

| SECTION 1 – INFORMATION ON THE MEMBER                                                                                                                                                                                                                                                                                                                                                                                      |                                                           |                                                     |                                                    |                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------|---------------------|
| Member name:                                                                                                                                                                                                                                                                                                                                                                                                               |                                                           | Group number:                                       |                                                    | Certificate number: |
| Address (No. / Street / Apt.):                                                                                                                                                                                                                                                                                                                                                                                             |                                                           |                                                     |                                                    |                     |
| City :                                                                                                                                                                                                                                                                                                                                                                                                                     | Province :                                                |                                                     | Postal Code :                                      |                     |
| Phone number :                                                                                                                                                                                                                                                                                                                                                                                                             |                                                           | E-mail address :                                    |                                                    |                     |
| Employer name / Policy holder :                                                                                                                                                                                                                                                                                                                                                                                            |                                                           | Group / Division number:                            |                                                    |                     |
| SECTION 2 – INFORMATION ON THE PATIENT                                                                                                                                                                                                                                                                                                                                                                                     |                                                           |                                                     |                                                    |                     |
| Patient name:                                                                                                                                                                                                                                                                                                                                                                                                              |                                                           |                                                     |                                                    |                     |
| Patient Date of Birth (YYYY/MM/DD):                                                                                                                                                                                                                                                                                                                                                                                        |                                                           | Relationship to member:                             |                                                    |                     |
| Have you applied for coverage with a provincial program? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>                                                                                                                                                                                                                                                                       |                                                           |                                                     |                                                    |                     |
| Has your application for coverage with the provincial program for this drug or supply been approved? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>                                                                                                                                                                                                                           |                                                           |                                                     |                                                    |                     |
| If you have applied for coverage with a provincial program, please provide us with a copy of the refusal or acceptance letter.                                                                                                                                                                                                                                                                                             |                                                           |                                                     |                                                    |                     |
| Are you enrolled in a drug manufacturer's patient assistance program? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>                                                                                                                                                                                                                                                          |                                                           |                                                     |                                                    |                     |
| If yes, please provide your patient assistance program identification number: _____                                                                                                                                                                                                                                                                                                                                        |                                                           |                                                     |                                                    |                     |
| SECTION 3 - AUTHORIZATION TO SHARE PERSONAL INFORMATION                                                                                                                                                                                                                                                                                                                                                                    |                                                           |                                                     |                                                    |                     |
| <b>I authorize any health professional (doctor, pharmacist, dentist), any person (service provider), any other insurance company, any public or private health institution, any government agency in relation to health or social services, to disclose and exchange requested information by the insurer or AGA Benefits Solutions, necessary for the evaluation of my request for prior authorization for that drug.</b> |                                                           |                                                     |                                                    |                     |
| Patient signature:                                                                                                                                                                                                                                                                                                                                                                                                         |                                                           | Date:                                               |                                                    |                     |
| Signature of the subscriber when patient is a minor:                                                                                                                                                                                                                                                                                                                                                                       |                                                           | Date:                                               |                                                    |                     |
| SECTION 4 - DRUG COVERED BY THE APPLICATION                                                                                                                                                                                                                                                                                                                                                                                |                                                           |                                                     |                                                    |                     |
| Drug Name:                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                           |                                                     |                                                    |                     |
| Dosage:                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                           |                                                     |                                                    |                     |
| Pharmaceutical Form:                                                                                                                                                                                                                                                                                                                                                                                                       |                                                           | Content / Strength:                                 |                                                    |                     |
| Anticipated duration of treatment:                                                                                                                                                                                                                                                                                                                                                                                         | From (YYYY/MM/DD) :                                       | To (YYYY/MM/DD) :                                   |                                                    |                     |
| Diagnosis:                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                           | Initial date of diagnosis (YYYY-MM-DD):             |                                                    |                     |
| Medication will be administered at the following location:                                                                                                                                                                                                                                                                                                                                                                 |                                                           |                                                     |                                                    |                     |
| <input type="checkbox"/> Home                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Health and social service center | <input type="checkbox"/> Long-term care center      | <input type="checkbox"/> Private clinic            |                     |
| <input type="checkbox"/> Hospital - internal patient                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Hospital - external patient      | <input type="checkbox"/> Elsewhere. Specify : _____ |                                                    |                     |
| If the treatment is not administered at home, please provide the following information:                                                                                                                                                                                                                                                                                                                                    |                                                           |                                                     |                                                    |                     |
| Name of the location where the drug will be administered:                                                                                                                                                                                                                                                                                                                                                                  |                                                           |                                                     | Telephone:                                         |                     |
| Address (No. / Street / Apt.):                                                                                                                                                                                                                                                                                                                                                                                             |                                                           | City :                                              | Province:                                          | Postal Code :       |
| SECTION 5 - TYPE OF APPLICATION                                                                                                                                                                                                                                                                                                                                                                                            |                                                           |                                                     |                                                    |                     |
| <input type="checkbox"/> Initial request                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Continued treatment              |                                                     | <input type="checkbox"/> Modification of treatment |                     |

