MEDAVIE BLUE CROSS™

PRIOR AUTHORIZATION REQUEST

PROCEDURES FOR PRIOR AUTHORIZATION

Completed forms can be faxed in confidence to 1-514-286-8480 for residents of Quebec and 1-844-661-2640 for residents of all other provinces

Upon receipt, this request will be confidentially reviewed according to payment criteria developed by Medavie Blue Cross in consultation with independent health care consultants. In some cases, additional clinical or diagnostic information may be required to process your claim.

For Quebec residents, the criteria for prior authorization are adjusted to meet the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

- Prior Authorization is a pre-approval process to determine if certain products will be reimbursed under a member's benefit plan.
- Please complete entire form. Incomplete forms cannot be processed.
- **For certain medications, approval for reimbursement may be conditional on confirmation of enrollment in the patient support program.**
- Prior Authorization may be limited to a specified period or quantity of medication.
  Some Medavie Blue Cross plans may require you to purchase a drug requiring prior authorization from a preferred pharmacy*. If your prior authorization request is approved, a case manager may contact you, your physician, or Patient Assistance Program to provide information about the program and to arrange to have your prescription transferred to the preferred pharmacy.
  **Not applicable in Quebec*.
- In cases where a request for Prior Authorization is declined, Medavie Blue Cross is denying payment for a product and is not challenging the medical opinion of the physician nor rendering a medical opinion.
- Any costs associated with the completion of this form or obtainment of additional medical information are the responsibility of the member.
- Renewal of the Prior Authorization will be considered by Medavie Blue Cross upon request from the patient/member. The renewal request should include information from the physician supporting continued use of the medication.
- Prior Authorization coverage is contingent on your continued status as a Medavie Blue Cross cardholder or beneficiary.
- If this is a request under the *Mesure du patient d'exception* for a Quebec resident, please include a completed *Patient d'exception* form that can be found here: www.medaviebc.ca/en/resources, in addition to this document.
- If you would like more information about our Patient First Network, including how your Patient Support Program can become integrated with our new enhanced Prior Authorization processes, please send an e-mail to: patientfirstnetwork@medavie.bluecross.ca.

Residents of All Other Provinces
PO BOX 220, MONCTON (NB) E1C 8L3
TEL.: 1-800-667-4511 FAX: 1-844-661-2640

Residents of Quebec
PO BOX 3300, STATION B, MONTREAL (QC) H3B 4Y5
TEL.: 1-888-588-1212 FAX: 1-514-286-8480

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Blue Cross Life Insurance Company of Canada underwrites all life and disability benefits.

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1 PHARMACY INFORMATION

This section is to be completed by the Professional coordinating the request on behalf of the member (PSP, Cancer Care Navigator or Pharmacy)

Decision communication preference: ☐ Fax, Number: _____ ☐ Telephone, Number: _____

Name of Program/Pharmacy: _____

Contact Name: _____ Contact E-mail: _____

2 PATIENT INFORMATION

Part A

Patient Name: _____ Date of Birth: _____ (mm/dd/yyyy)

E-mail address of patient (or of legal guardian if patient is underage): _____

Address: _____ Suite: _____ City: _____

Province: _____ Postal Code: _____ Telephone Number: _____

Policy Number: _____ ID Number: _____

Do you have valid Medicare coverage in your current province of residence? ☐ Yes ☐ No

Have you already purchased this prescription? ☐ Yes ☐ No

Please attach your paid-in-full receipt with this request form. If you have already submitted your receipt to Medavie Blue Cross, please indicate the date of the oldest receipt. Date: _____ (mm/dd/yyyy)

Part B – Coordination of Benefits

Do you or any dependant have coverage for this drug under any other plan or program? ☐ Yes ☐ No **If Yes, complete the following:**

Policy Number: _____ Carrier: _____

(If applicable, please attach Explanation of Benefits from prior carrier with complete form)

If the patient is a dependent, provide the birth day and month of the cardholder for the other carrier: _____ (mm/dd)

Public-Funded Program – Have you applied for coverage through a public-funded program? ☐ Yes ☐ No

If No, please indicate why: _____

Part C – Authorization

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at **www.medaviebc.ca.**

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at www.medaviebc.ca or call 1-800-667-4511.

Signature of Patient: **Date:** _____ (mm/dd/yyyy)

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Blue Cross Life Insurance Company of Canada underwrites all life and disability benefits.

