

DRUG AUTHORIZATION REQUEST FORM



COMPLETING YOUR FORM...

To ensure prompt processing of your request, please complete the following Drug Authorization Request Form in full. Note that there are sections that must be completed by you, the patient, and sections that must be completed by your prescriber. Once completed, submit the form to Entente Plus via your method of choice:

By email: drugspecial.autho@ententeplus.ca

By fax: 1-866-797-6483

By mail: Entente Plus, Drug Special Authorization Team,
P.O BOX 1606, Windsor ON N9A 6W1

Note that submission of an incomplete form may result in delays.

Your request will be reviewed and evaluated by our Drug Special Authorization Department who will share the results with you. Should you have any questions, call Entente Plus's Contact Centre at 1-800-361-9888.

OTHER DRUG COVERAGE...

If you are eligible for coverage by another plan (public or private), indicate that in Section 1B of the authorization form.

If you have provincial drug coverage, please ensure that your prescriber has applied for coverage under your primary provincial drug plan. The result of that application must be attached to the completed Special Authorization Request Form.

PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM

Please note: Incomplete information may delay your request for processing.

SECTION 1A – PATIENT INFORMATION

First Name		Certificate ID	Employer Name
Last Name		Date of Birth (YYYY/MM/DD)	Email Address
Street Address			Telephone (Home)
City	Province	Postal Code	Telephone (Mobile)

SECTION 1B - COORDINATION OF BENEFITS

Patient Support Program	Is the patient enrolled in any assistance program for the requested drug? ☐ Yes ☐ No			
	Program Name			Patient Identifier
	Contact First Name	Contact Last Name	Contact Phone	Contact Email
Drug Access Navigator	Is the patient in contact with an alternate drug access navigator (i.e., hospital)? ☐ Yes ☐ No			
	Organization Name			
	Contact First Name	Contact Last Name	Contact Phone	Contact Email
Provincial Coverage	Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ NA			
	What is the coverage decision? (Attach decision outcome letter) ☐ Approved ☐ Denied			
Other Private Coverage	Is this patient covered by any other plan? (If yes answer below) ☐ Yes ☐ No ☐ NA			
	Planholder First Name	Planholder Last Name		Date of Birth (YYYY/MM/DD)
	Relationship to Planholder ☐ Self ☐ Spouse ☐ Dependant ☐ Other _____			
	What is the coverage decision? (Attach outcome letter if received) ☐ Approved ☐ Denied			

SECTION 1C – CONSENT

I hereby authorize any licensed physician/dentist, medical practitioner, hospital, patient assistance program, clinic, or medically related facility to provide to Entente Plus information regarding my health as it relates to this request. I hereby authorize Entente Plus to obtain and exchange my personal information with other parties as required, including any health care provider, patient assistance program and/or Specialty Care Program vendor working with Entente Plus for the purpose of administering this benefit, and to any prescribed entity as defined by the Personal Health Information Protection Act, 2004, for analysis or statistical purposes related to managing, evaluating, or planning for all or part of the health system, including resource allocation and the delivery of health services. I acknowledge that my personal information is needed to assess eligibility for this drug, to administer the group benefits plan, and where applicable, to the Specialty Care Program and patient support services on my behalf. I acknowledge that my personal information may be exchanged and transferred between these parties for these purposes and may include information about my drug claims, diagnosis, medical condition, treatment, and other health related information. I acknowledge that providing my consent will help Entente Plus to assess my claim and that refusing to consent may result in delay or denial of my claim. This consent may be revoked by me at any time by sending written instructions to that effect at the address indicated below. I understand that personal information may be subject to disclosure to those authorized under applicable law within Canada only when the information is needed to administer this benefit and/or to confirm the accuracy of this information. I certify that the information given is true, correct, and complete to the best of my knowledge.

Signature of Patient	Date (YYYY/MM/DD)
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If under 16 years of age (14 years of age in Quebec), the signature of the parent / guardian is required.

PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM
TIRZEPATIDE (Mounjaro)

**Entente
Plus⁺**

SECTION 2A – DRUG REQUESTED FOR EVALUATION

Product Name and Strength

Dose

Frequency of Administration

Route (ex. oral, IV, etc.)

Therapy Duration

Is the patient currently on the requested therapy?
(If yes provide therapy start date)

☐ Yes ☐ No

Therapy Start Date (Y/M/D) _____

If already established on therapy, please attach proof of payment and details of prior coverage. Individuals established on therapy through compassionate coverage will only be considered if they met this plan's criteria on initiation of therapy.

SECTION 2B – LOCATION OF ADMINISTRATION

☐ Home

For Infusion Centers please complete information below

☐ Physician's Office

Name and Address of Infusion Center

☐ Hospital (In-Patient)

☐ Hospital (Out-Patient)

City

Province

Postal Code

☐ Infusion Center

SECTION 2C – DRUG REQUESTED FOR EVALUATION

For use of Mounjaro at a dose of up to 10 mg weekly

For use as an adjunct to diet, exercise, and maximum tolerated dose of metformin or a second antihyperglycemic medication to improve glycemic control in adult patients with type 2 diabetes mellitus when diet and exercise plus maximal tolerated dose of metformin or a second antihyperglycemic medication do not achieve adequate glycemic control.

