

# Novo Nordisk: Insulin, GLP-1 Pricing, and Access Accountability

Research checked: 9 September 2026. Publication date: 9 September 2026. New research edition.

## 1. Executive assessment: several prices, several accountability questions

Novo Nordisk is a Denmark-based pharmaceutical group whose United States business has a substantial role in diabetes and obesity treatment. Its portfolio makes the company relevant to two different access debates: affordability of established insulin products and financing of newer GLP-1 medicines. The group reported 2025 global net sales of DKK 309,064 million, including DKK 127,089 million for Ozempic. These are manufacturer revenue figures across markets, not amounts paid by American patients.<sup>1</sup>

This report finds documented changes in published prices and access programs, a federal settlement concerning historical risk communication, and continuing public scrutiny of the relationship between list prices and the prices ultimately paid. These records answer different questions. The 2017 Victoza resolution concerned alleged failures to communicate an FDA-required risk message; it was not a judicial determination that current Ozempic or Wegovy pricing is unlawful.<sup>2</sup> A Senate hearing on pricing is an oversight proceeding, not a verdict against the company.<sup>3</sup>

Two distinctions are particularly important as of the research date. First, the company announced a \$675 monthly wholesale acquisition cost for specified semaglutide medicines beginning January 1, 2027. That announcement is forward-looking: its effective date had not arrived when this report was prepared.<sup>4</sup> Second, Medicare's negotiated maximum fair prices and the manufacturer's direct-purchase offers are separate arrangements. A single headline figure should not be presented as the amount every patient can pay.

Our assessment is that Novo Nordisk provides an unusually useful example of why pricing transparency must identify a product, presentation, market, payer, date, and eligibility group. A lower published price can be meaningful without resolving every access barrier. Conversely, a rebate explanation does not by itself establish that a particular uninsured person, deductible-exposed patient, or public program has affordable access. Both assertions require evidence about the transaction actually faced by that group.

This is a newly prepared public-source report. It neither reconstructs an unavailable historical Pharma Foundation document nor establishes who performed prior analysis. It does not advise readers to select, stop, or substitute a medicine. Its purpose is to organize the evidence needed to evaluate corporate conduct and affordability claims without confusing company announcements, government findings, and this report's own analysis.

## 2. Timeline: risk communication, insulin cuts, and semaglutide scrutiny

The historical sequence shows that access issues change as a portfolio evolves. Novo Nordisk's 2017 federal resolution followed allegations concerning Victoza marketing and its risk evaluation and mitigation strategy. DOJ described conduct during 2010-2014, with a separate disgorgement component concerning 2010-2012. The announced total was \$58.65 million, comprising \$12.15 million in disgorgement and \$46.5 million addressing False Claims Act allegations.<sup>2</sup> These time periods should remain attached to any short summary of the matter.

In March 2023, the company announced United States list-price reductions for several established insulin products, effective January 2024. The announced reductions included 75% for NovoLog and NovoLog Mix 70/30 and 65% for Levemir and Novolin; the announcement also covered corresponding unbranded products.<sup>5</sup> This was a change to list prices, not a claim that all patients previously paid those prices or that their bills would fall by the same percentages.

The Senate HELP Committee held a hearing with then-chief executive Lars Fruergaard Jørgensen on September 24, 2024, focused on Ozempic and Wegovy prices.<sup>3</sup> His written testimony emphasized development investment, discounts, rebates, and formulary decisions. Those submissions are valuable evidence of the company's explanation, but they are not independent verification of every numerical or causal assertion in that explanation.<sup>6</sup>

FDA announced on February 21, 2025, that the shortage of semaglutide injection products was resolved. Its notice also acknowledged that localized supply disruption could persist while product moved through distribution.<sup>7</sup> A national shortage determination therefore should not be read as proof that every pharmacy had every presentation immediately available.

| Date           | Documented development                     | Interpretation                           |
|----------------|--------------------------------------------|------------------------------------------|
| September 2017 | Victoza federal resolution                 | Historical compliance matter             |
| January 2024   | Announced insulin cuts take effect         | Product-specific list-price policy       |
| September 2024 | Senate pricing hearing                     | Oversight and company testimony          |
| February 2025  | FDA resolves national injection shortage   | Supply determination                     |
| January 2027   | Announced WAC and negotiated-price changes | Future applicability at this review date |

In February 2026, Novo Nordisk announced the forthcoming semaglutide list-price reduction.<sup>4</sup> The sequence does not establish that any single political, commercial, or regulatory event caused the decision. Demonstrating causation would require internal decision records or a stronger empirical design than chronological proximity. It does establish that a report relying only on the 2024 debate would omit a material announced change.

### 3. Principal evidence: what the record does and does not establish

The clearest historical enforcement record concerns Victoza's risk communication. DOJ alleged that some sales representatives minimized or undermined a message required under the FDA's risk-management program. The issue concerned a potential risk of medullary thyroid carcinoma and the communication obligations attached to the product. The resolution should be described as a settlement of specified allegations, with the separate legal bases and periods preserved.<sup>2</sup> It does not provide an estimate of patient injuries caused, establish a current risk rate, or determine the appropriateness of any individual's prescription.

