

IMPORTANT – PLEASE READ CAREFULLY BEFORE COMPLETING THIS FORM

If you live anywhere in Canada, except Quebec: Read the text below carefully to find out if you must fill out this form.

If you live in Quebec: You must fill out this form.

If you have submitted a claim for a type 2 diabetes medication in the last four months, Ozempic and Rybelsus may be covered without you having to fill out this prior authorization form.

To find out if a form is required in your situation, please consult the WebRx® tool in the iA Mobile app and in My Client Space (ia.ca/myaccount). After you enter the prescribed medication, the tool will confirm whether, based on your diabetes claims history, the prior authorization form is required.

If your request has been denied at the pharmacy, you can fill out the form to allow us to evaluate your request.

Please refer to page 4 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? <input type="checkbox"/> Yes – Provide a copy of the response received (approval or denial) <input type="checkbox"/> No
Provincial plan coverage	Has a claim been submitted to the patient’s provincial plan? <input type="checkbox"/> Yes – Provide a copy of the response received (approval or denial) <input type="checkbox"/> No
Patient support program	Is the patient enrolled in a patient support program? <input type="checkbox"/> Yes <input type="checkbox"/> 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

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Daytime phone _____ Extension _____ Member email _____

PART 2 – TO BE COMPLETED BY PRESCRIBING PHYSICIAN

⚠ Please answer all the questions in every section, without exception. Incomplete or missing information may delay the processing of your claim.

SECTION A – DRUG REQUESTED FOR EVALUATION

- Ozempic (semaglutide) – Authorization will be given for a weekly initial maximum dose of 1 mg.
- Rybelsus (semaglutide) – Authorization will be given for an initial maximum dose of 14 mg per day.

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

- Type 2 diabetes
- If other, please specify: _____

Administration of semaglutide in combination with metformin?

- Yes
- No, please specify the reasons why semaglutide will not be administered in combination with metformin: _____

Previous drugs or treatments

Name of drug or treatment		Treatment duration												
Name: _____ Dosage: _____	<input type="checkbox"/> Inadequate response <input type="checkbox"/> Intolerance <input type="checkbox"/> Contraindication Specify: _____ _____ _____	From: <table style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="border-bottom: 1px solid black; width: 15px;">Y</td><td style="border-bottom: 1px solid black; width: 15px;">M</td><td style="border-bottom: 1px solid black; width: 15px;">D</td></tr> <tr><td style="border-bottom: 1px solid black; width: 15px;"> </td><td style="border-bottom: 1px solid black; width: 15px;"> </td><td style="border-bottom: 1px solid black; width: 15px;"> </td></tr> </table> To: <table style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="border-bottom: 1px solid black; width: 15px;">Y</td><td style="border-bottom: 1px solid black; width: 15px;">M</td><td style="border-bottom: 1px solid black; width: 15px;">D</td></tr> <tr><td style="border-bottom: 1px solid black; width: 15px;"> </td><td style="border-bottom: 1px solid black; width: 15px;"> </td><td style="border-bottom: 1px solid black; width: 15px;"> </td></tr> </table>	Y	M	D				Y	M	D			
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