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Eloralintide: The Weight Loss Peptide That Is Not a GLP-1

Inside the first selective amylin peptide to post GLP-1 level results in a 48 week trial, and why researchers are watching it so closely.

RESEARCH SERIES

Quick read: Eloralintide (say it: el-or-a-LIN-tide) works on a hunger hormone called amylin, not on GLP-1. In a 48 week study published in *The Lancet*, people on the highest weekly dose lost about **20% of their body weight**. Placebo lost **0.4%**. Phase 3 trials are now running. It is not approved anywhere yet.

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The Hook

For the last five years, almost every big weight loss headline has been about one family of drugs: GLP-1s. Semaglutide. Tirzepatide. Retatrutide. Same pathway, bigger numbers.

Eloralintide is different. It does not touch the GLP-1 receptor at all. It works on **amylin**, a hormone your pancreas already makes every time you eat. And in a 48 week Phase 2 trial, the top dose matched the weight loss numbers of the best GLP-1 drugs, with a side effect pattern researchers describe as **dose dependent and mostly mild to moderate**.[1]

Did you know? Google searches for "eloralintide" grew roughly **3x in the last three months** and hit their all time high in August 2026 (Semrush, US database). Almost nobody outside research circles had heard the word a year ago.

Why This Matters

Obesity now affects more than **2 billion adults** worldwide, and forecasts say nearly two thirds of adults will be affected by 2050.[3] GLP-1 drugs changed the game, but they have limits: weight loss plateaus, some people cannot tolerate the nausea, and weight often comes back after stopping.

That is why scientists are hunting for a **second pathway**. If two different hormone signals can be combined, the thinking goes, you might get more weight loss with fewer side effects. Amylin is the leading candidate for that second signal, and eloralintide is the most selective amylin peptide with published human data so far.[4,5]

The Science, In Plain English

What is amylin?

Think of your pancreas as a kitchen that sends two text messages when you eat. One message is insulin ("store this sugar"). The other is **amylin** ("slow down, you are getting full"). Amylin is a 37 amino acid peptide released alongside insulin. It slows your stomach from emptying, turns down a hormone called glucagon, and tells a part of your brainstem that the meal is done.[4,6]

Natural amylin has two problems as a medicine. It breaks down in minutes, and it clumps together. Scientists solved that decades ago with a daily injection called pramlintide, but it was weak and inconvenient. The new generation, including eloralintide, is engineered to last a full week.[6]

What makes eloralintide "selective"?

Amylin receptors are built from a calcitonin receptor plus a helper protein. Older amylin drugs like cagrilintide hit both the amylin receptor and the plain calcitonin receptor. Eloralintide is built to prefer the amylin receptor. In lab tests it activated the human AMY1 receptor about **12 times more strongly** than the calcitonin receptor and about **11 times more** than AMY3.[2]

Why care? In rats, eloralintide caused **significantly less food aversion** than cagrilintide. Researchers think that receptor selectivity may be part of why the human side effect profile looked the way it did, though this is still being studied.[2,7]

The simple version: GLP-1 drugs and eloralintide both tell your brain you are full. They just use different phone lines. That is exactly why scientists want to test them together.