The Senate record addresses a separate question: why American purchasers face particular prices for GLP-1 products. The hearing's critical title expresses the committee's framing; it is not a neutral adjudicated finding. The company submitted its own account, including an assertion that a large share of gross sales was returned through rebates, discounts, and fees and that Ozempic's net price had declined since launch.<sup>6</sup> To evaluate that explanation, an analyst would need product-level, period-specific rebate and net-revenue data linked to utilization and benefit design.

The annual report supplies another type of evidence. It records sales and costs under corporate financial reporting, including substantial research and development expenditure. Novo Nordisk reported DKK 52,039 million in 2025 research and development costs.<sup>1</sup> That amount demonstrates expenditure at the group level; it is not a calculation of the research cost attributable to one prescription, nor a demonstrated minimum price required for a particular drug. Allocating costs to an individual product would require explicit methods for unsuccessful research, shared facilities, financing, and the timing of expenditure.

FDA's shortage notice is authoritative for its regulatory determination and stated supply assessment.<sup>7</sup> It is not evidence that products sold outside the approved supply chain are equivalent to approved medicines. This report therefore does not turn an affordability discussion into guidance about compounded or alternative formulations. The legal and clinical questions would require separate, current evidence.

Taken together, the materials support focused accountability: examine historical communication obligations; test current affordability claims against eligibility and real bills; and separate supply from coverage. They do not support a blanket conclusion that every product, employee, or pricing decision is implicated in one historical case. The most useful public report is specific enough that a reader can tell which conclusion would change if a new source appeared.

## 4. Pricing and access: interpreting the quantitative record

For transparency purposes, wholesale acquisition cost is a published manufacturer benchmark; net price reflects deductions such as negotiated discounts and rebates; patient out-of-pocket cost depends on coverage and program conditions. These categories are conceptually different even when a public discussion calls all of them “price.” This report uses the labels in the originating documents and avoids manufacturing a single comparable average from incompatible figures.

The company's March 2023 announcement provides a concrete historical benchmark: it set NovoLog's vial list price at \$72.34 beginning January 2024 and described a 75% reduction, while separately identifying pen-package prices.<sup>5</sup> A vial should not be relabeled a monthly supply without prescribing and use information. The percentage also should not be interpreted as a measured 75% reduction in national insulin spending, because spending combines unit prices, quantities, product mix, and payment arrangements.

CMS's fact sheet reports a negotiated 30-day-equivalent price of \$274 for the selected drug grouping Ozempic/Rybelsus/Wegovy for 2027. It separately specifies package-level amounts, including \$276.78 for the listed Ozempic pen and Rybelsus tablet package and \$385.63 for the listed Wegovy package.<sup>8</sup> Those different numbers are not inherently inconsistent: they represent different units and aggregation methods. The negotiated amount is also not a universal copayment.

The company's February 2026 announcement sets a future \$675 monthly WAC and explicitly states that the change does not alter direct-to-patient self-pay prices.<sup>4</sup> Its checked Wegovy price guide separately lists self-pay offers, introductory conditions, and insurance-related savings terms. The displayed injection offer includes \$349 per month for specified doses after introductory fills, with restrictions; the guide defines a month as a box of four pens and reserves the company's ability to modify or cancel offers.<sup>9</sup>

| Figure  | Category                                           | Avoid interpreting it as         |
|---------|----------------------------------------------------|----------------------------------|
| \$72.34 | Historical announced NovoLog vial WAC              | Universal monthly patient cost   |
| \$274   | 2027 Medicare 30-day-equivalent negotiated figure  | Every package price or copayment |
| \$675   | Announced 2027 semaglutide monthly WAC             | Present self-pay offer           |
| \$349   | Conditional listed Wegovy injection self-pay offer | Unrestricted lifetime guarantee  |

Our analysis is that headline comparisons become unreliable unless their denominators are retained. A meaningful access evaluation would track coverage denials, prescription abandonment, continuity, and actual patient payments before and after each change. None of the cited announcements alone supplies that complete longitudinal dataset.

## 5. Outcomes, company position, and status at the research date

The documented historical outcome is the 2017 monetary resolution of the Victoza matter. This report does not present that closed enforcement announcement as an active proceeding or assume that it resolves unrelated litigation. A public-source review of selected records cannot provide a complete current docket search for every entity in a multinational group.

The company's central position in its 2024 testimony was that the American payment system separates published prices from manufacturer receipts and that payer incentives can limit the effect of unilateral price cuts. It cited changes in Levemir formulary access as part of its explanation for discontinuation.<sup>6</sup> The report treats this as an attributed company account. It has not independently replicated those coverage percentages or isolated the respective contributions of payer decisions, competition, production strategy, and product lifecycle.

