

DRUG SPECIAL AUTHORIZATION REQUEST FORM, AND ADHERENCE SUPPORT PROGRAM INFORMATION



COMPLETING YOUR FORM...

To ensure prompt processing of your request, please complete the following Special 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 Humania Assurance via your method of choice:

By email: medicaments.autoprealable@humania.ca

By fax: 1.866.797.6483

By mail: Humania Assurance, Drug Special Authorization Department,
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 Humania Assurance's Contact Centre at 1.800.818.7236.

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.

ADHERENCE SUPPORT PROGRAM

Some drug treatment plans are complicated, and patients can sometimes find it difficult to follow their prescriber's instructions when taking their medication. If your special authorization drug is approved, you may be eligible for adherence support services. A medication management specialist can work with you to ensure that you have the support necessary to take your medication as instructed and adhere to your drug treatment plan.

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 Humania Assurance information regarding my health as it relates to this request. I hereby authorize Humania Assurance to obtain and exchange personal information with other parties as required, including any health care provider and/or patient assistance program working with Humania Assurance for the purpose of administering this benefit. I acknowledge that my personal information is needed to assess eligibility for this drug, to administer the group benefits plan, and where applicable, to administer patient support programs 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 Humania Assurance 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)
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 ANTI-OBESITY AGENTS



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 ☐ 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 – DRUG REQUESTED FOR EVALUATION

Please check off the box next to the drug you are requesting for evaluation:

☐ Contrave (naltrexone/bupropion)
☐ Saxenda (liraglutide)
☐ Wegovy (semaglutide)
☐ Zepbound (tirzepatide)

*Contrave and Zepbound are eligible for adults only, Saxenda and Wegovy are eligible for adults and adolescents 12 years of age and greater. Combination therapy will NOT be eligible for consideration.

Initial approval (6 months):

For use as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management in patients aged 12 years and older.

Patient's age: _____ Patient's gender¹: _____

Date of current measurements (*within 60 days of submission*): _____

Patient's current measurements:

Height (cm/in): _____ Weight (kg/lb): _____ BMI (kg/m²): _____

Contributing risk factor(s): _____

¹ Refers to sex assigned at birth.

**PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM
ANTI-OBESITY AGENTS**



Has the patient increased physical activity (defined as a minimum of 150 minutes of vigorous exercise per week) for a minimum of 6 months?

☐ YES ☐ NO

If NO, provide rationale: _____

If the patient cannot tolerate vigorous exercise, does the patient participate in regular low impact physical activity (i.e. walking, swimming, etc.)?

☐ YES ☐ NO

Has the patient received nutritional training from a dietician?

☐ YES ☐ NO

List two or more reduced calorie diets the patient has attempted:

1) _____

2) _____

Additional diets trialed (if applicable): _____

Has the patient undergone bariatric surgery?

☐ YES ☐ NO

If YES, Date of surgery: _____

Weight prior to surgery (kg/lb): _____

Weight post-surgery after weight loss plateaued (kg/lb): _____

Renewals:

Subsequent renewals will only be considered for patients aged 12 years and older if $\geq 5\%$ of body weight was lost and maintained (or a decrease of $\geq 4\%$ in BMI for pediatric patients) after initial treatment course. Patient's baseline and current height, weight, and body mass index (BMI) must be indicated.

Baseline measurements:

Date of baseline measurements: _____

Patient's baseline measurements:

Height (cm/in): _____ Weight (kg/lb): _____ BMI (kg/m^2): _____

Current measurements:

Date of current measurements (*within 60 days of submission*): _____

Patient's current measurements:

Height (cm/in): _____ Weight (kg/lb): _____ BMI (kg/m^2): _____

PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM



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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 along with any original paid “Official Pharmacy” receipts to :		
Fax : 1.519.739.6483 or 1.866.797.6483		Mail: Humania Assurance Drug Special Authorization Department, P.O. Box 1606, Windsor ON N9A 6W1
Email : medicaments.autoprealable@humania.ca		

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