PRESCRIPTION DRUG SPECIAL AUTHORIZATION, PHARMACY PPN, AND ADHERENCE SUPPORT PROGRAM INFORMATION

Dear Patient:

Form Completion Instructions

Please have the following Special Authorization Request Form completed in full by <u>your physician</u>. If you are eligible for coverage by another plan (public or private) please have your physician indicate that in the authorization form. Your request will be reviewed and evaluated by our Drug Special Authorization Department who will communicate the results to you. Should you have any questions, you may contact our Customer Contact Centre at 1.888.711.1119.

Provincial Drug Coverage

For those patients eligible for provincial drug coverage (including, but not limited to Ontario Drug Benefit, British Columbia Pharmacare, Saskatchewan Special Support Program, Alberta Prescription Drug Program for Seniors, etc.): **Your primary drug coverage is your provincial drug program.** Please ensure that your physician has applied for such drug approval under your primary provincial drug plan. The result of this application for coverage to your primary provincial drug plan should be attached to the completed authorization form.

Preferred Pharmacy Network (PPN)

Depending on your benefit plan, you may be required to obtain your special authorization drug at an approved pharmacy if your claim is approved. If this applies to your benefit plan, a Care Coordinator working on behalf of Green Shield Canada[1]will contact you to help you find an approved pharmacy near you. The Care Coordinator will also work with you and your physician to arrange to have your prescription forwarded to the pharmacy you have selected. By completing this form, you authorize Green Shield Canada to, where applicable, communicate your choice of approved pharmacy to your physician. Should you choose not to speak with the Care Coordinator and obtain your special authorization drug at an approved pharmacy, your claim may not be paid under your benefit plan.

Adherence Support Program

Some drug treatment plans are complicated and patients can find it difficult to follow their physician's instructions when taking their medication. If your special authorization drug is approved, you may be eligible for adherence support services as part of the PPN program. Your Care Coordinator can work with you and your physician to ensure that you adhere to your drug treatment plan by helping you take your medication as instructed by your physician.

[1] The Care Coordinator who will be contacting you works for Health Forward who has been contracted by Green Shield Canada to provide PPN services.

LIRAGLUTIDE (i.e. SAXENDA®)
SPECIAL AUTHORIZATION REQUEST FORM

Please note: Incomplete and/or missing information may delay the processing of your request.

SECTION 1 – PATIENT INFORMATION

Surname	**Green Shield I.D. #**	**Employer Name**
First Name	**Date of Birth (Y/M/D)**	**Telephone Number**
Street Address	**City** **Province** **Postal Code**	

I hereby authorize any licensed physician/dentist, medical practitioner, hospital, clinic or medically related facility, to provide to Green Shield Canada information regarding my health as it relates to this request.

I hereby authorize Green Shield Canada to obtain and exchange personal information with other parties as required, including any health care provider, patient assistance program and/or preferred pharmacy network (PPN) vendor working with Green Shield Canada for the purpose of administering this benefit. I acknowledge that my personal information is needed to assess eligibility for this drug, to administer the group benefits plan, and where applicable, to administer pharmacy preferred provider network and patient support programs on my behalf. I acknowledge that my personal information may be exchanged and transferred between these parties for these purposes and may include information about my prescription drug claims, diagnosis, medical condition, treatment, and other health related information. I acknowledge that providing my consent will help Green Shield Canada 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 instructions to that effect at the address indicated below.

I understand that personal information may be subject to disclosure to those authorized under applicable law within Canada only when the information is needed to administer this benefit and/or to confirm the accuracy of this information.

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

Date _____ **Signature of Patient** _____

(If under 16 years of age, the signature of the parent / guardian is required.)

SECTION 2 – PHYSICIAN INFORMATION

Physician Name	**Physician Signature**	**Specialty (please indicate)**	**Date (Y/M/D)**
Street Address		**Telephone Number**	
City **Province** **Postal Code**		**Fax Number**	

Injectable-location of administration (CHECK ONE):

- ☐ **HOME**
- ☐ **PHYSICIAN'S OFFICE**
- ☐ **HOSPITAL (IN-PATIENT)**
- ☐ **HOSPITAL (OUT-PATIENT)**
- ☐ **LONG TERM CARE FACILITY**

SECTION 3 – DRUG REQUESTED FOR EVALUATION

For use as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management in adult patients.

Patient's current height, weight, and body mass index (BMI) must be indicated on the Drug Special Authorization form. Patient must have a body mass index (BMI) greater than 30kg/m^2 or a BMI greater than 27kg/m^2 in the presence of other risk factors (ie. hypertension, diabetes, or dyslipidemia).

Initial Approval:

Date of current measurements: _____

Patient's current:

HEIGHT (cm/in) _____ **WEIGHT (kg/lb)** _____ **BMI (kg/m^2)** _____

CONTRIBUTING RISK FACTORS _____

Initial approval period is 6 months after which time the plan member must reapply for renewal. Please note, patients will only be allowed one failed attempt per year.

Renewal: (will need to be completed every 6 months):

Renewals will be approved for a 6 month timeframe if ≥5% of body weight was lost and maintained after initial treatment course. Patient's baseline and current height, weight, and body mass index (BMI) must be indicated on the Drug Special Authorization form.

Date of baseline measurements: _____
Patient's baseline:
HEIGHT (cm/in) _____ **WEIGHT (kg/lb)**_____ **BMI (kg/m^2)** _____

Date of current measurements: _____
Patient's current:
HEIGHT (cm/in) _____ **WEIGHT (kg/lb)**_____ **BMI (kg/m^2)** _____

Continued on reverse

Additional comments pertaining to medication/medical condition:

Please provide us with information on other coverage (provincial or private) as it pertains to this patient and medication:
Applied for coverage: ☐ Yes ☐ No ☐ Approved ☐ Denied

SECTION 4 – MAILING INSTRUCTIONS

Once completed, return request form along with any original paid "Official Pharmacy" receipts to:
Green Shield Canada, Drug Special Authorization Department,
P.O. Box 1606, Windsor ON N9A 6W1

Forms can be faxed or emailed: Fax: 1-519-739-6483 or Toll Free: 1-866-797-6483 or Email: drugspecial.autho@greenshield.ca

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.