[Physician Name]
[Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Attn: Appeals/Prior Authorization Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for [Patient Name]
Patient Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group ID]

To Whom It May Concern,

I am writing to request coverage for **[Medication Name]** for my patient, **[Patient Name]**. This medication is medically necessary to treat [Patient Name]'s diagnosis of chronic obesity (ICD-10 code: [Code]).

Patient Clinical History:

- Current Weight: [Weight]
- Current BMI: [BMI]
- Co-morbidities: [e.g., Hypertension, Type 2 Diabetes, Sleep Apnea, Hyperlipidemia]

Previous Interventions:
The patient has attempted to lose weight through supervised diet and exercise for a period of [Number] months/years without achieving clinically significant results. Additionally, the patient has previously tried and failed the following medications or treatments: [List previous medications/treatments, or state "None"].

Clinical Rationale:
Based on the patient's BMI and associated health risks, weight reduction is critical to prevent further cardiovascular complications and manage existing metabolic conditions. **[Medication Name]** is indicated for chronic weight management and I believe it is the most appropriate pharmacological intervention for this patient at this time.

Please review this request for prior authorization. If you require additional medical records or information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]