Sample Letter of Medical Necessity

Please translate this sample letter on to your own physician's letterhead before printing.

[Date]

[Prescriber Name]
[Your Address]
[Your City, State, ZIP]
[Your phone number]
[Tax ID Number]
[DEA Number]

[Name of Rx Plan]
[Address of Rx Plan]

Re: Authorization for Qsymia® (phentermine and topiramate extended-release) capsules (CIV) use for **[Patient's name]**
Member ID:
Group #:
Rx Bin#:
Date of Birth:

To Whom It May Concern:

I am writing to document the medical necessity of Qsymia® (phentermine and topiramate extended-release) capsules CIV for my patient, [patient's name]. The enclosed documentation provides information about the patient's medical history, diagnosis, and my treatment rationale.

Qsymia was FDA approved on July 17, 2012 as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adults with an initial body mass index (BMI) of 30 kg/m^2 or greater (obese) or 27 kg/m^2 or greater (overweight) in the presence of at least one weight-related comorbidity such as hypertension, type 2 diabetes mellitus, or dyslipidemia. [Patient's name] was originally diagnosed with [disease(s)] in [year(s) of diagnosis(es)]. [Include a description of investigation leading to diagnosis(es) and any treatments that have never worked or stopped working and those to which patient response was inadequate.]

I plan to treat [patient name] with Qsymia. [Include statement about why Qsymia is right for the patient].

In my professional opinion, Qsymia is medically necessary and is the appropriate treatment choice for my patient at this time. Thus, Qsymia should qualify for reimbursement under my patient's benefit plan. Please feel free to contact me if you require additional information.

Sincerely,
Physician Name, MD and Signature

CC: [patient's name]

Ref: Qsymia® (phentermine and topiramate extended-release) capsules CIV package insert, 2012-2013

Medical Necessity Form

Medication* _____ ☐ New Therapy ☐ Continuing Therapy

Dose* _____

Patient Information

Last Name:* _____ First Name:* _____ Birth date*: _____ Gender*: ☐ Male ☐ Female

Street: _____ City:_____ State*: _____ ZIP:_____

Home phone: (_____) _____ Work/cell phone: (_____) _____

Insurance No.: _____ Policy/group No.: _____

Policyholder Name: _____ Policyholder birth date*:_____

Body Mass Index (BMI) (kg/m^2):_____ Waist Circumference (in.):_____ Height (in.):_____ Weight (lbs.):_____

Medical Necessity Information

ICD-9 CODE - Diagnoses & Weight-related comorbidities (Check all that apply):

- ☐ **250.02** Type 2 DM, uncontrolled, no complications
- ☐ **250.90** Type 2 DM, with unspecified complications
  - ☐ **V19.8** Family history of Type 2 DM
- ☐ **259.9** Obesity of endocrine origin
- ☐ **272.4** Dyslipidemia
- ☐ **278.00** Overweight/obesity (unspecified)
- ☐ **278.01** Morbid obesity
- ☐ **278.03** Cardiopulmonary obesity
- ☐ **278.1** Localized adiposity
- ☐ **311** Depression, NOS
- ☐ **327.23** Obstructive sleep apnea
- ☐ **401.9** Hypertension, essential (unspecified)
  - ☐ **V17.49** Family history of hypertension
- ☐ **715.20** Osteoarthritis
- ☐ **790.21** Impaired fasting glucose
- ☐ **Other** Specify by ICD-9 -CM _____
- ☐ **Other** Specify by ICD-9 -CM _____
- ☐ **Other** Specify by ICD-9 -CM _____
- ☐ **Other** Specify by ICD-9 -CM _____

Adjunct Therapies & Duration (Check all that apply):

- ☐ Calorie-restricted diet ____months
- ☐ Commercial weight-loss programs ____months
- ☐ Dietary Supplements ____months
- ☐ Gastric procedure Date _____
- ☐ Nutritionist ____months
- ☐ MD-directed program ____months
- ☐ Physical activity program ____months
- ☐ Weight-loss pharmacotherapy ____months
- ☐ Other :_____
- ☐ Other :_____
- ☐ Other :_____
- ☐ Other :_____

Prescriber's last name*: _____ First name*: _____

Practice name:_____ Speciality:_____

Street*:_____ City*: _____ State*: _____ ZIP*: _____

Phone: (_____) _____ Fax: (_____) _____

Prescriber Tax ID :_____ Prescriber NPI†: _____

DEA #: _____ Group NPI _____ State license #*: _____ PTAN††: _____

Please read the FDA-approved label for Qsymia before prescribing. If the indication for which you are prescribing Qsymia is not listed in the label, the FDA has not approved the efficacy, dosage amount or safety of Qsymia when used for such a use.

By signing below, I certify that the above therapy is medically reasonable and necessary.

Prescriber's Signature* _____ Date*_____

*Required field †National Provider Identifier ††Provider Transaction Access Number