Drug Prior Authorization Form
Ozempic, Rybelsus, Wegovy (semaglutide), Mounjaro (tirzepatide)

The purpose of this form is to obtain information required to assess your drug claim.

IMPORTANT: Please answer all questions. Your claim assessment will be delayed if this form is incomplete or contains errors.

Any costs incurred for the completion of this form are the responsibility of the plan member/patient.

Canada Life recognizes and respects the importance of privacy. Personal information collected is used for the purposes of assessing eligibility for this drug and for administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about Canada Life's personal information policies and practices (including with respect to service providers), refer to canadalife.com or write to Canada Life's Chief Compliance Officer.

I authorize Canada Life, any healthcare provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or patient support programs or other benefits programs, other organizations, or service providers working with Canada Life or any of the above, located inside or outside Canada, to exchange personal information when relevant and necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I acknowledge that the personal information is needed to assess eligibility for this drug and to administer the group benefits plan. I acknowledge that providing consent will help Canada Life to assess my claim and that refusing to consent may result in delay or denial of my claim. Canada Life reserves the right to audit the information provided on this form at any time and this consent extends to any audit of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information and for Canada Life to use and disclose it as set out above.

I certify that the information given below is true, correct, and complete to the best of my knowledge. Failure to provide true, correct and complete information on this form could result in revocation of any approval decision, a requirement to repay paid claims or other appropriate action.

Plan Member's signature: _____ Date: _____

Due to the high volume of requests for these drugs, assessments may take longer than normal.

Form Completion Instructions:

1. **Complete "Patient Information" sections.**
2. **Have the prescribing physician complete the "Physician Information" sections.**
3. **Send all pages of the completed form to us by mail, fax or email as noted below.**

Note: As email is not a secure medium, any person with concerns about their prior authorization form/medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

Mail to: **The Canada Life Assurance Company**
Drug Claims Management
PO Box 6000
Winnipeg MB R3C 3A5

Fax to: **The Canada Life Assurance Company**
Fax 1-833-204-5809
Attention: Drug Claims Management

Email to: **CLPrior.Authorization@canadalife.com**
Attention: Drug Claims Management

For additional information regarding Prior Authorization and Health Case Management, please visit our Canada Life website at canadalife.com or contact Group Customer Contact Services at 1-800-957-9777. Deaf or hard of hearing and require access to a telecommunications relay service? Please contact us: TTY to Voice: 711 or Voice to TTY: 1-800-855-0511.

(Continued on next page)

M6453(GLP-1)-11/23

Patient Information
Ozempic, Rybelsus, Wegovy (semaglutide), Mounjaro (tirzepatide)

Plan Member Information – Complete all sections of this page (please print)

Plan Member:	Patient Name:	
Plan Name:	Plan Number:	Plan Member ID Number:
Patient Date of Birth (DD/MM/YYYY):	Address (number, street, city, province, postal code):	

Please indicate preferred contact number and if there are any times when telephone contact with you about your claim would be most convenient.

May we contact you by email? (Note that some correspondence may still need to be sent by regular mail).

☐ Yes ☐ No If yes, please provide email address: _____

Tell us if you have been on this drug before

Is the patient currently on, or previously been on this drug? ☐ Yes ☐ No

If Yes, a) indicate start date (DD/MM/YYYY): _____

b) coverage provided by: _____

(if coverage is not provided by Canada Life please provide pharmacy print-out showing purchase of this drug)

Tell us if you have coverage with any other benefits plan

Does the patient have drug coverage under any other group benefits plan? ☐ Yes ☐ No

If Yes, name of other Insurance Company: _____

If other plan is with Canada Life, tell us the plan and ID number: _____

Name of plan member: _____

Relationship to patient: _____

Provide details and attach documentation of acceptance or decline:

_____

_____

Tell us about any Provincial or other coverage you may have

For Ozempic, patients covered under the following provincial drug programs must apply to the province first:

Alberta Coverage for Seniors Program, BC PharmaCare, Manitoba Pharmacare, Saskatchewan Drug Plan

Documentation of approval or decline must be submitted with this request form.

Does the patient have coverage under a provincial program or from any other source? ☐ Yes ☐ No

If Yes, name of program or other source: _____

Provide details and attach documentation of acceptance or decline: _____

Is the patient currently receiving disability benefits for the condition for which this drug has been prescribed? ☐ Yes ☐ No

(Continued on next page)

Physician Information
Ozempic, Rybelsus, Wegovy (semaglutide), Mounjaro (tirzepatide)

Note to Physician: In order to assess a patient's claim for this drug, we require detailed information on the patient's prescription drug history as requested below.

Attach extra information if necessary. *GENETIC TEST RESULTS ARE NOT REQUIRED.*

Physician's Information (please print)

Name of prescribing physician:

Specialty:

Address (number, street, city, province, postal code):

Telephone Number (including area code):	Fax Number (including area code):

1. Prescribed dosage and regimen:
   - ☐ Ozempic: 0.25mg once weekly for week 1-4, then increase to 0.5mg once weekly. After 4 weeks may increase to 1mg once weekly, if needed. After 4 weeks may increase to 2mg once weekly, if needed.
   - ☐ Rybelsus: 3mg daily for 30 days, then 7mg daily. May increase to 14mg daily after 30 days, if needed.
   - ☐ Mounjaro: 2.5mg once weekly for week 1-4, then 5mg once weekly. May increase up to 15mg once weekly, if needed.
   - ☐ Wegovy: 0.25mg once weekly for week 1-4, 0.5mg once weekly for week 5-8, 1mg once weekly for week 9-12, 1.7mg once weekly for week 13-16, followed by maintenance dose of 2.4 mg once weekly from week 17 and onwards.
2. Health Canada indication (include date of initial diagnosis) (MM/YYYY): _____
   - ☐ Type II Diabetes Mellitus
     - ☐ Ozempic
     - ☐ Rybelsus
     - ☐ Mounjaro

     Note: Ozempic, Rybelsus, and Mounjaro, are not covered for chronic weight management.
   - ☐ Chronic Weight Management
     - ☐ Wegovy

     Note: Wegovy is not covered under all benefit plans. Please have the patient confirm coverage before submitting request.