3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth: _____

Policy Number: _____ ID Number: _____

Day Phone Number (required): _____ Evening Phone Number (required): _____

E-mail address of patient or of legal guardian if patient is underage: _____

3A Patient Support Program (PSP) Enrollment

Is patient enrolled in the Patient Support Program? ☐ No ☐ Yes, specify Program ID #: _____

Indicate the name of the Patient Support Program: _____

PSP phone #: _____ PSP Fax #: _____

Product Name	Strength	Dosage	Diagnosis
WEGOVY (SEMAGLUTIDE)			☐ Risk of Myocardial Infarction (section 3B) ☐ Weight Management (section 3C or 3D)
ZEPBOUND (TIRZEPATIDE)			☐ Weight Management (section 3C or 3D)
SAXENDA (LIRAGLUTIDE)			☐ Weight Management (section 3C or 3D)

Indicate the specialty of the physician who initiated or recommended the treatment: _____

Is the patient currently on, or previously been on this drug? ☐ No ☐ Yes, indicate the treatment start date: _____ (mm/dd/yyyy)

↳ Prior coverage provided by: _____
(if not Medavie Blue Cross, please provide a pharmacy receipt showing purchase of this drug)

For Risk of Myocardial Infarction, please complete section 3B.
For Weight Management, please complete section 3C for initial request, and section 3D for renewals.

3B Risk of Myocardial Infarction

Risk of Myocardial Infarction

Most recent BMI (date): _____ (_____) (mm/dd/yyyy)

Does the patient have established cardiovascular disease? ☐ Yes ☐ No

↳ If yes, check all that apply:

- ☐ Acute coronary syndrome (ACS)
- ☐ Stable or unstable angina
- ☐ Coronary artery disease documented using angiography
- ☐ Coronary or other arterial revascularization (coronary artery bypass graft surgery, femoral popliteal bypass graft surgery, etc.)
- ☐ Stroke
- ☐ Transient ischemic attack
- ☐ Documented carotid disease
- ☐ Peripheral artery disease
- ☐ Abdominal aortic aneurysm
- ☐ Myocardial infarction (MI) → Date of the event: _____ (mm/dd/yyyy)
- ☐ Other. Specify: _____

Does the patient have diabetes? ☐ Yes ☐ No

↳ If yes, indicate which type: ☐ Type 1 ☐ Type 2

3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth: _____

Policy Number: _____ ID Number: _____

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E-mail address of patient or of legal guardian if patient is underage: _____

3C Weight Management - Initial Request

Weight Management

Please list all the drugs that have already been tried to treat this medical condition.

- **Obesity: weight management medication (Xenical, Saxenda, Contrave, Wegovy, Zepbound), GLP-1 agonist or other injectable incretin (Victoza, Ozempic, Trulicity, Rybelsus, Mounjaro)**

Product Name	Dosage	Start Date (mm/dd/yyyy)	BMI at Start Date (kg/m^2)	End Date (mm/dd/yyyy)	BMI at End Date (kg/m^2)	Response to Treatment

Assessment of the patient before the start of the treatment requested on this form:	
Date of evaluation:	_____ (mm/dd/yyyy)
Weight:	_____ ☐ lbs ☐ kg
Height (in cm):	_____ cm
BMI:	_____ kg/m^2
Waist circumference (in cm):	_____ cm
I confirm I have verified the above measurements: ☐ Yes ☐ No	_____ Signature

Patient's sex at birth*: ☐ Female ☐ Male ☐ Intersex

Is the patient of South Asian, Southeast Asian or East Asian ethnicity*? ☐ Yes ☐ No

**These questions are optional. Canadian Adult Obesity Clinical Practice Guidelines recommend different measured waist circumference and/or BMI cut-offs for females and males, and for those of South-, Southeast- or East Asian ethnicity.*

3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth: _____
Policy Number: _____ ID Number: _____
Day Phone Number (required): _____ Evening Phone Number (required): _____
E-mail address of patient or of legal guardian if patient is underage: _____

3C Weight Management - Initial Request (cont'd)

Patient's weight management history:	
Has the patient been following a reduced calorie **diet** or other dietary pattern that is associated with weight reduction for at least 6 months in the past 24 months? ☐ Yes ☐ No	If yes, specify the diet(s) and dates: Diet(s): _____ _____ From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)
Has the patient engaged in an increased level of **physical activity** for chronic weight management for at least 6 months in the past 24 months? ☐ Yes ☐ No	If yes, specify the physical activities and dates: Activities: _____ _____ From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)
Has the patient participated in **behavioural interventions** for chronic weight management for at least 6 months in the past 24 months? ☐ Yes ☐ No	If yes, specify the name and specialty of the provider or healthcare professional, or the name of the program: _____ _____ From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)
If you answered "no" to any of the above questions, please indicate why:	

