Medical Necessity Language Library

Three complete letter templates for GLP-1 prior authorization — initial therapy, medication switch, and continuation of care. Fill in the bracketed fields. Adapt every letter to your patient.

Each letter below is a template — not a form. Fill in the clinical details specific to your patient. Green bracketed fields [like this] are placeholders to replace. Do not copy letters verbatim — payers flag templated language. Every word you submit should reflect your patient's actual clinical picture.

HOW TO USE THESE TEMPLATES	
□□ Fill in every green field	Replace all bracketed placeholders with patient-specific data before sending.
□ Lead with clinical severity	Payers respond to clinical impact language: A1c, functional limitations, comorbidity burden — not just BMI.
□ Attach supporting documents	Lab results, prior auth denial letters, medication history, visit notes. The letter alone rarely wins.
□ Avoid generic phrases	'Failed conservative management' and 'medically necessary' alone are insufficient. Be specific.
□□ Don't copy verbatim	Payers flag form letters. Personalize every submission to the individual patient encounter.

LETTER 1 OF 3

Initial GLP-1 Therapy Authorization

Use when: requesting GLP-1 initiation for a patient who has not previously received a GLP-1 receptor agonist. Includes documentation of why non-GLP-1 alternatives are not appropriate.

 Before sending: confirm the payer's covered indications (obesity, T2DM, or both), step therapy requirements, and whether a Letter of Medical Necessity is required separately from the PA form. This template addresses both the medical necessity argument and contraindication/inappropriateness of non-GLP-1 alternatives. Delete sections that do not apply to your patient.

Date: *[_____]*

Re: Prior Authorization Request — GLP-1 Receptor Agonist Therapy

Patient Name: *[_____]*

Date of Birth: *[_____]*

Member ID / Insurance ID: *[_____]*

Prescribing Provider: *[_____]*

NPI: *[_____]*

Requested Medication & Dose: *[_____]*

To Whom It May Concern / Medical Director, *[PAYER NAME]*:

I am writing to request prior authorization for *[MEDICATION NAME, e.g., semaglutide 0.25 mg subcutaneous weekly]* for my patient, *[PATIENT NAME]*, a *[AGE]*-year-old *[male/female/patient]* under my care for the management of *[obesity / type 2 diabetes mellitus / obesity with comorbid conditions]*.

CLINICAL PICTURE

This patient presents with a current BMI of *[XX.X kg/m²]*, documented at today's visit. The following obesity-related comorbidities are present and active:

- *[e.g., Type 2 diabetes mellitus (HbA1c: ___%, date: ___)]*
- *[e.g., Hypertension, currently managed with ___ agents]*
- *[e.g., Hyperlipidemia (LDL: ___ mg/dL, date: ___)]*
- *[e.g., Obstructive sleep apnea, confirmed by polysomnography]*
- *[e.g., Non-alcoholic fatty liver disease / MASLD]*
- *[e.g., Osteoarthritis of the bilateral knees, limiting ambulation]*

- *[e.g., DELETE lines that do not apply]*

The patient's weight significantly contributes to the above conditions. *[Optional: expand on clinical impact — e.g., 'Despite three antihypertensive agents, blood pressure remains above goal, attributable in part to the patient's weight.']*

PRIOR TREATMENT HISTORY & LIFESTYLE INTERVENTION

This patient has engaged in supervised lifestyle intervention without achieving or sustaining clinically adequate weight reduction. Documented attempts include:

- *[e.g., Structured low-calorie diet counseling with registered dietitian, dates: ___ – ___, outcome: ___% weight loss, regained within ___ months]*
- *[e.g., Commercial weight management program (name: ___), dates: ___, outcome: ___ lbs lost, weight regained after program completion]*
- *[e.g., Provider-supervised exercise program, ___ months, adherent, outcome: modest weight loss without sustained reduction]*
- *[e.g., Behavioral counseling / cognitive behavioral therapy for weight, dates: ___]*

Despite these documented efforts, the patient has been unable to achieve or maintain a weight reduction sufficient to reduce comorbidity burden or improve metabolic parameters. Pharmacologic intervention is medically indicated.

WHY NON-GLP-1 WEIGHT MANAGEMENT MEDICATIONS ARE NOT APPROPRIATE

Per your plan's step therapy requirements, I am providing the following documentation of why commonly required non-GLP-1 alternatives are contraindicated or clinically inappropriate for this patient. Please delete any options that do not apply.

