

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 is FDA approved 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<sup>2</sup> or greater (obese) or 27 kg/m<sup>2</sup> or greater (overweight) in the presence of at least one weight-related comorbidity such as hypertension, type 2 diabetes mellitus, or dyslipidemia, and in pediatric aged 12 years and older with an initial BMI in the 95th percentile or greater standardized for age and sex. [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® Full Prescribing Information. Campbell, CA: VIVUS LLC; 2022.

100427.03-USP 12/2022

# 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<sup>2</sup>): \_\_\_\_\_ Waist Circumference (in.): \_\_\_\_\_ Height (in.): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_

## Medical Necessity Information

ICD-10 CODE - Diagnoses & Weight-related comorbidities (Check all that apply):

**E11.65** Type 2 Diabetes Mellitus, with hyperglycemia

**E11.8** Type 2 DM, with unspecified complications

**Z83.3** Family history of type 2 DM

**E34.9** Endocrine disorder

**E78.4** Other Hyperlipidemia

**E66.2** Morbid Obesity with alveolar hypoventilation

**E66.01** Morbid obesity (excess calories)

**E66.3** Overweight

**E65** Localized adiposity

**F33.40** Major depressive disorder

**G47.33** Obstructive sleep apnea

**I10** Hypertension, essential (unspecified)

**Z82.49** Family history of hypertension

**M19.93** Osteoarthritis, secondary

**R73.01** Impaired fasting glucose

**Other** Specify by ICD-10 -CM \_\_\_\_\_

**Other** Specify by ICD-10 -CM \_\_\_\_\_

**Other** Specify by ICD-10 -CM \_\_\_\_\_

**Other** Specify by ICD-10 -CM \_\_\_\_\_

Adjunct Therapies & Duration (Check all that apply):

Calorie-restricted diet \_\_\_\_\_ months

Nutritionist \_\_\_\_\_ months

Other : \_\_\_\_\_

Commercial weight-loss programs \_\_\_\_\_ months

MD-directed program \_\_\_\_\_ months

Other : \_\_\_\_\_

Dietary Supplements \_\_\_\_\_ months

Physical activity program \_\_\_\_\_ months

Other : \_\_\_\_\_

Gastric procedure Date \_\_\_\_\_

Weight-loss pharmacotherapy \_\_\_\_\_ months

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