

## **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](mailto: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

|                                |                                                                                                                                                                  |                   |                      |                            |
|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------------------|----------------------------|
| <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 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 SETMELANOTIDE (Imcivree)



## 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

|                                                                                                                                                                                                                               |                                                               |          |             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------|-------------|
| <input type="checkbox"/> Home<br><input type="checkbox"/> Physician's Office<br><input type="checkbox"/> Hospital (In-Patient)<br><input type="checkbox"/> Hospital (Out-Patient)<br><input type="checkbox"/> Infusion Center | <b>For Infusion Centers please complete information below</b> |          |             |
|                                                                                                                                                                                                                               | Name and Address of Infusion Center                           |          |             |
|                                                                                                                                                                                                                               | City                                                          | Province | Postal Code |

## SECTION 2C – DRUG REQUESTED FOR EVALUATION

### Initial approval (6 months):

- ☐ For weight management in adult and pediatric patients 6 years of age and older with obesity\* due to:
- Clinically or genetically confirmed Bardet-Biedl syndrome (BBS), OR
  - Genetically confirmed biallelic pro-opiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency due to variants interpreted as pathogenic, likely pathogenic, or of uncertain significance

Physician must be an endocrinologist, pediatric endocrinologist, and/or specialist in weight management or obesity.

\*Clinical obesity is defined as BMI  $\geq 30$  kg/m<sup>2</sup> (for those  $\geq 16$  years) or weight  $> 97$ th percentile for age and sex<sup>1</sup> on growth charts (for those aged 6 to 15 years).

<sup>1</sup>Refers to sex assigned at birth.

Does the patient have Clinically or genetically confirmed Bardet-Biedl syndrome (BBS)?

☐ YES ☐ NO

Does the patient have genetically confirmed biallelic pro-opiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency due to variants interpreted as pathogenic, likely pathogenic, or of uncertain significance? ☐ YES ☐ NO

Physician is an endocrinologist, pediatric endocrinologist, and/or specialist in weight management or obesity

☐ YES ☐ NO

**PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM**  
**SETMELANOTIDE (Imcivree)**

Patient's age: \_\_\_\_\_

For patients 6 to 15 years of age, is weight over the 97th percentile for age and sex<sup>1</sup> on growth charts?

☐ YES ☐ NO

Date of current measurements: \_\_\_\_\_

Patient's current measurements:

Height (cm/in): \_\_\_\_\_ Weight (kg/lb): \_\_\_\_\_ BMI (kg/m<sup>2</sup>): \_\_\_\_\_

**Renewal Criteria (12 months):**

Subsequent renewals will only be considered for the following:

- Patients aged 18 and over if  $\geq 5\%$  of body weight OR BMI was lost and maintained after initial treatment course.
- Patients aged 6 to 17 years of age if  $\geq 5\%$  of BMI was lost and maintained 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<sup>2</sup>): \_\_\_\_\_

Current measurements:

Date of current measurements: \_\_\_\_\_

Patient's current measurements:

Height (cm/in): \_\_\_\_\_ Weight (kg/lb): \_\_\_\_\_ BMI (kg/m<sup>2</sup>): \_\_\_\_\_

## **PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM**



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

| <b>SECTION 3A – PRESCRIBER INFORMATION AND SIGNATURE</b>                           |                |                                                                                                               |
|------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------|
| First Name                                                                         | License Number | Specialty                                                                                                     |
| Last Name                                                                          | Telephone      | Fax                                                                                                           |
| Street Address                                                                     |                |                                                                                                               |
| City                                                                               | Province       | Postal Code                                                                                                   |
| Signature                                                                          |                | Date (YYYY/MM/DD)                                                                                             |
| <b>SECTION 3B – SUBMISSION INSTRUCTIONS</b>                                        |                |                                                                                                               |
| Return request form along with any original paid "Official Pharmacy" receipts to : |                |                                                                                                               |
| <b>Fax</b> : 1.519.739.6483 or<br>1.866.797.6483                                   |                | <b>Mail:</b> Humania Assurance<br>Drug Special Authorization Department,<br>P.O. Box 1606, Windsor ON N9A 6W1 |
| <b>Email</b> : medicaments.autoprealable@humania.ca                                |                |                                                                                                               |

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