GLP-1 MEDICATIONS
Prior Authorization Request Form

Plan Member/Patient: Please complete pages 1 and 2 and have your physician complete pages 3 and 4. Completion of this form is not a guarantee of approval. All costs incurred to complete this form are the plan member's responsibility.

PART 1: INFORMATION TO BE COMPLETED BY THE PATIENT

Plan Member Name:	Patient Name:
Plan Member Date of Birth (YYYY/MM/DD):	Patient Date of Birth (YYYY/MM/DD):
Plan Sponsor/Employer:	If you (the patient) are someone other than the covered member, please indicate your relation to the covered member: □ Spouse □ Dependant
Policy/Plan Number:	
Certificate Number:	

Patient Address: _____ _____ _____ _____ _____
Number Street City Province Postal Code

Patient Email: _____ Patient Phone Number: (_____)_____

PART 2: CONSENT TO COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

As of the date hereof, I hereby authorize any person or organization who has personal health information about me, including any health care professional (which includes but is not limited to physicians, medical specialists, physiotherapists, pharmacists or any other person who has examined or treated me), health care institution, pharmacy patient support program, and other medical-related facility, and any authorized agent of mine to release and disclose to Cubic Health Inc. ("Cubic"), the company that runs the Facet Program, any personal information regarding my past medical history and current medical condition, including any relevant clinical notes (collectively, the "Personal Health Information"), which may be required to adjudicate the Request for Prior Authorization to which this Consent forms a part (the "Request").

I understand and agree that Cubic will keep any Personal Health Information obtained from such persons, organizations and/or agents secure and confidential and in accordance with applicable legislation and that my Personal Health Information will not be shared with any other party.

I authorize Cubic to collect, use and maintain my personal information, such as name, address, email address, and the Personal Health Information it deems necessary, for the purposes of adjudicating the Request or any purposes in any way ancillary thereto.

I authorize Cubic to collect, use and disclose my personal information in accordance with its Privacy Policy located at: https://www.facetprogram.ca/en/privacy/.

I hereby acknowledge and understand that:

- access to and use of my Personal Information will be limited to Cubic pharmacists and other Cubic employees in the course of their employment;
- by filling out the Request, I am not guaranteed approval for any level of coverage;
- Cubic is an independent clinical review panel and is not affiliated with my employer, plan sponsor, plan administrator or insurance company and that Cubic has been engaged for the purpose of ensuring that criteria for the approval of claims are satisfied before approval is granted, and to ensure that the criteria for coverage are implemented consistently;
- Cubic has no interest, financial or otherwise, in the decision rendered in adjudicating the Request;
- Cubic specifically assumes no responsibility for the completeness or accuracy of any Personal Information which may be provided to Cubic in connection with the Request, and Cubic disclaims all liability for any loss or damage suffered by any person, including (without limitation) me, as a result of the processing or outcome of the Request; and
- I have no claim against Cubic for any loss or damage (direct, indirect, incidental, consequential or otherwise) I may suffer as a result of the handling, processing or outcome of the Request.

I understand and agree to the terms above *(If patient is <18 years old, parent/guardian to sign below).*

_____ _____ _____

Patient Full Name (please print) Patient Signature Date Signed (YYYY/MM/DD)

OpenCircle BENEFITS

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FOR PATIENTS OVER THE AGE OF 65 OR THOSE RESIDING IN BC, MB, AND SK:
Certain drugs require prior approval from Provincial or Pharmacare Programs before they are eligible for coverage.

ALL INITIAL AND RENEWAL SUBMISSIONS FOR PROVINCIALLY ELIGIBLE DRUGS MUST BE SUBMITTED TO THE PROVINCIAL PLAN FIRST. PLEASE ATTACH THE PROVINCIAL PLAN'S COVERAGE DECISION WITH THIS SUBMISSION.

PART 3: CO-ORDINATION OF BENEFITS

Are you currently on, or have previously been on this medication? □ Yes □ No	If yes, start date: (YYYY/MM/DD): _____ Coverage provided by: _____ ***A history of claims from pharmacy records demonstrating previous use is required***
Do you or your dependants have health benefits coverage through another health benefits company or insurance company? □ Yes □ No	If yes, name of other health benefits company/insurance company: _____ Policy/Plan Number: _____ Certificate Number: _____ Name of person holding coverage: _____

Are you currently receiving disability benefits (short-term or long-term) for the condition for which this medication has been prescribed?
□ Yes □ No

Have you applied for coverage or received any financial support for this medication:

From another insurance plan? □ Yes □ No	If yes, name of covered family member: _____ Relationship: _____ Name of insurance company: _____ Please provide details including coinsurance and any applicable maximums: _____ ***Please attach documentation of acceptance or declination.***
From a provincial program? □ Yes □ No	If yes, name of provincial program(s): _____ ***Please attach documentation of acceptance or declination.***
From a patient assistance/compassionate care program? □ Yes □ No	If yes, name of program(s): _____ Patient Assistance Program ID Number: _____ Patient Assistance Program Contact Name: _____ Patient Assistance Program Contact Information: _____

Please note, obtaining a compassionate (bridge) dose without prior authorization approval does not secure coverage.

PART 4: CURRENT/PAST PHARMACY INFORMATION

Please provide contact details of the pharmacy/pharmacies from which the patient has received medications over the last two years.

