Drug Prior Authorization Form
Wegovy (semaglutide)

The purpose of this form is to obtain information required to assess your drug claim.

IMPORTANT: Please answer all questions. Your claim assessment will be delayed if this form is incomplete or contains errors.

Any costs incurred for the completion of this form are the responsibility of the plan member/patient.

Privacy

Protecting your personal information. At Canada Life, we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

How we use your personal information. Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to provide you with advice, evaluate your eligibility for products, price our products, collect feedback on our customer service, process claims and other financial transactions, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. If you provided your social insurance number (SIN), we'll use it for tax reporting. Your SIN is also used to link your products together and to keep your information separate from other customers with similar names.

Who we share personal information with. We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, our Canadian subsidiaries, and other organizations that provide us services such as paramedical examiners, medical laboratories, MIB, LLC., specialty coverage providers, independent medical examiners, and pharmacy benefits managers. As well, we may share your information with claims assessors, travel assistance providers, technology suppliers, other insurance or reinsurance companies, other financial institutions, and credit reporting agencies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies, and may be communicated outside your province of residence or outside Canada. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information. We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by updating your privacy preferences through your **online account** or by submitting a request through our **privacy centre** at **canadalife.com/privacy**. This includes choosing whether you receive customer experience surveys, the use of your SIN for non-tax reporting purposes, and whether and how you want to receive information and offers from Canada Life using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights through our privacy centre such as access to or correction of your personal information.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

Want to learn more? Please visit **canadalife.com/privacy.**

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Drug Prior Authorization Form
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Privacy consent, authorization, and declaration

I understand that my personal information will be collected, used and shared as set out above.

Canada Life reserves the right to audit the information provided on this form at any time and this consent extends to any audit of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information and for Canada Life to use and disclose it as set out above.

I certify that the information given below is true, correct, and complete to the best of my knowledge. Failure to provide true, correct and complete information on this form could result in revocation of any approval decision, a requirement to repay paid claims or other appropriate action.

I agree that by submitting this form or authorizing it to be submitted, I am consenting to the terms set out in this section, even if I have not signed the form.

Plan Member's signature: _____ Date: _____

Form completion instructions

1. Complete "Patient Information" sections.
2. Please review and sign the form.
3. Have the prescribing physician complete the "Physician Information" sections.
4. Send all pages of the completed form to us by mail, fax or email as noted below.

Note: As email is not a secure medium, any person with concerns about their prior authorization form/medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

Mail to:
The Canada Life Assurance Company
Drug Claims Management
PO Box 6000
Winnipeg MB R3C 3A5

Fax to:
The Canada Life Assurance Company
Fax 1-204-946-7664
Attention: Drug Claims Management

Email to:
cldrug.services@canadalife.com
Attention: Drug Claims Management

For additional information regarding Prior Authorization and Health Case Management, please visit our Canada Life website at **canadalife.com** or contact Group Customer Contact Services at 1-800-957-9777. Deaf or hard of hearing and require access to a telecommunications relay service? Please contact us: TTY to Voice: 711 or Voice to TTY: 1-800-855-0511.

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Patient Information
Wegovy (semaglutide)

Plan member information – Complete all sections of this page (please print)

Plan Member: Patient Name:

Plan Name: Plan Number: Plan Member ID Number:

Patient Date of Birth (dd/mm/yyyy): Address (number, street, city, province, postal code):

Please indicate preferred contact number and if there are any times when telephone contact with you about your claim would be most convenient:

May we contact you by email? (Note that some correspondence may still need to be sent by regular mail). ☐ Yes ☐ No

If yes, please provide email address:

Treatment history with this drug

Is the patient currently on, or previously been on this drug? ☐ Yes ☐ No

If Yes, a) indicate start date (dd/mm/yyyy):

b) coverage provided by:

(if coverage is not provided by Canada Life please provide pharmacy print-out showing purchase of this drug)

Other benefit plans

Does the patient have drug coverage under any other group benefits plan? ☐ Yes ☐ No