Check all adiposity-related complications that apply:	Provide related test results, scores and information:
☐ Prediabetes ↳ ☐ Impaired fasting glucose ☐ Impaired glucose tolerance ☐ A1C 6.0 to 6.4% or ☐ Type 2 diabetes	A1C: _____ % (_____ (mm/dd/yyyy)) **- If prediabetes, also provide:** Fasting glucose: _____ mmol/L (_____ (mm/dd/yyyy)) 2-hour glucose tolerance: _____ mmol/L (_____ (mm/dd/yyyy))
☐ Sleep Apnea	Apnea Hypopnea Index: _____ Requires a CPAP: ☐ Yes ☐ No

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3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth: _____
Policy Number: _____ ID Number: _____
Day Phone Number (required): _____ Evening Phone Number (required): _____
E-mail address of patient or of legal guardian if patient is underage: _____

3C Weight Management - Initial Request (cont'd)

Check all adiposity-related complications that apply:	Provide related test results, scores and information:
☐ Cardiovascular risk or ☐ Heart disease ↳ ☐ Angina pectoris ☐ Stent placement ☐ Coronary artery bypass ☐ Prior myocardial infarction ☐ Stroke ☐ Symptomatic peripheral vascular disease ☐ Heart failure	Blood pressure: _____ mm Hg (_____ (mm/dd/yyyy)) HDL-C: _____ mmol/L (_____ (mm/dd/yyyy)) Total cholesterol: _____ mmol/L (_____ (mm/dd/yyyy)) Is the patient using antihypertensive medication? ☐ Yes ☐ No ↳ If yes, specify drug name(s) and dosage(s): **- <u>If cardiovascular risk, also provide</u>:** Framingham risk score: _____ % (_____ (mm/dd/yyyy))
☐ Borderline hypertension or ☐ Hypertension	Blood pressure: _____ mm Hg (_____ (mm/dd/yyyy)) Is the patient using antihypertensive medication? ☐ Yes ☐ No ↳ If yes, specify drug name(s) and dosage(s):
☐ Impaired function or mobility	Number of flights of stairs the patient is able to manage: _____ Is the patient using pain medication? ☐ Yes ☐ No ↳ If yes, specify drug name(s) and dosage(s): Does the patient require walking aids? ☐ Yes ☐ No ↳ If yes, specify walking aids required: _____

(continued on next page)

3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth: _____
Policy Number: _____ ID Number: _____
Day Phone Number (required): _____ Evening Phone Number (required): _____
E-mail address of patient or of legal guardian if patient is underage: _____

3C Weight Management - Initial Request (cont'd)

Check all adiposity-related complications that apply:	Provide related test results, scores and information:
☐ Elevated liver function or ☐ NAFLD/MASLD or ☐ NASH/MASH	ALT: _____ U/L (_____) (mm/dd/yyyy) **- <u>If NAFLD/MASLD or NASH/MASH, also provide</u>:** FIB-4: _____ (_____) (mm/dd/yyyy) Fasting insulin (optional): _____ ☐ uIU/mL ☐ pmol/L
☐ Polycystic ovary syndrome (PCOS) or ☐ Male sexual dysfunction	Blood pressure: _____ mm Hg (_____) (mm/dd/yyyy) HDL-C: _____ mmol/L (_____) (mm/dd/yyyy) Triglycerides: _____ mmol/L (_____) (mm/dd/yyyy) Non-HDL-C: _____ mmol/L (_____) (mm/dd/yyyy) A1C: _____ % (_____) (mm/dd/yyyy) Fasting glucose: _____ mmol/L (_____) (mm/dd/yyyy) 2-hour glucose tolerance: _____ mmol/L (_____) (mm/dd/yyyy) Is the patient using antihypertensive medication? ☐ Yes ☐ No ↳ If yes, specify drug name(s) and dosage(s): **- <u>If polycystic ovary syndrome (PCOS), also provide</u>:** <u>Ovulatory function</u>: ☐ Normal ovulatory cycles ☐ Oligo-ovulatory cycles ☐ Anovulation **- <u>If male sexual dysfunction, also provide</u>:** Is the patient using ED medications? ☐ Yes ☐ No Total testosterone: _____ nmol/L (_____) (mm/dd/yyyy)

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3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth: _____

Policy Number: _____ ID Number: _____

Day Phone Number (required): _____ Evening Phone Number (required): _____

E-mail address of patient or of legal guardian if patient is underage: _____

3C Weight Management - Initial Request (cont'd)

Check all adiposity-related complications that apply:	Provide related test results, scores and information:
☐ Esophagitis	Check all that apply: ☐ Two or more episodes of GERD per week ☐ Severe symptoms ☐ Esophagitis on endoscopy Does the patient require daily proton pump inhibitor (PPI) at standard dose or higher for longer than 8 weeks? ☐ Yes ☐ No ↳ If yes, specify drug name(s) and dosage(s):

3D Weight Management - Renewal Request

Please provide information on the evolution of the disease to evaluate the response to treatment.

