

## 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](mailto: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

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

|                             |                          |
|-----------------------------|--------------------------|
| <b>Signature of Patient</b> | <b>Date (YYYY/MM/DD)</b> |
|-----------------------------|--------------------------|

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

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

### 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 (YYYY/MM/DD)

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

☐ Physician's Office

☐ Hospital (In-Patient)

☐ Hospital (Out-Patient)

☐ Infusion Center

**For Infusion Centers please complete information below**

Name and Address of Infusion Center

City

Province

Postal Code

### SECTION 2C – DIAGNOSIS AND COMMENTS

Diagnosis

Diagnostic Code (i.e. ICD-10)

Additional Comments

### SECTION 2D – CURRENT/PREVIOUS TREATMENT FOR DIAGNOSIS

☐ Patient has not tried other therapies for this diagnosis (skip Section 2D)

Drug/Regimen #1

Start (YYYY/MM/DD)

End (YYYY/MM/DD)

☐ Lack of Response

Dose / Frequency / Details

☐ Intolerance (explain)

☐ Other (explain)

Drug/Regimen #2

Start (YYYY/MM/DD)

End (YYYY/MM/DD)

☐ Lack of Response

Dose / Frequency / Details

☐ Intolerance (explain)

☐ Other (explain)

Drug/Regimen #3

Start (YYYY/MM/DD)

End (YYYY/MM/DD)

☐ Lack of Response

Dose / Frequency / Details

☐ Intolerance (explain)

☐ Other (explain)

Additional information on current, previous or required treatment for diagnosis (attach document if required)

**PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM**

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

**Entente  
Plus<sup>+</sup>****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:

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

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

**ELIGIBLE CRITERIA****ORLISTAT (XENICAL)**

Please present this Eligible Criteria sheet to your physician to use as reference when completing the Special Authorization Request.

**ELIGIBLE CRITERIA**

Patient's height, weight, and body mass index (BMI) must be indicated on the Drug Special Authorization form. Patient must have a body mass index (BMI) greater than 30kg/m or a BMI greater than 27kg/m in the presence of other risk factors (ie. hypertension, diabetes, or dyslipidemia).

For the use in combination with antidiabetic agents (sulphonylureas, metformin, insulin) to improve blood glucose control in overweight or obese type 2 diabetes patients who are inadequately controlled on diet, exercise, and one or more of a sulphonylurea, metformin, or insulin.

*These drugs may have the potential for other uses outside of the indications identified, but are only eligible benefits of the controlled formularies under the conditions specified and with the proper documentation.*