## SECTION 6- SUMMARY OF PREVIOUS TRIALS OR CONTRAINDICATIONS

Please provide a list of medicines and/or treatments used to date to control this condition:

| Name of drug/treatment currently or previously prescribed | Content - strength / Dosage | Trial Period         |                    | Reason for Discontinuation                                                                                                                                                                   |
|-----------------------------------------------------------|-----------------------------|----------------------|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                           |                             | From<br>(YYYY-MM-DD) | To<br>(YYYY-MM-DD) |                                                                                                                                                                                              |
|                                                           |                             |                      |                    | <input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance <input type="checkbox"/> Ineffective <input type="checkbox"/> Relapse<br><input type="checkbox"/> Other Specify: _____ |
|                                                           |                             |                      |                    | <input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance <input type="checkbox"/> Ineffective <input type="checkbox"/> Relapse<br><input type="checkbox"/> Other Specify: _____ |
|                                                           |                             |                      |                    | <input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance <input type="checkbox"/> Ineffective <input type="checkbox"/> Relapse<br><input type="checkbox"/> Other Specify: _____ |
|                                                           |                             |                      |                    | <input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance <input type="checkbox"/> Ineffective <input type="checkbox"/> Relapse<br><input type="checkbox"/> Other Specify: _____ |

## SECTION 7 - CLINICAL INFORMATION SPECIFIC TO THIS APPLICATION

### DIAGNOSTIC

- ☐ Weight Management  
☐ Risk of Myocardial Infarction  
☐ Other. Specify: \_\_\_\_\_

### WEIGHT MANAGEMENT

Please provide the following pre-treatment information as well as the date on which they were obtained :

|                            |                                                    |                           |
|----------------------------|----------------------------------------------------|---------------------------|
| <b>Weight</b>              | Initial assessment : _____ <b>kg/lbs</b>           | Date (YYYY/MM/DD) : _____ |
| <b>Height</b>              | Initial assessment : _____ <b>cm/in</b>            | Date (YYYY/MM/DD) : _____ |
| <b>Waist circumference</b> | Initial assessment : _____ <b>cm/in</b>            | Date (YYYY/MM/DD) : _____ |
| <b>BMI</b>                 | Initial assessment : _____ <b>kg/m<sup>2</sup></b> | Date (YYYY/MM/DD) : _____ |

I confirm I have verified the above measurements:   ☐ Yes   ☐ No   Signature: \_\_\_\_\_

Patient's sex at birth\*:   ☐ Female   ☐ Male   ☐ Intersex

Is the patient of South Asian, Southeast Asian or East Asian ethnicity\*?   ☐ Yes   ☐ No

*\*These questions are optional. Canadian Adult Obesity Clinical Practice Guidelines recommend different measured waist circumference and/or BMI cut*

