

## Special Authorization Request Form, for:

### **OZEMPIC, RYBELSUS (*semaglutide*)**

The purpose of this form is to obtain medical information required to assess your request for a drug on the Special Authorization (SA) list of the Reformulary. Please ensure that all information, including contact information, is complete. Completing this form is not a guarantee of approval.

#### **PART 1: COMPLETE THIS INFORMATION**

##### **Information about plan member**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Group number: \_\_\_\_\_ Certificate number: \_\_\_\_\_

Date of birth (DD/MM/YY): \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

#### **COORDINATION OF BENEFITS**

##### **Coverage through another health benefit plan or provincial plan**

Do you or your dependents have drug coverage through another health benefits, insurance company or provincial plan?  Yes  No

*If yes, provide the following:* Name of plan member: \_\_\_\_\_

Policy/Plan number: \_\_\_\_\_ Certificate number: \_\_\_\_\_

##### **Patient assistance program**

Have you enrolled in a patient assistance program?  Yes  No

*If yes, provide your patient assistance program ID number:* \_\_\_\_\_

Provide the patient assistance program:

Contact name: \_\_\_\_\_ Phone: \_\_\_\_\_

**PART 2: TO BE COMPLETED BY YOUR DOCTOR (PHYSICIAN)**

**Physician Information**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

License: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Physician's signature: \_\_\_\_\_

*(confirming the below information to be correct)*

**Drug being requested through Special Authorization**

New request       Request for continuation of therapy

DIN: \_\_\_\_\_ Product name: \_\_\_\_\_

Strength: \_\_\_\_\_ Dosage: \_\_\_\_\_

**Site of Administration**

Home       Private clinic       Hospital  
 Doctor's office       Cancer centre       LTC facility

**CLINICAL INFORMATION**

**Diagnosis**

Diabetes Mellitus Type 2

**Physician specialty**

Family physician with experience in treating diabetes  
 Endocrinologist

**Criteria for initial coverage, confirm the following:**

- Patient is 18 years of age or older; and
- Patient has diagnosis of Diabetes Mellitus Type 2; and
- Patient has intolerance, contraindication and/or inadequate glycemic control\* on metformin; and
- Patient is currently not taking a DPP-4 inhibitor (e.g., sitagliptin, saxagliptin, linagliptin, alogliptin)

**\*A minimum 3-month trial of maximally tolerated metformin is required to determine inadequate glycemic control (please provide details below)**

**NOTE:** Duration of initial approval is 1 year

**Criteria for continued coverage, confirm the following:**

- Patient demonstrates continued therapeutic benefit as shown by evidence of controlled diabetes, outweighing any potential risks of hypoglycemia, pancreatitis, etc.

**NOTE:** Duration of continued approval is indefinite

**SPECIAL NOTES**

Describe any intolerances to therapy: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information that the physician believes is important to this review? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date: June 2023