If Yes, name of other Insurance Company:

If other plan is with Canada Life, tell us the plan and ID number:

Name of plan member:

Relationship to patient:

Provide details and attach documentation of acceptance or decline:

Provincial programs or other coverage

Does the patient have coverage under a provincial program or from any other source? ☐ Yes ☐ No

If Yes, name of program or other source:

Provide details and attach documentation of acceptance or decline:

Is the patient currently receiving disability benefits for the condition for which this drug has been prescribed? ☐ Yes ☐ No

Patient support program details

Has the patient enrolled in the patient support program for this drug? ☐ Yes ☐ No

If yes, please provide the following information:

1. Patient support program patient ID Number:
2. Patient assistance program contact person name and phone number:

Contact Name: Phone Number:

Physician Information
Wegovy (semaglutide)

Note to Physician: In order to assess a patient's claim for this drug, we require detailed information on the patient's prescription drug history as requested below.

Attach extra information if necessary. GENETIC TEST RESULTS ARE NOT REQUIRED.

Physician's information (please print)

Name of prescribing physician:

Specialty:

Address (number, street, city, province, postal code):

Telephone Number (including area code):

Fax Number (including area code):

1. Prescribed dose and regimen:

☐ 0.25mg once weekly for weeks 1-4, 0.5mg once weekly for weeks 5-8, 1mg once weekly for weeks 9-12, 1.7mg once weekly for weeks 13-16, followed by maintenance dose of 2.4 mg once weekly from week 17 and onwards.

2. Health Canada Indication (include date of initial diagnosis)(mm/yyyy):

☐ Chronic Weight Management

Note: Wegovy is not covered under all benefit plans. Please have the patient confirm coverage before submitting request. Patients can use the Drug Search Tool on mycanadalifeatwork.com.

☐ Metabolic dysfunction-associated steatohepatitis (MASH)

Note: Wegovy is not covered under all benefit plans. Please have the patient confirm coverage before submitting request. Patients can use the Drug Search Tool on mycanadalifeatwork.com.

☐ Myocardial Infarction Prevention

Note: Wegovy is not covered under all benefit plans. Please have the patient confirm coverage before submitting request Patients can use the Drug Search Tool on mycanadalifeatwork.com

Complete questions 1 – 6 and Physician's information

Other (approved by Health Canada):

Complete questions 1 – 6 and Other condition (Health Canada approved)

3. What is the anticipated duration of treatment with this drug?

4. Where will treatment be administered? ☐ Home ☐ Physician's Office ☐ Private Clinic ☐ Hospital In-patient ☐ Hospital out-patient

5. Please provide medical rationale why this drug has been prescribed instead of an alternate drug in the same therapeutic class:

Physician's Information (continued) (please print)

6. Drug and Treatment History – **must be completed for every request.**

Drug(s) and Treatment(s) past and present	Dosing Regimen	Start Date (dd/mm/yyyy)	End Date (dd/mm/yyyy)	Clinical Results/Outcome
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:
				☐ Failure ☐ Intolerance ☐ Other Clinical details:

Chronic Weight Management

To be eligible for coverage, the patient must meet all of the following:

Does the patient have a history of at least one unsuccessful dietary effort/exercise regimen to lose body weight for at least 3-6 months prior to request?

☐ Yes ☐ No

Will Wegovy be used as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management? ☐ Yes ☐ No

Will Wegovy be used in combination with other semaglutide-containing drugs or any other GLP-1 receptor agonist? ☐ Yes ☐ No

For adolescents (age 12-17):

Does the patient have a BMI at the 95th percentile or greater for age and sex? ☐ Yes ☐ No

Current body weight: _____ kg Date assessed (DD/MM/YYYY): _____

For adults:

Does the patient meet one of the following:

☐ The patient has a BMI of ≥30 kg/m^2 OR

☐ The patient has a BMI 27-29 kg/m^2 AND

The patient has at least one of the following comorbidities. Select all that apply:

- ☐ Dyslipidemia
- ☐ Hypertension
- ☐ Obstructive sleep apnea
- ☐ Type II diabetes mellitus
- ☐ Prediabetes
- ☐ Cardiovascular disease
- ☐ None of the above

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Physician Information
Wegovy (semaglutide)

Metabolic dysfunction-associated steatohepatitis (MASH)

Initial Request

To be eligible for coverage, the patient must meet all of the following:

Does the patient have moderate to advanced liver fibrosis (consistent with stage F2 or F3)? ☐ Yes ☐ No

Was the diagnosis confirmed by a specialist with expertise in the management of MASH (e.g. gastroenterologist or hepatologist)? ☐ Yes ☐ No

Please indicate which test was performed to verify MASH diagnosis:

- ☐ Liver biopsy
- ☐ Vibration-controlled transient elastography (VCTE, e.g. Fibroscan)
- ☐ Magnetic Resonance Elastography (MRE)
- ☐ Shear wave elastography (SWE)

Does the patient have any documented cause of chronic liver disease other than metabolic dysfunction-associated steatotic liver disease (MASLD) (e.g. alcoholic steatohepatitis, acute fatty liver, autoimmune hepatitis, Hepatitis A, B or C, hemochromatosis, drug-induced liver disease)? ☐ Yes ☐ No

Does the patient have overweight or obesity? ☐ Yes ☐ No

If Yes, will Wegovy be used in conjunction with a reduced-calorie diet, increased physical activity, and behavioural modifications? ☐ Yes ☐ No

Will Wegovy be used in combination with other GLP-1 agonists? ☐ Yes ☐ No

Will the dose of Wegovy exceed the maximum weekly dose of 2.4mg? ☐ Yes ☐ No

Renewal Request

Has the patient experienced any of the following (select all that apply):

- ☐ Improvement in fibrosis stage by ≥ 1?
- ☐ Improvement of MASH based on serum biomarkers and/or imaging?

Does the patient have worsening of liver fibrosis? ☐ Yes ☐ No

Does the patient have overweight or obesity? ☐ Yes ☐ No

If Yes, will Wegovy continue to be used in conjunction with a reduced-calorie diet, increased physical activity, and behavioural modifications? ☐ Yes ☐ No

Myocardial Infarction Prevention

Current BMI: _____ kg/m^2 Date assessed (DD/MM/YYYY): _____

Will Wegovy be used in combination with other semaglutide-containing drugs or any other GLP-1 receptor agonist? ☐ Yes ☐ No

Please indicate which of the following diagnoses of established cardiovascular disease applies to the patient (select all that apply):

- ☐ Prior Myocardial infarction (MI)
- ☐ Prior ischemic or hemorrhagic stroke
- ☐ Symptomatic Peripheral Arterial Disease, defined by one of the following:
  - ☐ Intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest)
  - ☐ Peripheral arterial revascularization procedure
  - ☐ Amputation due to atherosclerotic disease

Other condition (Health Canada approved)

Provide any relevant information related to the disease and attach supporting documentation.

Physician Information
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Note for Physician: To be eligible for reimbursement, Canada Life may require your patient to purchase a drug requiring prior authorization from a pharmacy designated by Canada Life. If applicable, a health case manager will contact you with further information.

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

Physician's Signature: _____ Date (dd/mm/yyyy): _____

License Number: _____

It is important to provide the requested information in detail to help avoid delay in assessing claims for the above drug. This form may be subject to audit. The completed form can be returned to Canada Life by mail, fax, or email.

Note: As email is not a secure medium, any person with concerns about their prior authorization form/medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

Mail to:
The Canada Life Assurance Company
Drug Claims Management
PO Box 6000
Winnipeg MB R3C 3A5

Fax to:
The Canada Life Assurance Company
Fax 1-204-946-7664
Attention: Drug Claims Management

Email to:
cldrug.services@canadalife.com
Attention: Drug Claims Management