Pharmacy Name	Location (Street and City)	Phone Number

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Prescribing Physician: Please provide information on your patient's medical condition/drug history.

PART 1: PRESCRIBER INFORMATION

Physician Name:	Registration Number:	Speciality:
Address:		
Fax Number: (_____)_____ *(required)*	Phone Number: (_____)_____	
E-mail: _____		

PART 2: MEDICATION REQUESTED[1]

☐ Mounjaro *(tirzepatide)* ☐ Ozempic[2] *(semaglutide)* ☐ Rybelsus *(semaglutide)* ☐ Wegovy *(semaglutide)* ☐ Other:_____

Notes:

1. *Coverage is dependent on the terms and conditions of each individual benefits plan. Medications requested for treatment of weight management may be an exclusion of the benefits plan.*
2. *Initial approvals for Ozempic used in Type 2 Diabetes are restricted to a maximum dose of 1mg per week. Any increases in dose require prior approval.*

Directions for Use (i.e., prescribed dose & frequency): _____

Anticipated duration of treatment:_____

Where will the treatment be administered? □ Home □ Physician's Office □ Private Clinic □ Hospital (Inpatient) □ Hospital (Outpatient)
Name of Facility: _____ Address: _____

PART 3: CLINICAL INFORMATION

Please specify the indication for the requested medication (select all that apply and complete corresponding sections below):
☐ Type 2 Diabetes Mellitus ☐ Weight Management ☐ Other: _____

Does patient have any relevant drug allergies? □ Yes □ No	Nature of allergy, if applicable:

FOR TYPE 2 DIABETES MELLITUS*

A copy of the baseline and most recent blood work results (within the last 3 months) must be attached to support this request

Does the patient have inadequate glycemic control? □ Yes □ No

Glycated hemoglobin (HbA1c)

Target HbA1c: _____% Baseline HbA1c: _____% Most recent* HbA1c: _____%
**must be within the last 3 months*

Has the patient tried, or is the patient currently taking metformin? □ No □ Yes

If yes, please specify:

1. Maximally tolerated metformin dose used: _____
2. Dates of maximally tolerated metformin used: from:_____ to:_____
(DD/MM/YYYY) (DD/MM/YYYY)

If metformin was discontinued or not trialed, please justify why not, and describe the nature of the intolerance or contraindication if applicable:

Concurrent medication(s)/therapy with the requested drug, if any:

FOR WEIGHT MANAGEMENT

Patient's current weight *(required)*: _____kg	Patient's calculated BMI *(required)*: _____kg/m^2

Has the patient been diagnosed with any of the following weight-related comorbidities? If yes, check all that apply **and provide documentation**:
□ Hypertension □ Type 2 Diabetes Mellitus □ Dyslipidemia □ Obstructive Sleep Apnea

The requested medication will be used with the following weight management strategies (select all that apply):

□ Dietary interventions / reduced calorie diet □ Increased physical activity □ Other:_____

□ None, please justify:_____

OpenCircle BENEFITS

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PART 4: RELEVANT CURRENT/PREVIOUS THERAPIES – *Please list all current and/or previously tried medications for the requested condition. If standard therapies could not be tried because of contraindication, please specify below. For each medication listed, please provide details including drug name, dosage tried, dates of treatment and outcome.*

Medication Name	Dose	Duration of Treatment		Outcome *(Please provide details of intolerance, therapeutic failure, or contraindication)*
		Start Date (MM/YYYY)	End Date (MM/YYYY)	

PART 5: OTHER CLINICAL INFORMATION – *Please provide detailed information to support medical necessity of the requested medication, including any contraindications to relevant medications, as well as relevant lab tests which may support choice of medication therapy. This may include information about diagnosis, co-morbid conditions, disease severity, drug interactions, contraindications, and past treatment failures.*

PART 6: RENEWAL REQUEST

Medication name:	Date patient started on current medication (MM/YYYY):
Current dosing regimen:	Dosing requested (if different from current dosing regimen):
For Type 2 Diabetes Mellitus *please attach most recent blood work* *Renewals will only be considered in patients who have demonstrated a decrease in HbA1c after 12 months.*	
Baseline HbA1c:_____% Date (DD/MM/YYYY):_____	Current HbA1c:_____% Date (DD/MM/YYYY):_____
For Weight Management *please attach supporting documentation* *Renewals will only be considered in patients who have demonstrated a decrease in baseline body weight OR BMI.*	
Baseline weight: _____ kg Date (DD/MM/YYYY):_____	Baseline BMI:_____ kg/m^2 Date (DD/MM/YYYY):_____
Current weight: _____ kg Date (DD/MM/YYYY):_____	Current BMI:_____ kg/m^2 Date (DD/MM/YYYY):_____
Please provide/attach any additional clinical information to support the renewal of the requested medication:	

Please be advised further information may be requested if needed to facilitate determination of coverage.

I hereby certify that the information provided is true, correct, and complete.

_____ _____

Physician's Signature Date Signed (YYYY/MM/DD)

Please submit the completed form to OpenCircle Benefits by:

Fax: 780-455-6068 or **E-mail:** pa@opencirclebenefits.ca

Questions? Please call OpenCircle at 780-455-5845 (Edmonton) or 1-877-263-7266 (toll-free)