REQUEST FOR PRIOR AUTHORIZATION FOR A DRUG FOR WEIGHT MANAGEMENT AND OBESITY

GROUP INSURANCE

Please refer to page 3 for instructions.

☐ **Renewal** ☐ **Initial claim**

PART 1 – TO BE COMPLETED BY THE PLAN MEMBER/PATIENT

Member name _____

Policy no. _____ Certificate no. _____

Patient name (if different) _____

Relationship to plan member: ☐ Spouse ☐ Dependent child Date of birth of the patient Y M D

Coordination of benefits

If the patient has his or her own drug plan or is registered with a provincial drug plan, the request must first be submitted to that plan.

Coverage by another drug plan	Is the patient covered by another drug plan? ☐ Yes – Provide a copy of the response received (approval or denial) ☐ No
Provincial plan coverage	Has a claim been submitted to the patient's provincial plan? ☐ Yes – Provide a copy of the response received (approval or denial) ☐ No
Patient support program	Is the patient enrolled in a patient support program? ☐ Yes ☐ No If yes – Name of program: _____ Contact name: _____ Telephone: _____ Extension: _____

I agree that the statements included in this form will serve as a basis to review my own or my dependent's drug claim.

If the drug claim being reviewed is for my dependent, **I confirm** that I have the authorization to discuss the information about him or her with respect to the request.

On behalf of myself and my dependent, **I authorize** my physician or healthcare provider to disclose and exchange with Industrial Alliance Insurance and Financial Services Inc. (iA Financial Group) the information requested in this form regarding the drug for myself or my dependent. **I consent** to the release of the information contained in this claim form to iA Financial Group, its employees, agents, reinsurers, service providers and other organizations working with iA Financial Group for the purposes of the underwriting, administration and processing of this request.

If my Social Insurance Number is used as my identification number, **I authorize** its use for the administration of my group benefits.

I agree that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature _____ Date Y M D

Address _____ Postal code

Daytime phone _____ Extension _____ Member email _____

PART 2 – TO BE COMPLETED BY PRESCRIBING PHYSICIAN

⚠ **Important:** Incomplete or missing information may delay processing of this request.

SECTION A – DRUG REQUESTED FOR EVALUATION

☐ Contrave (naltrexone/bupropion)
☐ Saxenda (liraglutide)
☐ Xenical (orlistat)

Strength: _____ Administration route (e.g. oral, etc.): _____

Dosage: _____ Treatment duration: _____

Will the drug be administered in a hospital? ☐ Yes ☐ No

Is the patient participating or has he/she already participated in a clinical study for this drug? ☐ Yes (study end date) Y M D ☐ No

Is the patient already using the drug? ☐ Yes (date treatment started) Y M D ☐ No

SECTION B – INITIAL REQUEST

Diagnosis / Therapeutic indication

☐ Overweight / Obesity
and
☐ As a complement to a reduced-calorie diet and increased physical activity for long-term weight management.

Clinical information

Date of measurements: Y M D Height: _____ ☐ cm ☐ in Weight: _____ ☐ kg ☐ lb BMI _____ kg/m²

Weight-related comorbidity factor(s): _____

Goal targeted (details): _____

Additional information

Has a personalized action plan been established?

☐ Yes ☐ No Specify: _____

Is the patient currently participating in a weight management program or being monitored by a nutritionist or other health practitioner?

☐ Yes ☐ No

Specify which nutritional therapy and physical activity strategies are implemented for weight management?

_____

_____

When were these strategies initiated? _____

What have been the results of theses strategies? _____

Previous therapies

Name of drug or treatment		Treatment duration
Name: _____ Dosage: _____	☐ Inadequate response ☐ Intolerance ☐ Contraindication Specify: _____	From: Y M D To: Y M D
Name: _____ Dosage: _____	☐ Inadequate response ☐ Intolerance ☐ Contraindication Specify: _____	From: Y M D To: Y M D
Name: _____ Dosage: _____	☐ Inadequate response ☐ Intolerance ☐ Contraindication Specify: _____	From: Y M D To: Y M D

SECTION C – RENEWAL REQUEST

Clinical information needed to assess response to treatment

Subsequent renewals will only be considered for patients who achieve a weight loss of at least 5% and maintain this weight loss after initial treatment.

Patient's initial and current height, weight and body mass index (BMI) must be provided.

Date of initial measurements: Y M D Height: _____ ☐ cm ☐ po Weight: _____ ☐ kg ☐ lb BMI: _____ kg/m²

Date of current measurements: Y M D Height: _____ ☐ cm ☐ po Weight: _____ ☐ kg ☐ lb BMI: _____ kg/m²

Additional information (optional)

Physician's first and last name (please print) _____

Address _____ Postal code _____

Telephone _____ Fax _____

Physician's email _____ License number _____

☐ General practitioner ☐ Specialist ☐ Other, specify _____

Signature _____ Date Y M D

STAMP

For internal use:

⚠ **Important:** Incomplete or missing information may delay processing of this request.

INSTRUCTIONS AND IMPORTANT INFORMATION

How to fill out the form

Step 1: Plan member / patient must complete Part 1
Step 2: Prescribing physician must complete Part 2.

— Any fees for the completion of the enclosed form are the responsibility of the plan member/patient.

— Your claims assessment will be delayed if the enclosed form is incomplete or contains errors.

— The purpose of the enclosed form is to obtain information required to assess your claim for a drug on iA Financial Group's Prior Authorization list. The drug must meet the criteria for coverage under your plan. In Quebec, drugs on the RAMQ Exception Drug list must also meet the criteria for coverage under your plan.

— Completion and submission of this form does not guarantee approval. You will receive reimbursement for the prior authorization drug only if the request has been reviewed and approved by iA Financial Group.

— You will be notified whether the request has been approved or denied. You can expect to receive notification within 10 days of when your request is received.

— To verify the status of the claim, log in to My Client Space.

How to submit your form

By fax (according to your province of residence):

Quebec	**All other provinces**
1-855-884-9811	1-877-780-7247

By mail (according to your province of residence):

Quebec	**All other provinces**
Health and Dental Claims Department	Health and Dental Claims Department
PO Box 800, Station Maison de la poste	PO Box 4643, Station A
Montreal QC H3B 3K5	Toronto ON M5W 5E3

By Secure Messaging: Log in to the My Client Space website and click on the ***My messages***.

If you have any questions, please contact Customer Service at 1-877-422-6487.

Business hours: Monday to Friday, 8 am to 8 pm (ET)