

GLP-1 Prior Authorization & Appeal Letter Kit

This free sample includes the documentation checklist and one of the kit's seven fill-in letters. The full kit adds the initial medical-necessity letter plus five appeal letters (one per common denial), an agent quick-reference, and a submission tracker.

What payers look for — documentation checklist

Confirm each item is in the chart before you submit. These are what a utilization reviewer looks for first.

- Measured height, weight, and calculated BMI (kg/m^2), with the date measured.
- Obesity diagnosis coded to specificity (e.g., E66.9 / E66.01) plus the BMI Z-code (Z68.__).
- If BMI 27–29.9: at least one qualifying weight-related comorbidity, with its ICD-10 code.
- Documented reduced-calorie diet AND increased physical activity, with duration and result.
- Any prior anti-obesity medications tried, with outcome or reason stopped.
- The requested drug, strength, and titration, plus a monitoring and reassessment plan.

Sample letter — medical-necessity (initial prior authorization)

[Your practice letterhead]

[Date]

[Payer / PBM name] • [Prior Authorization Department] • [Address or fax]

RE: Prior authorization request — [Drug name] for chronic weight management

Patient: [Name] DOB: [__/__/____] Member ID: [_____] Group: [_____]

Requested medication: [Drug, strength, directions] Diagnosis: [E66.___] + BMI Z-code [Z68.___]

To the Medical Director:

I am the treating [physician / NP / PA] for the above patient and am requesting prior authorization for [DRUG, STRENGTH] for chronic weight management. This request meets the plan's coverage criteria, documented below.

Diagnosis and anthropometrics.

The patient has a diagnosis of [obesity / overweight with comorbidity], ICD-10 [E66.___]. Measured on [date]: height [___], weight [___], BMI [___] kg/m².

Weight-related comorbidities.

[List each with ICD-10 code — e.g., hypertension (I10), type 2 diabetes (E11.9), dyslipidemia (E78.5), OSA (G47.33).]

Prior weight-management efforts.

The patient has followed a reduced-calorie diet with increased physical activity for [duration], with [result]. [List prior anti-obesity medications tried, with outcome.]

Plan of care and monitoring.

Requested: [DRUG, STRENGTH], titrated per label. I will monitor at [interval] — weight, %TBWL, tolerability — and reassess continuation at ~[3–4] months per label. I attest this therapy is medically necessary. I am available for a peer-to-peer review.

Sincerely, [Name, credentials] [NPI] [Practice • phone • fax]

Want the whole kit? Initial letter + 5 appeal letters (not-medically-necessary, step therapy, formulary, missing docs, BMI dispute) + agent quick-reference + tracker — editable Word, instant download, \$49 at swiftclinicalsolutions.com/resources.

Templates and education only — not legal, billing, or HIPAA-compliance advice. Verify against your payer's policy and clinical judgment. No outcome guaranteed.