

Special Authorization Request Form, for:

Weight management drugs: SAXENDA (*liraglutide*), XENICAL (*orlistat*), CONTRAVE (*naltrexone/bupropion*)

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

Weight loss management

Physician specialty

N/A

CLINICAL INFORMATION (cont.)

Criteria for initial coverage for weight loss management, confirm the following:

SAXENDA (*liraglutide*)

Adult patients:

- Patient is 18 years of age or older; and
- Patient has a body mass index (BMI) ≥ 30 kg/m²; and
- Patient has at least one weight-related comorbidity (e.g., hypertension, diabetes, cardiovascular disease, arthritis or dyslipidemia); and
- Patient has failed a previous weight management intervention (e.g., failure to lose $\geq 5\%$ of body weight through at least 6 months of lifestyle modification); and
- SAXENDA will be used with a reduced calorie diet and increased physical activity; and
- SAXENDA is not used in combination with any other GLP-1 receptor agonist (e.g., semaglutide, liraglutide (VICTOZA), lixisenatide, dulaglutide, exenatide); and
- SAXENDA is not to be used in combination with other weight-reducing agents

Adolescent patients:

- Patient is between 12 - 17 years of age; and
- Patient has had an inadequate response to reduced calorie diet and increased physical activity alone; and
- Patient has a BMI of ≥ 95 th percentile for age and sex (see <https://www.cdc.gov/healthyweight/bmi/calculator.html>); and
- Patient has at least one weight-related co-morbidity (e.g., type 2 diabetes, hypertension, obstructive sleep apnea); and
- SAXENDA is not used in combination with any other GLP-1 receptor agonist (e.g., semaglutide, liraglutide (VICTOZA), lixisenatide, dulaglutide, exenatide); and
- SAXENDA is not to be used in combination with other weight-reducing agents

NOTE: Duration of initial approval is 16 weeks

Request for continuation of therapy, confirm the following:

Adult patients:

- Patient has lost at least 5% of their initial body weight or has continued to maintain their initial 5% weight loss

Adolescent patients:

- Pediatric patient has a reduction in BMI of at least 1% from baseline or the patient has continued to maintain their initial 1 percent reduction in BMI from baseline

NOTE: Duration of continued approval is 6 months

XENICAL (orlistat)

Adult patients:

- Patient is 18 years of age or older; and
- Patient has a body mass index (BMI) ≥ 30 kg/m²; and
- Patient has at least one weight-related comorbidity (e.g., hypertension, diabetes, cardiovascular disease, arthritis or dyslipidemia); and
- Patient has failed a previous weight management intervention (e.g., failure to lose $\geq 5\%$ of body weight through at least 6 months of lifestyle modification); and
- XENICAL will be used with a reduced calorie diet and increased physical activity; and
- XENICAL is not to be used in combination with other weight-reducing agents

Adolescent patients:

- Patient is between 12 - 17 years of age; and
- Patient has had an inadequate response to reduced calorie diet and increased physical activity alone; and
- Patient has a BMI of ≥ 95 th percentile for age and sex (see <https://www.cdc.gov/healthyweight/bmi/calculator.html>); and
- Patient has at least one weight-related co-morbidity (e.g., type 2 diabetes, hypertension, obstructive sleep apnea); and
- XENICAL is not to be used in combination with other weight-reducing agents

NOTE: Duration of initial approval is 16 weeks

Request for continuation of therapy, confirm the following:

Adult patients:

- Patient has lost at least 5% of their initial body weight or has continued to maintain their initial 5% weight loss

Adolescent patients:

- Pediatric patient has a reduction in BMI of at least 1% from baseline or the patient has continued to maintain their initial 1 percent reduction in BMI from baseline

NOTE: Duration of continued approval is 6 months

CONTRAVE (naltrexone/bupropion)

- Patient is 18 years of age or older; and
- Patient has a body mass index (BMI) ≥ 30 kg/m²; and
- Patient has at least one weight-related comorbidity (e.g., hypertension, diabetes, cardiovascular disease, arthritis or dyslipidemia); and
- Patient has failed a previous weight management intervention (e.g., failure to lose $\geq 5\%$ of body weight through at least 6 months of lifestyle modification); and
- CONTRAVE will be used with a reduced calorie diet and increased physical activity; and
- CONTRAVE is not to be used in combination with other weight-reducing agents

NOTE: Duration of initial approval is 16 weeks

Request for continuation of therapy, confirm the following:

- Patient has lost at least 5% of their initial body weight or has continued to maintain their initial 5% weight loss

NOTE: Duration of continued approval is 6 months

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 2022