Phentermine and phentermine/topiramate (Qsymia®):

[Select all that apply:]

- This patient is currently prescribed *[medication, e.g., amphetamine salts / methylphenidate / lisdexamfetamine]* for the treatment of Attention Deficit Hyperactivity Disorder (ADHD). Concurrent use of phentermine with a CNS stimulant is associated with additive cardiovascular risk, including hypertension and tachycardia, and is not recommended per prescribing guidance.
- This patient has a history of *[cardiovascular disease / uncontrolled hypertension / arrhythmia / hyperthyroidism / glaucoma]*, representing a contraindication to sympathomimetic agents including phentermine.
- This patient has a history of substance use disorder involving stimulants, making phentermine prescribing clinically inappropriate due to Schedule IV classification and abuse potential.
- Phentermine/topiramate (Qsymia®) is additionally contraindicated in this patient due to *[pregnancy / history of kidney stones / metabolic acidosis / known hypersensitivity to topiramate]*.
- *[Other provider-documented reason phentermine is not appropriate for this patient]*

Orlistat (Xenical® / Alli®):

- This patient works as *[e.g., a manufacturing line worker / machine operator / commercial driver / healthcare provider on active call]* and does not have reliable, timely access to restroom facilities throughout the workday. Orlistat's gastrointestinal side effects — including oily stools, fecal urgency, and oily spotting —

are predictable, dose-dependent, and well-documented. These effects occur unpredictably and frequently enough to create significant occupational impairment for this patient, making orlistat use professionally and practically untenable.

- This patient has a documented history of *[chronic kidney disease / malabsorption syndrome / cholestasis / cholelithiasis]*, which represents a contraindication to orlistat therapy.
- This patient takes *[cyclosporine / levothyroxine / warfarin / antiretroviral medications]*, which have clinically significant interactions with orlistat that preclude its safe use in this patient.
- This patient previously trialed orlistat *[dates: ___ – ___]* and discontinued due to *[intolerable GI side effects / inability to maintain fat-restricted diet due to ___ / inadequate response: ___ kg/lbs lost over ___ months]*.
- *[Other provider-documented reason orlistat is not appropriate for this patient]*

Naltrexone/bupropion (Contrave®):

- This patient has a history of *[seizure disorder / anorexia nervosa / bulimia nervosa / current or recent use of MAOIs]*, representing a contraindication to bupropion-containing products.
- This patient requires chronic opioid therapy for the management of *[pain condition]*. Naltrexone is an opioid antagonist and would precipitate opioid withdrawal and render opioid analgesics ineffective; concurrent use is contraindicated.
- This patient is currently managed for *[major depressive disorder / bipolar disorder]* on *[medication]*. Addition of bupropion would require complex psychopharmacological coordination and was determined to be clinically inadvisable by the treating *[psychiatrist / prescribing provider]*.
- *[Other provider-documented reason naltrexone/bupropion is not appropriate]*

MEDICAL NECESSITY STATEMENT

In my clinical judgment, *[MEDICATION NAME]* is medically necessary for this patient. The patient's obesity and associated comorbidities represent a significant and progressive health risk. Non-GLP-1 pharmacologic alternatives are contraindicated or clinically inappropriate as documented above. GLP-1 receptor agonist therapy is the next appropriate evidence-based step in this patient's treatment plan and is consistent with current obesity medicine guidelines (AACE/ACE, TOS, USPSTF).

I am available to provide additional clinical documentation, peer-to-peer review, or supporting records at your request. Please do not hesitate to contact my office.

Sincerely,

[Provider Name, Degree]
[Specialty / Title]
[Practice Name]
[Address]
[Phone]
[NPI]

Attachments: office visit note, laboratory results, medication history, *[other supporting documentation]*

LETTER 2 OF 3

GLP-1 Medication Switch — Prior Intolerance

Use when: requesting authorization for a different GLP-1 agent after the patient experienced inadequate response or intolerable adverse effects on a previously covered GLP-1.

 Key distinction for payers: this is not a request to 'try something better' — it is a clinically driven switch based on documented tolerance failure or inadequate response. Be specific about the adverse effects, their severity, and how they impaired the patient's ability to continue therapy. Include dates and doses.

Date: *[_____]*

Re: Prior Authorization Request — GLP-1 Medication Switch

Patient Name: *[_____]*

Date of Birth: *[_____]*

Member ID / Insurance ID: *[_____]*

Prescribing Provider: *[_____]*

NPI: *[_____]*

Previously Authorized Medication: *[_____]*

Requested New Medication & Dose: *[_____]*

To Whom It May Concern / Medical Director, *[PAYER NAME]*:

I am writing to request prior authorization for a change in GLP-1 receptor agonist therapy for my patient, *[PATIENT NAME]*, a *[AGE]*-year-old *[male/female/patient]* currently under my care for *[obesity / type 2 diabetes mellitus]*. I am requesting authorization for *[NEW MEDICATION, e.g., semaglutide 0.25 mg subcutaneous weekly]* in place of *[PRIOR MEDICATION, e.g., liraglutide 1.2 mg subcutaneous daily]*, which was previously authorized and dispensed.