Please note that use in obesity without the diagnosis of type 2 diabetes mellitus will not be considered. Combination therapy with other GLP-1 receptor agonists will not be eligible for consideration. Specific rationale as to the nature of the intolerance or contraindication if metformin has not been trialed is required for consideration of monotherapy.

Diagnosis: _____

Target HbA1c: _____

If target is not <7%, please provide rationale: _____

Baseline HbA1c (prior to starting any antihyperglycemic therapy): _____

Current HbA1c (within the last 3 months): _____

Please confirm you are requesting approval for dosing of up to 10 mg per week. ☐ Yes ☐ No

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Dates of maximally tolerated metformin use: _____

Dose of maximally tolerated metformin use: _____

Response to metformin therapy: _____

If metformin was discontinued or not trialed, please provide specific rationale as to the nature of the intolerance or contraindication:

Has the patient trialed any additional antihyperglycemic therapies? ☐ Yes ☐ No

If YES, please include name/dose/duration and the outcome of prior treatment(s).

1) Medication: _____ Dose: _____ Duration: _____

Outcome: _____

2) Medication: _____ Dose: _____ Duration: _____

Outcome: _____

3) Medication: _____ Dose: _____ Duration: _____

Outcome: _____

*****Note: Restrictions will enforce a maximum dosing of 10mg per week*****

For use of Mounjaro at a dose of up to 15 mg weekly

Initial approval (12 months):

For use as an adjunct to diet, exercise, and maximum tolerated dose of metformin and a second antihyperglycemic medication to improve glycemic control in adult patients with type 2 diabetes mellitus when diet and exercise plus maximal tolerated dose of metformin, a second antihyperglycemic medication, and Mounjaro 10 mg weekly for a minimum of 6 months do not achieve adequate glycemic control.

Please note that use in obesity without the diagnosis of type 2 diabetes mellitus will not be considered. Combination therapy with other GLP-1 receptor agonists will not be eligible for consideration. Specific rationale as to the nature of all intolerances and/or contraindications if metformin and other antihyperglycemics have not been trialed is required for consideration of monotherapy.

Diagnosis: _____

Target HbA1c: _____

If target is not <7%, please provide rationale: _____

Current HbA1c (within the last 3 months, and must be drawn at least 6 months after consistent use of Mounjaro 10mg weekly; consistent use/compliance will be verified via claims data)

*****Note: a copy of the bloodwork MUST be attached***:** _____

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Please confirm you are requesting approval for dosing of up to 15 mg per week.

☐ Yes ☐ No

Dates of Mounjaro 10mg weekly use: _____

Metformin use:

Dose: _____ Duration: _____

Outcome: _____

Will metformin be used in combination with Mounjaro 15mg weekly therapy? ☐ Yes ☐ No

If NO, please explain why: _____

Second Antihyperglycemic agent used:

Medication: _____ Dose: _____ Duration: _____

Outcome: _____

Will this agent be used in combination with Mounjaro 15mg weekly therapy? ☐ Yes ☐ No

Note: Continued use of a second, non-metformin antihyperglycemic agent in combination with Mounjaro 15mg weekly is required for consideration.

Has the patient trialed any additional antihyperglycemic therapies? ☐ Yes ☐ No

If YES, please include name/dose/duration and the outcome of prior treatment(s).

1) Medication: _____ Dose: _____ Duration: _____

Outcome: _____

Will this agent be used in combination with Mounjaro 15mg weekly therapy? ☐ Yes ☐ No

If NO, please explain why: _____

2) Medication: _____ Dose: _____ Duration: _____

Outcome: _____

Will this agent be used in combination with Mounjaro 15mg weekly therapy? ☐ Yes ☐ No

If NO, please explain why: _____

3) Medication: _____ Dose: _____ Duration: _____

Outcome: _____

Will this agent be used in combination with Mounjaro 15mg weekly therapy? ☐ Yes ☐ No

If NO, please explain why: _____

*****Note: Restrictions will enforce a maximum dosing of 15mg per week*****

PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM
TIRZEPATIDE (Mounjaro)

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Renewal for 15mg weekly dose only (open-ended):

Subsequent renewals will only be considered in patients who have demonstrated a decrease in HbA1c after 12 months.

Baseline HbA1c (prior to increase to 15 mg weekly): _____

Current HbA1c ****Note: a copy of the bloodwork MUST be attached****: _____

PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM

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**Entente
Plus⁺****SECTION 3A – PRESCRIBER INFORMATION AND SIGNATURE**

First Name	License Number	Specialty
Last Name	Telephone	Fax
Street Address		
City	Province	Postal Code
Signature		Date (YYYY/MM/DD)

SECTION 3B – SUBMISSION INSTRUCTIONS

Return request form to:

Fax : 1-519-739-6483 or 1-866-797-6483	Mail: Entente Plus Drug Special Authorization Team, P.O BOX 1606, Windsor ON N9A 6W1
Email : drugspecial.autho@ententeplus.ca	

COST OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.