Date of initial evaluation (pretreatment): _____ (mm/dd/yyyy) Date of most recent evaluation: _____ (mm/dd/yyyy)

Items measured:	Initial evaluation (pretreatment):	Most recent evaluation:
Weight:	_____ ☐ lbs ☐ kg	_____ ☐ lbs ☐ kg
Height (in cm):	_____ cm	_____ cm
BMI:	_____ kg/m^2	_____ kg/m^2
Waist circumference (in cm):	_____ cm	_____ cm

Has the patient been on **Wegovy** 2.4 mg weekly or maximum tolerated dose of 1.7 mg weekly for at least 12 weeks? ☐ Yes ☐ No

or

Has the patient been on **Zepbound** 5 mg weekly or higher for at least 12 weeks? ☐ Yes ☐ No

or

Has the patient been on **Saxenda** 3 mg weekly or maximum tolerated dose of 2.4 mg weekly for at least 12 weeks? ☐ Yes ☐ No

↳ If you answered "no" to any of the above questions, specify how many weeks the patient has been on that dose: _____ weeks

3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth: _____
Policy Number: _____ ID Number: _____
Day Phone Number (required): _____ Evening Phone Number (required): _____
E-mail address of patient or of legal guardian if patient is underage: _____

3D Weight Management - Renewal Request (cont'd)

Indicate test results, scores and information showing improvement in the patient's adiposity-related complications:		
Items assessed	**Initial (pretreatment)**	**Most recent**
A1C (%):		
Fasting glucose (mmol/L):		
2-hour glucose tolerance (mmol/L):		
Blood pressure (mm Hg):		
Antihypertensive drug name(s) and dosage(s):		
HDL-C (mmol/L):		
Total cholesterol (mmol/L):		
Triglycerides (mmol/L):		
Non-HDL-C (mmol/L):		
Framingham risk score (%):		
Patient had new myocardial infarction or stroke:	N/A	☐ Yes ☐ No
Patient had new cardiovascular-related hospitalization:	N/A	☐ Yes ☐ No
Patient had new coronary revascularization:	N/A	☐ Yes ☐ No
Number of flights of stairs the patient is able to manage:		
Improvement in knee functionality (i.e., speed and walk distance):	N/A	☐ Yes ☐ No
Uses walking aids:	☐ Yes ☐ No	☐ Yes ☐ No
Pain medication name(s) and dosage(s):		
ALT (U/L):		
FIB-4:		
Fasting insulin (☐ uIU/mL ☐ pmol/L):		
Apnea Hypopnea Index:		
Requires a CPAP:	☐ Yes ☐ No	☐ Yes ☐ No

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3 SPECIALTY DRUG INFORMATION

Name of patient: _____ Date of Birth: _____
Policy Number: _____ ID Number: _____
Day Phone Number (required): _____ Evening Phone Number (required): _____
E-mail address of patient or of legal guardian if patient is underage: _____

3D Weight Management - Renewal Request (cont'd)

Indicate test results, scores and information showing improvement in the patient's adiposity-related complications:		
Items assessed	**Initial (pretreatment)**	**Most recent**
Improved esophagitis symptoms (specify):		
Proton pump inhibitor name(s), dosage(s) and duration of use:		
Ovulatory function:	☐ Normal ovulatory cycles ☐ Oligo-ovulatory cycles ☐ Anovulation	☐ Normal ovulatory cycles ☐ Oligo-ovulatory cycles ☐ Anovulation
Total testosterone (nmol/L):		
Decrease of erectile dysfunction incidents:	N/A	☐ Yes ☐ No
ED medication name(s), dosage(s) and frequency of use:		

3E Additional Information

Please indicate any additional information pertaining to this request.

MEDAVIE BLUE CROSS™

PRIOR AUTHORIZATION REQUEST

HEALTH PROFESSIONAL STATEMENT

I certify that I have reviewed all pages of this request and that all information provided is true, correct and complete.

First Name: _____ Last Name: _____ Permit Number: _____

Specialty: _____

Clinic Name: _____

Address: _____ Suite: _____

City: _____ Province: _____ Postal Code: _____

E-mail: _____ Telephone: _____ Fax: _____

Signature: Date: _____
(mm/dd/yyyy)

It is important to provide the requested information in detail to help avoid delay in assessing claims for the above drug. This form may be subject to audit.

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