[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 Semaglutide
Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group ID]

To Whom It May Concern,

I am writing to request a formal review and coverage for Semaglutide for my patient, [Patient Name]. While Semaglutide is FDA-approved for the treatment of Type 2 Diabetes, I am prescribing this medication off-label for chronic weight management due to the patient's specific clinical profile and the presence of life-threatening comorbidities.

Clinical Diagnosis and History:
The patient is currently diagnosed with [Primary Diagnosis, e.g., Obesity ICD-10 E66.01] with a current BMI of [BMI Number] kg/m. Additionally, the patient suffers from the following weight-related comorbidities:

- [Comorbidity 1, e.g., Hypertension]
- [Comorbidity 2, e.g., Hyperlipidemia]
- [Comorbidity 3, e.g., Obstructive Sleep Apnea]
- [Comorbidity 4, e.g., Prediabetes/Insulin Resistance]

Previous Interventions:
The patient has attempted to achieve weight loss through the following supervised methods without long-term success:

- [Duration] of lifestyle modification, including calorie-restricted diet and increased physical activity.
- Previous pharmacotherapy: [List medications tried, e.g., Phentermine, Orlistat, etc.].
- [Other treatments].

Clinical Rationale:
Clinical evidence demonstrates that GLP-1 receptor agonists, such as Semaglutide, are highly

effective in reducing weight and improving metabolic health in patients with [Patient's Condition]. Given the patient's failure to respond to traditional therapies and the significant risks associated with their current comorbidities, I believe Semaglutide is a medical necessity to prevent further cardiovascular and metabolic decline.

I request that you approve this request for [Patient Name] to begin treatment immediately. Please contact my office at [Phone Number] if you require additional medical records or documentation.

Sincerely,

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