*offs for females and males, and for those of South-, Southeast- or East Asian ethnicity.*

Will the drug be taken in combination with any other GLP-1 receptor agonist?   ☐ Yes   ☐ No

### RISK OF MYOCARDIAL INFARCTION

Does the patient have established cardiovascular disease?   ☐ Yes   ☐ No

↳ If yes, check all that apply:   ☐ Acute coronary syndrome (ACS)   ☐ Coronary artery disease documented using angiography

☐ Stable or unstable angina   ☐ Stroke   ☐ Transient ischemic attack   ☐ Documented carotid disease

☐ Coronary or other arterial revascularization (coronary artery bypass graft surgery, femoral popliteal bypass graft surgery, etc.)   ☐ Peripheral artery disease

☐ Abdominal aortic aneurysm   ☐ Myocardial infarction (MI)   ➡ Date of the event:: \_\_\_\_\_

☐ Other. Specify: \_\_\_\_\_

Does the patient have diabetes?   ☐ Yes   ☐ No   ➡ If yes, indicate which type:   ☐ Type 1   ☐ Type 2

Continue to page 3

| Patient's weight management history:                                                                                                                                                                                          |                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| Has the patient been following a reduced calorie diet or other dietary pattern that is associated with weight reduction for at least 6 months in the past 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, specify the diet(s) and dates:<br>Diet(s): _____<br>From _____ to _____                                                             |
| Has the patient engaged in an increased level of physical activity for chronic weight management for at least 6 months in the past 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No                        | If yes, specify the physical activities and dates:<br>Activities: _____<br>From _____ to _____                                              |
| Has the patient participated in behavioural interventions for chronic weight management for at least 6 months in the past 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No                                 | If yes, specify the name and specialty of the provider or healthcare professional, or the name of the program: _____<br>From _____ to _____ |
| If you answered "no" to any of the above questions, please indicate why: _____                                                                                                                                                |                                                                                                                                             |

| Check all adiposity-related complications that apply:                                                                                                                                                                                                                                                                                                                                                                                                  | Provide related test results, scores and information:                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Prediabetes<br>↳ <input type="checkbox"/> Impaired fasting glucose<br><input type="checkbox"/> Impaired glucose tolerance<br><input type="checkbox"/> A1C 6.0 to 6.4%<br><b>or</b> <input type="checkbox"/> Type 2 diabetes                                                                                                                                                                                                   | A1C: _____ % (Date: _____)<br><br><b>If prediabetes, also provide:</b><br>Fasting glucose: _____ mmol/L (Date: _____)<br>2-hour glucose tolerance: _____ mmol/L (Date: _____)                                                                                                                                                                                                                                |
| <input type="checkbox"/> Sleep Apnea                                                                                                                                                                                                                                                                                                                                                                                                                   | Apnea Hypopnea Index: _____<br>Requires a CPAP: <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                     |
| <input type="checkbox"/> Cardiovascular risk <b>or</b><br><input type="checkbox"/> Heart disease<br>↳ <input type="checkbox"/> Angina pectoris<br><input type="checkbox"/> Stent placement<br><input type="checkbox"/> Coronary artery bypass<br><input type="checkbox"/> Prior myocardial infarction<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Symptomatic peripheral vascular disease<br><input type="checkbox"/> Heart failure | Blood pressure: _____ mm Hg (Date: _____)<br>HDL-C: _____ mmol/L (Date: _____)<br>Total cholesterol: _____ mmol/L (Date: _____)<br>Is the patient using antihypertensive medication?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>↳ If yes, specify drug name(s) and dosage(s) : _____<br><br><b>If cardiovascular risk, also provide:</b><br>Framingham risk score: _____ % (Date: _____) |
| <input type="checkbox"/> Borderline hypertension<br><b>or</b><br><input type="checkbox"/> Hypertension                                                                                                                                                                                                                                                                                                                                                 | Blood pressure: _____ mmHg (Date: _____)<br>Is the patient using antihypertensive medication?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>↳ If yes, specify drug name(s) and dosage(s): _____                                                                                                                                                                                             |

