INFORMATION DRUG REQUEST
DRUG REQUIRING PRIOR AUTHORIZATION

Weight loss drugs

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? ☐ YES ☐ NO

Has your application for coverage with the provincial program for this drug or supply been approved? ☐ YES ☐ NO

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? ☐ YES ☐ NO

If yes, please provide your patient assistance program identification number: _____

SECTION 3 - AUTHORIZATION TO SHARE PERSONAL INFORMATION

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.

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:

☐ Home ☐ Health and social service center ☐ Long-term care center ☐ Private clinic

☐ Hospital - internal patient ☐ Hospital - external patient ☐ 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

☐ Initial request	☐ Continued treatment	☐ Modification of treatment

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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 (YYYY-MM-DD)	To (YYYY-MM-DD)	
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify:
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify:
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify:
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ 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 :

Weight Initial assessment : _____ **kg/lbs** Date (YYYY/MM/DD) : _____

Height Initial assessment : _____ **cm/in** Date (YYYY/MM/DD) : _____

Waist circumference Initial assessment : _____ **cm/in** Date (YYYY/MM/DD) : _____

BMI Initial assessment : _____ **kg/m^2** 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 MYOCARDINAL 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

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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? ☐ Yes ☐ No	If yes, specify the diet(s) and dates: Diet(s): _____ _____ 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? ☐ Yes ☐ No	If yes, specify the physical activities and dates: Activities: _____ _____ From _____ to _____
Has the patient participated in behavioural interventions for chronic weight management for at least 6 months in the past 24 months? ☐ Yes ☐ No	If yes, specify the name and specialty of the provider or healthcare professional, or the name of the program: _____ _____ 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:
☐ Prediabetes ☐ *Impaired fasting glucose* ☐ *Impaired glucose tolerance* ☐ *A1C 6.0 to 6.4%* **or** ☐ Type 2 diabetes	A1C: _____% (Date:_____) **If prediabetes, also provide:** Fasting glucose: _____mmol/L (Date:_____) 2-hour glucose tolerance: _____mmol/L (Date:_____)
☐ Sleep Apnea	Apnea Hypopnea Index: _____ Requires a CPAP: ☐ Yes ☐ No
☐ Cardiovascular risk **or** ☐ Heart disease ☐ Angina pectoris ☐ Stent placement ☐ Coronary artery bypass ☐ Prior myocardial infarction ☐ Stroke ☐ Symptomatic peripheral vascular disease ☐ Heart failure	Blood pressure: _____mm Hg (Date:_____) HDL-C: _____ mmol/L (Date:_____) Total cholesterol: _____ mmol/L (Date:_____) Is the patient using antihypertensive medication? ☐ Yes ☐ No If yes, specify drug name(s) and dosage(s) : _____ **If cardiovascular risk, also provide:** Framingham risk score: _____% (Date:_____)
☐ Borderline hypertension **or** ☐ Hypertension	Blood pressure: _____mmHg (Date:_____) Is the patient using antihypertensive medication? ☐ Yes ☐ No If yes, specify drug name(s) and dosage(s): _____ _____

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

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☐ Esophagitis	Check all that apply: ☐ Two or more episodes of GERD per week ☐ Severe symptoms ☐ Esophagitis on endoscopy Does the patient require daily proton pump inhibitor (PPI) at standard dose or higher for longer than 8 weeks? ☐ Yes ☐ No → If yes, specify drug name(s) and dosage(s): _____ _____ _____

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:	_____ ☐ lbs ☐ kg	_____ ☐ lbs ☐ kg
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	☐ Yes ☐ No
Patient had new cardiovascular-related hospitalization:	N/A	☐ Yes ☐ No

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