

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)
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If under 16 years of age (14 years of age in Quebec), the signature of the parent / guardian is required.

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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 ☐ Intolerance (explain) ☐ Other (explain)
Dose / Frequency / Details			
Drug/Regimen #2	Start (YYYY/MM/DD)	End (YYYY/MM/DD)	☐ Lack of Response ☐ Intolerance (explain) ☐ Other (explain)
Dose / Frequency / Details			
Drug/Regimen #3	Start (YYYY/MM/DD)	End (YYYY/MM/DD)	☐ Lack of Response ☐ Intolerance (explain) ☐ Other (explain)
Dose / Frequency / Details			
Additional information on current, previous or required treatment for diagnosis (attach document if required)			

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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.

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.