

Prescription Drug Prior Authorization Request Wegovy, Poviztra (semaglutide)

IMPORTANT: The assessment of your claim may be delayed if this form is incomplete or contains errors. If your claim is approved, the effective date of coverage will be the date the prior authorization request was approved. Requests for coverage prior to the approval date will be considered on an exception basis only. Approval for coverage of this drug may be reassessed at any time at the Insurance Company's discretion.

This section is to be completed by the Plan Member (and the Patient if different than the Plan Member)

PLAN MEMBER INFORMATION			
Plan Member Name (first, middle, last):	Phone Number (incl. area code):	Email Address:	
Employer Name:	Plan Contract No:	Plan Member ID No:	
PATIENT INFORMATION			
Plan Member Name (first, middle, last):	Relationship to Plan Member:	Date of Birth (DD/MM/YYYY):	
Address:	City:	Province:	Postal Code:
Phone Number: () - Ext:	Email Address:		
COORDINATION OF BENEFITS			
A. Other Coverage			
Does the patient have other coverage?	Yes ☐ No ☐		
If Yes, Coverage provided by (indicate insurance company):	If Yes, Plan Contract No:	If Yes, Plan Member ID No:	
B. Patient Assistance Program			
Is the patient enrolled in a patient assistance program?	Yes ☐ No ☐		
If Yes, Program Name:	If Yes, Name of Program Contact Person:	If Yes, Contact's Person Phone Number: () - Ext:	
C. Provincial Coverage			
Has a request for reimbursement been submitted under a provincial plan?			
☐ Yes – Please attach a copy of your acceptance or denial		☐ No – Please briefly explain why an application has not been made:	
PATIENT AND PLAN MEMBER AUTHORIZATION (*If patient is under 16 years of age, the signature of a legal representative is required)			
I authorize the Health Solutions Prior Authorization Program (the Program) to collect and use the personal information disclosed on this form, and any other personal information known to the Program regarding the above-named patient, for the purposes of participating in program services and to contact and obtain any such personal information from, and to disclose any such personal information to, any physician, pharmacist, other health care professional or agent having knowledge of this patient's health relevant to this request and any related claim. I consent to being contacted by the Program via phone, text or email and to the transfer of personal information by phone, fax or email between the Program, my insurer, and my health care provider(s) for the purposes of determining my eligibility for the Program and the delivery of Program services. Email and text may be used during my participation to inform me about my status in the Program and Program services, and to provide notifications and reminders. I acknowledge that neither email nor text are secure methods of communication. Electronic communication is at my option and I may withdraw this option to communicate electronically at any time. I certify that the information given is true, correct and complete to the best of my knowledge.			
Signature of Patient or legal representative:		Date Signed (DD/MM/YYYY)	
Signature of Plan Member:		Date Signed (DD/MM/YYYY)	

This section must be completed by the attending Physician.

