a model State enforcement protocol so that outcomes are uniform across jurisdictions.

(7) *Calibrated access.* A clear bioequivalence pathway for peptide generics and public-health communication by government, and coverage for severe obesity with comorbidities, would limit grey-market migration.

7. CONCLUSION

India's post-patent GLP-1 market shows that a law can be sound on paper and thin in practice. The prohibition on promoting prescription-only drugs rests on firm constitutional ground, but it is addressed to the wrong actors, depends on an unverifiable prescription trail and operates without public evidence. The immediate need is to bring influencers, platforms and clinics within a clear liability rule; the durable need is a transparent enforcement and pharmacovigilance regime. As more weight-management drugs, including oral forms, reach the market, regulating demand as carefully as supply will determine whether affordability becomes access or exposure.