What the Research Says

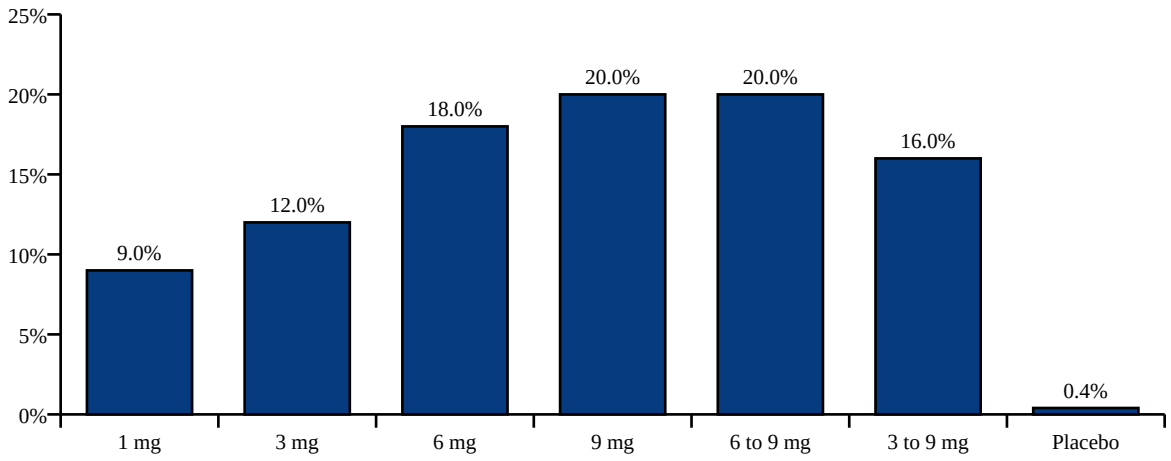
Phase 1: first human doses

Two early studies came first. A single dose study in 48 healthy adults showed the peptide lasts long enough for once weekly dosing and produced mostly mild side effects.[2] A 12 week study in 100 adults with obesity or overweight followed. Weight loss ranged from **2.6% to 11.3%** across dose groups, and stomach side effects were infrequent: nausea in 8%, vomiting in 4%.[8]

Phase 2: the Lancet trial

The big result came in November 2025. Researchers at 46 US sites enrolled 263 adults with obesity or overweight and no diabetes. They were randomly assigned to placebo or one of six once weekly eloralintide plans for 48 weeks.[1]

Average body weight lost after 48 weeks (Phase 2, The Lancet 2025)



Once-weekly dose groups. 263 adults with obesity or overweight, no diabetes.

Dose group	Average weight change	Nausea	Fatigue
Placebo	-0.4%	14%	12%
1 mg weekly	-9%	11%	0%
3 mg weekly	-12%	13%	13%
6 mg weekly	-18%	64%	29%
9 mg weekly	-20%	33%	43%
6 to 9 mg step up	-20%	54%	46%
3 to 9 mg step up	-16%	25%	21%

Source: Billings et al., The Lancet, 2025.[1] Weight change is the efficacy estimand at week 48. Side effects are the share of people reporting them at any point.

Two things stand out. First, weight loss climbed with dose and had not clearly leveled off at 48 weeks. Second, side effects also climbed with dose. The lowest doses had nausea rates **at or below placebo**, while the 6 mg group had the highest nausea rate in the trial. Starting low and stepping up (3 to 9 mg) cut nausea to 25% while keeping most of the weight loss.[1]

How it stacks up against other new peptides

A 2026 network meta analysis pooled six trials of the new amylin based peptides (4,642 people). Ranked by percent weight loss versus placebo, high dose eloralintide came in **second**, behind amycretin and ahead of the cagrilintide plus semaglutide combination. All three beat semaglutide 2.4 mg in that indirect comparison. The authors warn the data are still early and low certainty.[5]

Peptide	How it works	Best reported weight loss vs placebo	Status (2026)
Eloralintide	Selective amylin receptor agonist, weekly	-18.0% (network meta analysis, high dose)	Phase 3 (ENLIGHTEN)
Cagrilintide + semaglutide	Dual amylin/calcitonin + GLP-1	-17.2%	Phase 3
Amycretin	Amylin + GLP-1 in one molecule	-24.0%	Phase 2 to 3
Semaglutide 2.4 mg	GLP-1 receptor agonist	-11.5%	FDA approved
Tirzepatide	GLP-1 + GIP receptor agonist	About -20% at 72 weeks (SURMOUNT-1)	FDA approved

Sources: Kamrul-Hasan et al. 2026 network meta analysis;[5] Lempesis and Dalamaga 2026 review.[3] Cross trial comparisons are indirect and should be read with caution.

The Big Picture

Eli Lilly, the company behind tirzepatide, is also the company behind eloralintide. That matters because the obvious next experiment is to combine them. Early Phase 1b work has tested eloralintide with tirzepatide in several dose pairings, and a Phase 2 combination arm has been reported as supportive.[9,10]

Phase 3 trials, called the **ENLIGHTEN** program, began in 2026. They cover adults with obesity, adults with obesity and type 2 diabetes, and weight maintenance after initial loss. Primary completion dates are currently listed in 2028.[11,12]

The bottom line: Eloralintide is the strongest evidence yet that a non GLP-1 pathway can deliver GLP-1 level weight loss. Whether it ends up used alone, or as the second half of a two hormone combo, is the question Phase 3 will answer.

What To Know

It is not approved. Eloralintide has no approved use in any country. Everything in this paper comes from clinical trials of an investigational compound.[1,11]

Side effects track with dose. The same trials that showed 20% weight loss also showed nausea in up to 64% of a dose group. Slower step up dosing reduced that. Long term safety is still being studied.[1]

Unanswered questions remain. Durability beyond 48 weeks, what happens after stopping, heart outcomes, and results in people with diabetes are all open.[3,5]

Research grade material is a different category. Peptides sold for laboratory research are not medicines and are not made for human use. Any health decision should be made with a qualified healthcare provider.

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