PHYSICIAN INFORMATION					
Physician Name (first, middle, last):		License No.		Specialty:	
Address:		City:		Province:	Postal Code:
Phone Number: () - Ext:		Fax Number: () -			
DRUG REQUESTED FOR PRIOR AUTHORIZATION					
Drug Name: ☐ Poviztra ☐ Wegovy	Route of admin.	Strength	Dosage	Patient's Weight	Anticipated Duration of Therapy:
Is the patient currently on, or have they previously been on, the drug requested for prior authorization? Yes ☐ No ☐					If Yes, Start Date: (MM/YYYY):
Where will the drug be administered?					
☐ Home	☐ Private Clinic	☐ Physician's Office	☐ Hospital - ☐ Inpatient ☐ Outpatient		
If applicable, Name of Private Clinic				Phone Number of Private Clinic: () -	
Detailed Diagnosis / Indication for Use:					
Chronic Weight Management - adults					
☐ Drug is being prescribed in accordance with its Health Canada indication as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management in adult patients Patient has an initial body mass index (BMI) of: ☐ 30 kg/m ² or greater (obesity) 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, dyslipidemia, or obstructive sleep apnea ☐ Current body weight: _____ (lb/kg) Current BMI: _____ Date: _____					
Chronic Weight Management - pediatrics					
☐ Drug is being prescribed in accordance with its Health Canada indication as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management in pediatric patients aged 12 to less than 18 years ☐ Patient had an inadequate response to reduced calorie diet and physical activity alone ☐ Patient has an initial BMI at the 95th percentile or greater for age and sex (obesity) ☐ Patient has a body weight above 60 kg (132 lbs) ☐ Current body weight: _____ (lb/kg) Current BMI: _____ Date: _____					
Metabolic dysfunction-associated steatohepatitis (MASH) – Wegovy only					
☐ Drug is being prescribed in accordance with its Health Canada indication for the treatment of non-cirrhotic metabolic dysfunction-associated steatohepatitis (MASH) in adults with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) ☐ The patient has a histological NAS (Non-alcoholic fatty liver disease Activity Score) above or equal to 4 with a score of 1 or more in steatosis, lobular inflammation and hepatocyte ballooning based on a central pathologist evaluation of the baseline liver biopsy ☐ The patient has a reduced calorie diet and increased physical activity ☐ Drug is prescribed by a physician experienced in the diagnosis and treatment of liver diseases					
Renewal Request					
Chronic Weight Management - adults					
☐ Prescriber confirms that the patient has lost at least 5% of initial body weight or continue to maintain their initial 5% weight lost while on semaglutide ☐ Drug is continued to be used as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management ☐ Current body weight: _____ (lb/kg) Current BMI: _____ Date: _____					
Chronic Weight Management - pediatrics					
☐ Prescriber confirms that the patient has clinically responded (i.e., baseline BMI reduction or maintain their reduction in BMI from baseline) to semaglutide and therapy should be continued ☐ Drug is continued to be used as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management ☐ Current body weight: _____ (lb/kg) Current BMI: _____ Date: _____					

Metabolic dysfunction-associated steatohepatitis (MASH)

☐ Prescriber confirms that the patient has clinically responded to WEGOVY (semaglutide) and therapy should be continued

Current Medications or Previous Treatment

Has the patient ever used medications or received treatment for this condition? Yes ☐ No ☐

If no, please explain:

If yes, please use the following chart to list the medications or treatment already used for this condition

Medication or Treatment Name (current or past)	Dose	Start Date (MM/YYYY)	End Date (MM/YYYY)	Outcome of Treatment
				☐ Ineffective ☐ Intolerance ☐ Contraindication Other:
				☐ Ineffective ☐ Intolerance ☐ Contraindication Other:
				☐ Ineffective ☐ Intolerance ☐ Contraindication Other:
				☐ Ineffective ☐ Intolerance ☐ Contraindication Other:
				☐ Ineffective ☐ Intolerance ☐ Contraindication Other:
				☐ Ineffective ☐ Intolerance ☐ Contraindication Other:

ADDITIONAL INFORMATION THAT SUPPORTS THE USE OF THE REQUESTED MEDICATION

PHYSICIAN AUTHORIZATION

I **certify** that I am a physician licensed to practice medicine in Canada and that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. The information in this statement will be kept in a Group Benefits health file with the Insurer and Prior Authorization Program and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I **consent** to such unedited release of any information contained herein.

Physician Signature:

Date Signed (DD/MM/YYYY)

PRIOR AUTHORIZATION REQUEST PROCESS

In some cases, additional diagnostic or clinical information may be required. The information provided on this form is considered confidential. This prior authorization request form must be completed by your attending physician and or pharmacist where applicable. The cost, if any, for obtaining this information is at the expense of the Patient/Plan Member.

PLEASE SEND PRIOR AUTHORIZATION REQUESTS TO:

Fax to:

1-844-751-9981

Attention: Health Solution Prior Authorization Program

Mail to:

Health Solutions Prior Authorization Program

1685 Tech Ave, Mississauga

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