

**Date:** [Date]

**TO:** [Insurance Company Name]

**ATTN:** [Appeals/Prior Authorization Department]

**FAX:** [Fax Number if applicable]

**ADDRESS:** [Insurance Address]

**RE: Letter of Medical Necessity for [Patient Name]**

**Patient DOB:** [Date of Birth]

**Member ID:** [Member ID Number]

**Group Number:** [Group Number]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to document the medical necessity for treatment with [Specific GLP-1 Medication Name, e.g., Wegovy, Ozempic, Zepbound].

**Diagnosis and Clinical History:**

The patient has been diagnosed with [Primary Diagnosis, e.g., Type 2 Diabetes (ICD-10 code) or Chronic Obesity (ICD-10 code)]. The patient currently has a BMI of [Patient BMI] kg/m2 and suffers from the following weight-related comorbidities:

- [Comorbidity 1, e.g., Hypertension]
- [Comorbidity 2, e.g., Sleep Apnea]
- [Comorbidity 3, e.g., Prediabetes]

**Previous Treatments:**

Prior to this request, the patient has attempted the following interventions without achieving sustained clinical success:

- [Previous Medication 1] - Duration: [Time], Result: [Failure/Side Effects]
- [Previous Medication 2] - Duration: [Time], Result: [Failure/Side Effects]
- Structured lifestyle modifications (diet and exercise) for [Number] months.

**Clinical Justification:**

Based on the patient's medical history and current health status, I have determined that [GLP-1 Medication Name] is a necessary component of their treatment plan. Clinical data suggests that this medication will significantly improve the patient's [HbA1c levels / Weight loss goals] and reduce the risk of long-term cardiovascular complications.

In summary, [GLP-1 Medication Name] is medically necessary for this patient. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]