|                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Impaired function or mobility                                                                                                   | Number of flights of stairs the patient is able to manage: _____<br>Is the patient using pain medication? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>↳ If yes, specify drug name(s) and dosage(s): _____<br>_____<br>Does the patient require walking aids? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>↳ If yes, specify walking aids required: _____<br>_____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Elevated liver function<br><b>or</b><br><input type="checkbox"/> NAFLD/MASLD<br><b>or</b><br><input type="checkbox"/> NASH/MASH | ALT: _____ U/L (Date: _____)<br><b>If NAFLD/MASLD or NASH/MASH, also provide:</b><br>FIB-4: _____ U/L (Date: _____)<br>Fasting insulin (optional): _____ <input type="checkbox"/> uIU/mL <input type="checkbox"/> pmol/L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <input type="checkbox"/> Polycystic ovary syndrome (PCOS)<br><b>or</b><br><input type="checkbox"/> Male sexual dysfunction                               | Blood pressure: _____ mm Hg (Date: _____)<br>HDL-C: _____ mmol/L (Date: _____)<br>Triglycerides: _____ mmol/L (Date: _____)<br>Non-HDL-C: _____ mmol/L (Date: _____)<br>A1C: _____ % (Date: _____)<br>Fasting glucose: _____ mmol/L (Date: _____)<br>2-hour glucose tolerance: _____ mmol/L (Date: _____)<br>Is the patient using antihypertensive drug? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>↳ If yes, specify drug name(s) and dosage(s): _____<br>_____<br><b>If polycystic ovary syndrome (PCOS), also provide:</b><br><u>Ovulatory function:</u><br><input type="checkbox"/> Normal ovulatory cycles<br><input type="checkbox"/> Oligo-ovulatory cycles<br><input type="checkbox"/> Anovulation<br><b>If male sexual dysfunction, also provide:</b><br>Is the patient using ED medications? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Total testosterone: _____ mmol/L (Date: _____) |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Esophagitis | <p><u>Check all that apply:</u></p> <input type="checkbox"/> Two or more episodes of GERD per week<br><input type="checkbox"/> Severe symptoms<br><input type="checkbox"/> Esophagitis on endoscopy<br><p>Does the patient require daily proton pump inhibitor (PPI) at standard dose or higher for longer than 8 weeks?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><p>↳ If yes, specify drug name(s) and dosage(s):</p> <p>_____</p> <p>_____</p> <p>_____</p> |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### SECTION 8 - CLINICAL INFORMATION REGARDING RENEWAL

Has the patient lost at least 5% of their initial body weight?    ☐ Yes    ☐ No

Date of initial evaluation (pretreatment): \_\_\_\_\_      Date of most recent evaluation: \_\_\_\_\_

| Items measured:              | Initial evaluation (pretreatment): | Most recent evaluation: |
|------------------------------|------------------------------------|-------------------------|
| Weight:                      | _____ kg/lbs                       | _____ kg/lbs            |
| Height (in cm):              | _____ cm                           | _____ cm                |
| BMI:                         | _____ kg/m2                        | _____ kg/m2             |
| Waist circumference (in cm): | _____ cm                           | _____ cm                |

Has the patient been on Wegovy 2.4 mg weekly or maximum tolerated dose of 1.7 mg weekly for at least 12 weeks?    ☐ Yes    ☐ No

or

Has the patient been on Saxenda 3 mg weekly or maximum tolerated dose of 2.4 mg weekly for at least 12 weeks?    ☐ Yes    ☐ No

↳ If you answered "no" to any of the above questions, specify how many weeks the patient has been on that dose: \_\_\_\_\_ weeks

