Public Service Health Care Plan

Drug Prior Authorization Form

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

PROTECTED "B" WHEN COMPLETED

PART 1 – Instructions

Please use this form to submit your application for Ozempic or Rybelsus to Canada Life.

1. Complete parts 2 to 7 in full and have your attending physician or nurse practitioner complete parts 8 to 9.
2. Please apply for coverage through the appropriate provincial/territorial health program before submitting this application to Canada Life (if applicable).
3. Send to Canada Life. See part 10.

Please note that physician's fees for providing medical information are not covered under the Public Service Health Care Plan (PSHCP).

All forms under the Public Service Health Care Plan (PSHCP) must be submitted through the plan member. We may disclose personal information about claims with your employer, your service provider, and/or a person acting on your behalf when necessary to confirm eligibility and to mutually manage your assessment.

PART 2 – Plan member information - You must complete this section fully. If you are unsure of your plan or certificate number, please see your Public Service Health Care Plan (PSHCP) benefit card, the Canada Life PSHCP Member Service website or Part 10 for our contact information.

Plan name: **Public Service Health Care Plan**

Plan number

Plan member certificate number

Plan member name

First name

Last name

Plan member address

Number and street

City or town

Province/Territory/State

Postal/Zip Code

Country

Date of birth Day Month Year

PART 3 – Patient information

Patient name		Patient's relationship to plan member			Patient's date of birth			If dependant child is between 21 and 25 years old, are they a full-time student?	
First name	Last name	Self	Spouse or common-law partner	Dependant child	Day	Month	Year	Yes	No
		☐	☐	☐				☐	☐

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

   If "Yes", please answer the questions below.

   a. Indicate the date you started this medication. Day Month Year

   b. Coverage provided by: _____

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

2. Has the patient enrolled in the Patient Support Program for this drug? ☐ Yes ☐ No

   If "Yes", please provide the following information: Patient Support Program ID number: _____

   Patient Support Program contact name: _____ Phone number: _____

PART 4 – Coordination of benefits - Complete this section to indicate whether the patient has benefit coverage under any other plan.

1. Does the patient have prescription drug coverage under any other benefit plan? ☐ Yes ☐ No

   If "Yes", please answer the questions below.

2. Name of the insurance company? _____

3. Is the other plan with Canada Life? ☐ Yes ☐ No

   If "Yes", please provide: Canada Life plan number _____ Certificate number _____

   Name of plan member _____ Relationship to patient _____

   Other insurance plan member's signature of authorization: X _____

Provide details and attach documentation of your other insurance company's acceptance or denial of this drug:

_____

PART 5 – Provincial or territorial coverage

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.

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

   If "Yes", name of program or other source: _____

Provide details and attach documentation of the province or territory's acceptance or denial of this drug:

_____

PART 6 – Privacy

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.

Please refer to the PSHCP Privacy Statement (canada.ca/en/treasury-board-secretariat/services/benefit-plans/health-care-plan/public-service-health-care-plan-privacy-statement-september-2009.html) for further information on how your privacy is protected. Where there is a difference between the Privacy Act (//laws-lois.justice.gc.ca/eng/acts/P-21/) and the PSHCP Privacy Statement and Canada Life's Privacy guidelines, Canada Life will apply the most stringent requirements.

PART 7 – Confirmation, authorization and signature

I authorize Canada Life, any healthcare or dentalcare provider, my plan sponsor, the Federal PSHCP Administration Authority, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside Canada, to exchange personal information when 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. 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.

In accordance with the Positive Enrolment Authorization and Declaration (welcome.canadalife.com/pshcp/review-authorizations-and-declarations.html) accepted during the completion of Positive Enrolment (refer to your Positive Enrolment Record if you completed Positive Enrolment by paper), I agree to the collection, use and disclosure of personal information as set out in the Privacy section, Canada Life's Privacy guidelines and the PSHCP Privacy Statement.

I certify that the information given on this claim form 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 signature X _____ **Date** Day | Month | Year

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PART 8 – Patient medical information - To be completed by the attending physician or nurse practitioner.

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

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): Month Year

☐ Type II Diabetes Mellitus

☐ Ozempic

☐ Rybelsus

☐ Mounjaro

Note: Ozempic, Rybelsus, and Mounjaro are not covered for chronic weight management.

☐ Chronic Weight Management

☐ Wegovy

Complete questions 1 – 5 and Patient medical 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 with an approved indication for this condition. Genetic test results are not required.

_____

_____

5. Drug and treatment history – **must be completed for every request.** If coverage for these drugs was not provided by the PSHCP, please submit a pharmacy printout for the last 12 months.

Prescription drug(s) and treatment(s) past and present	Dosing regimen	Start date (mmm-dd-yyyy)	End date (mmm-dd-yyyy)	Clinical results/outcome
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:

PART 8 – Patient medical information, continued - To be completed by the attending physician or nurse practitioner.

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 the 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: Day Month Year

For adults:

Current body weight: _____ kg Date assessed: Day Month Year

Current BMI: _____ kg/m^2 Date assessed: Day Month Year

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

☐ Dyslipidemia

☐ Hypertension

☐ Obstructive sleep apnea

☐ Type II diabetes mellitus

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: Day Month Year

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PART 8 – Patient medical information, continued - To be completed by the attending physician or nurse practitioner.

Other condition (Health Canada approved)

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

Start date of treatment: Day | Month | Year

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.

PART 9 – Attending physician's or nurse practitioner's information, confirmation, and signature

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge.

Physician or nurse practitioner's name

Name and designation

Specialty

Registration number

Physician or nurse practitioner's address

Number and street

City or town

Province/Territory/State

Postal/Zip Code

Telephone number (including area code)

Fax number (including area code)

Signature X _____ **Date** Day | Month | Year

PART 10 – Submitting your application

Please send the completed form to:

MAIL

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

FAX

Drug Claims Management
1-833-204-5809

EMAIL

CLPrior.Authorization@canadalife.com

Questions?

Call toll free 1-855-415-4414
Monday to Friday from 8 am to 5 pm, your local time or sign in to your account on the Canada Life PSHCP Member Services website at canadalife.com/pshcp and go to the Contact Us page.

Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us:
TTY to Voice: 711 • Voice to TTY: 1-800-855-0511

Clear