     Patients can use the Drug Search Tool on mycanadalifeatwork.com.

   Complete questions 1 – 5 and Physician's Information

   - ☐ Other (approved by Health Canada): _____

   Complete questions 1 – 5 and Other condition (Health Canada approved)
3. Where will treatment be administered? ☐ Home ☐ Physician's Office ☐ Private clinic ☐ Hospital in-patient ☐ Hospital out-patient
4. Please provide medical rationale why this drug has been prescribed instead of an alternate drug in the same therapeutic class:

_____

_____

(Continued on next page)

canada life™

Physician Information
Ozempic, Rybelsus, Wegovy (semaglutide), Mounjaro (tirzepatide)

Physician's Information (continued) (please print)

5. Drug and Treatment History – **must be completed for every request.**

Drug(s) and Treatment(s) past and present	Dosing Regimen	Start Date (DD/MM/YYYY)	End Date (DD/MM/YYYY)	Clinical Results/Outcome
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:

Ozempic/Rybelsus/Mounjaro for Type II Diabetes Mellitus

To be eligible for coverage, the patient must meet all of the following:

Does the patient have an HbA1c level of 7.0% or greater? ☐ Yes ☐ No

Does the patient have inadequate glycemic control despite diet and exercise? ☐ Yes ☐ No

Has the patient had an inadequate response to maximum tolerated dose of metformin? ☐ Yes ☐ No

If no, please provide details:

Does the patient have contraindication to metformin? ☐ Yes ☐ No

If yes, please list: _____

AND

Has the patient tried another anti-diabetic agent? ☐ Yes ☐ No

If yes, please list: _____

The dose of (select the applicable statement):

☐ Ozempic will not exceed 2mg per week.
☐ Rybelsus will not exceed 14mg daily.
☐ Mounjaro will not exceed 15mg per week.

Will requested drug be used in combination with another GLP-1 receptor agonist? ☐ Yes ☐ No

Please ensure Drug and Treatment History chart is completed.

Wegovy for Chronic Weight Management

Initial Request

To be eligible for coverage, the patient must meet all of the following:

Will Wegovy be used as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management? ☐ Yes ☐ No

Will Wegovy be used in combination with other semaglutide-containing drugs or any other GLP-1 receptor agonist? ☐ Yes ☐ No

For adolescents (age 12-17):

Does the patient have a BMI at the 95th percentile or greater for age and sex? ☐ Yes ☐ No

Current body weight: _____ kg Date assessed (DD/MM/YYYY): _____

For adults:

Current body weight: _____ kg Date assessed (DD/MM/YYYY): _____

Current BMI: _____ kg/m^2 Date assessed (DD/MM/YYYY): _____

Does the patient have any of the following comorbidities? Select all that apply:

☐ Dyslipidemia
☐ Hypertension
☐ Obstructive sleep apnea
☐ Type II diabetes mellitus

(Continued on next page)

Physician Information
Ozempic, Rybelsus, Wegovy (semaglutide), Mounjaro (tirzepatide)

Physician's Information (continued) (please print)

Wegovy for Chronic Weight Management (continued)

Renewal Request

To be eligible for coverage, the patient must meet all of the following:

Will Wegovy continue to be used as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management?

☐ Yes ☐ No

Has the patient achieved and maintained a 5% or more loss of body weight? ☐ Yes ☐ No

Current body weight: _____ kg Date assessed (DD/MM/YYYY): _____

Other condition (Health Canada approved)

Please provide any relevant information related to the disease and attach supporting documentation.

_____

_____

_____

Start date of treatment (DD/MM/YYYY): _____

Describe the patient's response to treatment, particularly in relation to the signs and symptoms of their disease at initial presentation.

Attach copies of relevant test results, specialist's consultation or clinical notes.

_____

_____

_____

Note for Physician: To be eligible for reimbursement, Canada Life may require your patient to purchase a drug requiring prior authorization from a pharmacy designated by Canada Life. If applicable, a health case manager will contact you with further information.

I certify that the information provided is true, correct, and complete.

Physician's Signature: _____ Date: _____

License Number: _____

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. The completed form can be returned to Canada Life by mail, fax, or email.

Note: As email is not a secure medium, any person with concerns about their prior authorization form/medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

Due to the high volume of requests for these drugs, assessments may take longer than normal.

Mail to: **The Canada Life Assurance Company**
Drug Claims Management
PO Box 6000
Winnipeg MB R3C 3A5

Email to: **CLPrior.Authorization@canadalife.com**
Attention: Drug Claims Management

Fax to: **The Canada Life Assurance Company**
Fax 1-833-204-5809
Attention: Drug Claims Management