**Indicate test results, scores and information showing improvement in the patient's adiposity-related complications:**

| Items assessed                                          | Initial (pretreatment) | Most recent                                              |
|---------------------------------------------------------|------------------------|----------------------------------------------------------|
| A1C (%):                                                |                        |                                                          |
| Fasting glucose (mmol/L):                               |                        |                                                          |
| 2-hour glucose tolerance (mmol/L):                      |                        |                                                          |
| Blood pressure (mm Hg):                                 |                        |                                                          |
| Antihypertensive drug name(s) and dosage(s):            |                        |                                                          |
| HDL-C (mmol/L):                                         |                        |                                                          |
| Total cholesterol (mmol/L):                             |                        |                                                          |
| Triglycerides (mmol/L):                                 |                        |                                                          |
| Non-HDL-C (mmol/L):                                     |                        |                                                          |
| Framingham risk score (%):                              |                        |                                                          |
| Patient had new myocardial infarction or stroke:        | N/A                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Patient had new cardiovascular-related hospitalization: | N/A                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |

|                                                                                       |                                                                                                                                             |                                                                                                                                             |
|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| Patient had new coronary revascularization:                                           | N/A                                                                                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |
| Number of flights of stairs the patient is able to manage:                            |                                                                                                                                             |                                                                                                                                             |
| Improvement in knee functionality (i.e., speed and walk distance):                    | N/A                                                                                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |
| Uses walking aids:                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |
| Pain medication name(s) and dosage(s):                                                |                                                                                                                                             |                                                                                                                                             |
| ALT (U/L):                                                                            |                                                                                                                                             |                                                                                                                                             |
| FIB-4:                                                                                |                                                                                                                                             |                                                                                                                                             |
| Fasting insulin ( <input type="checkbox"/> uUI/mL <input type="checkbox"/> pmol/L ) : |                                                                                                                                             |                                                                                                                                             |
| Apnea Hypopnea Index:                                                                 |                                                                                                                                             |                                                                                                                                             |
| Requires a CPAP:                                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |
| Improved esophagitis symptoms (specify):                                              |                                                                                                                                             |                                                                                                                                             |
| Proton pump inhibitor name(s), dosage(s) and duration of use:                         |                                                                                                                                             |                                                                                                                                             |
| Ovulatory function:                                                                   | <input type="checkbox"/> Normal ovulatory cycles<br><input type="checkbox"/> Oligo-ovulatory cycles<br><input type="checkbox"/> Anovulation | <input type="checkbox"/> Normal ovulatory cycles<br><input type="checkbox"/> Oligo-ovulatory cycles<br><input type="checkbox"/> Anovulation |
| Total testosterone (nmol/L):                                                          |                                                                                                                                             |                                                                                                                                             |
| Decrease of erectile dysfunction incidents:                                           | N/A                                                                                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |
| ED medication name(s), dosage(s) and frequency of use:                                |                                                                                                                                             |                                                                                                                                             |

#### SECTION 9- ADDITIONAL INFORMATION (optional)

#### SECTION 10 – SIGNATURE OF AUTHORIZED PRESCRIBER

|                                      |                             |        |
|--------------------------------------|-----------------------------|--------|
| Print name of authorized prescriber: | Specialty of the physician: |        |
| Signature of authorized prescriber:  | License Number:             | Date : |

#### SECTION 11 - IMPORTANT PATIENT INFORMATION

Fees may be charged to complete this form, it is the patient's responsibility to pay them.  
Ensure all required sections of the form have been completed and signed before returning it.  
Attach any additional documents required on this form.  
Your request may be delayed if we do not have all the necessary information.  
The drug will be eligible only if it meets the criteria established by the insurer.

#### HOW TO RETURN THE FORM

Submit a claim through the **members portal**  
Claim type *Prior authorization drugs*

By mail : AGA Benefit Solutions  
3500 de Maisonneuve Blvd. W, suite 2200  
Westmount (QC) H3Z 3C1