COURSE OF PRIOR GLP-1 THERAPY

[PRIOR MEDICATION NAME] was initiated on *[start date]* at a starting dose of *[dose]*. The medication was titrated per prescribing protocol to *[maximum tolerated dose, e.g., 1.8 mg / 1.2 mg daily]* by *[date of max dose]*. The patient received *[X]* months of therapy in total.

REASON FOR MEDICATION CHANGE

The medication change is requested for the following clinically documented reason(s). Please select and complete all that apply:

Option A — Adverse Effects / Intolerance:

Despite dose reduction and supportive management, the patient experienced persistent and clinically significant adverse effects that precluded continuation of *[PRIOR MEDICATION]*. Specifically:

- *[e.g., Persistent nausea rated 7–9/10 severity occurring daily regardless of dose adjustment, dietary modification, or injection timing changes. Nausea persisted for ___ weeks at the ___ mg dose and led to a ___ lb unintentional weight loss from inability to maintain adequate caloric intake.]*
- *[e.g., Recurrent vomiting requiring two urgent care visits on ___ and ___, with documented dehydration. Unable to maintain oral hydration.]*
- *[e.g., Severe injection site reactions: persistent subcutaneous nodules, erythema > 5 cm, and pain requiring dose delay on ___ occasions over ___ weeks.]*
- *[e.g., Significant injection fatigue and patient-reported psychological burden associated with daily injections (liraglutide), which resolved on trial of weekly subcutaneous formulation. Weekly dosing is clinically preferable for this patient's adherence and quality of life.]*
- *[Other documented adverse effect: describe severity, duration, impact on adherence]*

Option B — Inadequate Therapeutic Response:

The patient was adherent to *[PRIOR MEDICATION]* at a dose of *[dose]* for *[X]* months. Despite adherence and concurrent lifestyle modification, the patient achieved only *[X]%* weight reduction (goal: ≥ 5% body weight at 3 months or ≥ 10% by 6 months per AACE guidelines). *[Optional: 'HbA1c remained at ___% (goal < ___%) despite full-dose therapy for ___ months.']* In my clinical judgment, a trial of an agent with a different pharmacologic profile is warranted.

WHY THE REQUESTED AGENT IS APPROPRIATE

[REQUESTED MEDICATION] is appropriate for this patient for the following reasons:

- *[e.g., Once-weekly subcutaneous injection is expected to improve patient adherence and reduce injection burden compared to daily dosing on prior therapy.]*
- *[e.g., Clinical trial data (SURMOUNT-1, SELECT, STEP trials) demonstrate superior weight reduction and/or glycemic efficacy with the requested agent compared to prior-generation GLP-1 agents.]*
- *[e.g., The requested agent's side effect profile and titration schedule may be better tolerated based on this patient's documented sensitivities.]*
- *[e.g., Patient has comorbid OSA — tirzepatide (Zepbound®) is FDA-approved for the treatment of moderate-to-severe OSA in adults with obesity, directly addressing this comorbidity.]*
- *[Other clinical rationale for this specific agent]*

In my clinical judgment, continued GLP-1 receptor agonist therapy with *[REQUESTED MEDICATION]* is medically necessary. The prior agent was not clinically successful due to the documented reasons above. Switching agents within this class is consistent with evidence-based obesity medicine practice and is not a discretionary preference — it is the appropriate clinical response to a documented treatment failure.

I am available for peer-to-peer review and can provide office visit notes, adverse event documentation, and weight trend data upon request.

Sincerely,

[Provider Name, Degree]
[Specialty / Title]
[Practice Name]
[Phone]
[NPI]

Attachments: office visit notes documenting adverse effects / response data, weight trend log, prior medication administration record, *[other supporting documentation]*

LETTER 3 OF 3

Continuation of GLP-1 Therapy

Use when: the initial authorization period has ended and the patient requires ongoing coverage for a GLP-1 medication that has demonstrated clinical benefit.

 Continuation letters live and die on response data. Lead with numbers: weight lost, HbA1c reduction, blood pressure improvement, comorbidity improvement. Payers are looking for evidence that the medication is working. 'Patient is tolerating well' alone is not sufficient — show measurable clinical benefit.

Date: *[_____]*

Re: Prior Authorization Renewal — Continuation of GLP-1 Therapy

Patient Name: *[_____]*

Date of Birth: *[_____]*

Member ID / Insurance ID: *[_____]*

Prescribing Provider: *[_____]*

NPI: *[_____]*

Current Medication & Dose: *[_____]*

Original Authorization Date: *[_____]*

Renewal Period Requested: *[_____]*

To Whom It May Concern / Medical Director, *[PAYER NAME]*:

I am writing to request renewal of prior authorization for *[MEDICATION NAME & DOSE]* for my patient, *[PATIENT NAME]*, a *[AGE]*-year-old *[male/female/patient]*, who has been under my care for *[obesity / type 2 diabetes mellitus / obesity with comorbid conditions]* since *[date]*. This medication was originally authorized on *[date]* and has been in continuous use since that time.