In 2026, the company also presented lower future WAC as a way to help people whose cost sharing is linked to list price.<sup>4</sup> The two positions are not necessarily logically incompatible: a price cut can benefit some patients while producing different consequences elsewhere in the distribution system. The empirical question is the balance of effects and who benefits, not whether either side can point to a single mechanism in isolation.

The financial report shows that Novo Nordisk remained a large operating business, with insulin, GLP-1, obesity, and rare-disease revenue streams.<sup>1</sup> It does not support treating a historical settlement payment as the company's annual profit, pricing margin, or total expenditure on compliance. The categories have different purposes and should not be placed in a ratio labeled “profit from misconduct.”

For access programs, the live document itself matters. The Wegovy guide viewed for this review contained a later introductory-offer end date than some indexed descriptions of the same URL. This illustrates why a dated screenshot or archived copy of the actual terms should accompany future quantitative audits. This report relies on the opened document rather than an earlier search snippet.<sup>9</sup> Terms should be checked again before any patient-facing tool displays an offer.

Our current-status assessment is therefore bounded: announced insulin changes and the federal resolution are documented historical events; FDA made a national shortage determination in 2025; the forthcoming 2027 WAC and Medicare changes are recorded policy developments; conditional savings offers exist. We do not claim that these facts establish universal affordability or that their full downstream outcomes have already been measured. Future editions should replace announcements with implementation evidence as effective dates pass.

## 6. Implications, method, and limits

This review used nine primary or first-party sources: federal enforcement and regulatory documents, congressional records, Medicare documentation, and the company's own disclosures and offer terms. Sources were selected for their direct relevance to identity, conduct, price definitions, or current access. The review included fresh searches for 2026 developments and inspection of the underlying pages or PDFs. Search results were discovery aids rather than the evidentiary basis for central claims.

The sources carry different incentives and authority. DOJ describes the government's enforcement position and resolution. Company statements establish what the company announced or argued. Congress records oversight questions and submitted testimony. FDA determines regulatory supply status. CMS describes negotiated prices within a defined program. No one source should be used as a substitute for the others when the question changes.

A dated access ledger could address some of the remaining evidence gaps. Each observation would need product and package, geography, price type, payer or assistance program, eligibility terms, source date, and last verification date. Versioned price records would preserve historical changes; an expired promotion could remain in the historical series with an end date while being distinguished from verified current terms. Such a dataset was not assembled for this report.

A stronger outcomes study would compare patient payments and filled prescriptions across matched populations before and after a change. It should account for insurance status, formulary changes, dose and presentation, switching, and time trends. A transparent design would publish exclusions and uncertainty rather than infer national savings from a small convenience sample. Patient records would require appropriate consent and protection; this report uses no identifiable patient data.

Several limitations remain. Product-specific net prices are often unavailable in a form that permits independent replication. The review does not calculate a clinically appropriate price or adjudicate patent, coverage, or safety disputes. It does not independently verify every corporate statement about research costs, discounts, or supply. The presence of a source in this report does not imply endorsement of all claims elsewhere in that source.

The practical conclusion is that Novo Nordisk's record requires precise labels and current dates. Historical compliance issues warrant accurate reporting, while later pricing changes warrant equally careful inclusion. Readers should be able to distinguish a confirmed event, an allegation, a company explanation, a future commitment, and an unanswered access question without having to reconstruct those distinctions themselves.

## References

1. Novo Nordisk. *Financial performance - Annual Report 2025*. 2026. [Open source](#)
2. U.S. Department of Justice. *Novo Nordisk Agrees to Pay \$58 Million for Failure to Comply with FDA-Mandated Risk Program*. September 5, 2017. [Open source](#)
3. U.S. Senate HELP Committee. *Why Is Novo Nordisk Charging Americans with Diabetes and Obesity Outrageously High Prices for Ozempic and Wegovy?* September 24, 2024. [Open source](#)
4. Novo Nordisk. *Novo Nordisk announces significant reduction in US list price for Wegovy, Ozempic, and Rybelsus (semaglutide medicines), building on continued efforts to expand access*. February 24, 2026. [Open source](#)
5. Novo Nordisk, company release distributed by PR Newswire. *Novo Nordisk to lower U.S. prices of several pre-filled insulin pens and vials up to 75% for people living with diabetes in January 2024*. March 14, 2023. [Open source](#)
6. Lars Fruergaard Jørgensen / Novo Nordisk, submitted to U.S. Senate HELP Committee. *Written testimony*. September 24, 2024. [Open source](#)
7. U.S. Food and Drug Administration. *FDA Determines Semaglutide Shortage is Resolved*. February 21, 2025. [Open source](#)
8. Centers for Medicare & Medicaid Services. *Medicare Drug Price Negotiation Program: Negotiated Prices for Initial Price Applicability Year 2027*. November 2025. [Open source](#)
9. Novo Nordisk / NovoCare. *Wegovy Price guide*. Document code US26NC00049, April 2026; live version checked September 9, 2026. [Open source](#)