DOCUMENTED CLINICAL RESPONSE

The following objective clinical improvements have been documented during the current authorization period:

- Weight response: *[Starting weight: ___ lbs / kg on ___. Current weight: ___ lbs / kg on ___. Total reduction: ___ lbs / ___%. Trend: sustained loss / plateau with maintained weight loss / improved body composition with resistance training.]*

- Glycemic response (if applicable): *[Baseline HbA1c: ___% on ___. Most recent HbA1c: ___% on ___. Reduction: ___%. [Optional: fasting glucose ___→___ mg/dL.] Patient is [approaching / at / below] HbA1c target of ___%.]*
- Cardiovascular parameters: *[Baseline blood pressure: ___/___. Current BP: ___/___ — improvement of ___ points systolic. [Optional: antihypertensive medications reduced from ___ agents to ___.] [Optional: LDL ___→___ mg/dL / triglycerides ___→___ mg/dL.]]*
- Comorbidity improvement: *[e.g., 'Patient's obstructive sleep apnea has improved — CPAP pressure reduced from ___ to ___ cmH2O per sleep medicine follow-up on ___.'] [e.g., 'Joint pain severity reduced from ___/10 to ___/10, improving functional mobility and reducing NSAID use.'] [e.g., 'Liver enzymes (ALT/AST) normalized from ___ to ___ U/L over therapy course.']]*
- Functional status / quality of life: *[Optional but valuable: 'Patient reports improved energy, ability to exercise, and participation in daily activities. Prior to therapy, patient was unable to ___ [walk one block / climb stairs / perform occupational duties] without significant limitations.']*

ADHERENCE & TOLERABILITY

The patient has been adherent to *[MEDICATION NAME]* throughout the authorization period, with *[X]* of *[Y]* expected doses administered. *[Optional: 'Medication was obtained without interruption through [pharmacy/specialty pharmacy].']* The patient is currently tolerating the medication at the *[dose]* dose without clinically significant adverse effects.

WHY DISCONTINUATION IS NOT CLINICALLY APPROPRIATE

GLP-1 receptor agonist therapy is a chronic disease management intervention, not a short-term treatment. Discontinuation of this medication would predictably result in:

- Weight regain: Published data (STEP 4 trial: Rubino et al., NEJM 2021) demonstrate that discontinuation of semaglutide results in significant weight regain — approximately two-thirds of lost weight within one year — with return of associated comorbidities.
- Metabolic deterioration: *[e.g., 'HbA1c is expected to rise with discontinuation, likely requiring intensification of diabetic regimen.'] [e.g., 'Blood pressure is expected to return to baseline, requiring re-escalation of antihypertensive therapy.']*
- Functional regression: *[e.g., 'The patient's improved mobility and reduction in joint pain symptoms would be expected to reverse, impairing the patient's ability to maintain the exercise program that is currently supporting ongoing weight management.']*
- This medication is not elective for this patient — it is a component of active management of a chronic, relapsing disease. Obesity is recognized as a chronic disease by the AMA, AACE, TOS, and WHO, requiring long-term pharmacologic treatment.

In my clinical judgment, continued authorization for *[MEDICATION NAME]* is medically necessary and appropriate. The patient has demonstrated clinically meaningful and objective response to therapy. Discontinuation would be expected to result in significant and measurable clinical deterioration. I respectfully request renewal of authorization for *[X months / 12 months]*.

I am available for peer-to-peer review at your request. Please contact my office to schedule. Supporting documentation, including office visit notes and laboratory results, is attached.

Sincerely,

[Provider Name, Degree]
[Specialty / Title]
[Practice Name]
[Phone]
[NPI]

Attachments: office visit notes from authorization period, weight trend log, laboratory results (HbA1c, metabolic panel, lipids), *[specialist notes / sleep study / imaging if applicable]*

INFORMED PLATE

About This Resource

These letter templates were created by a board-certified medical professional to support clinicians writing GLP-1 prior authorization letters. They are intended as starting-point language only — not clinical protocols, legal documents, or guaranteed authorization language.

Prior authorization requirements vary significantly by payer, plan year, formulary tier, and covered indication. Always verify current payer-specific criteria directly with the relevant insurance carrier before submitting. Adapt every letter to your individual patient's clinical picture. Do not submit templated language verbatim — payers flag form letters.

Medical Disclaimer

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