

IMPORTANT – PLEASE READ CAREFULLY BEFORE COMPLETING THIS FORM**YOU DO NOT NEED TO FILL OUT THIS FORM IF:**

You have submitted a claim for a medication to treat type 2 diabetes within the last four months.

Semaglutide may be covered without you having to fill out this prior authorization form.

Consult the WebRx® tool in the iA Mobile app and in My Client Space (ia.ca/myaccount). After you enter the prescribed medication, the tool will confirm whether semaglutide is covered based on your history of diabetes-related claims.

Depending on your plan, reimbursement for brand-name medications (Ozempic and Rybelsus) may be limited to the cost of the lowest-priced generic equivalent.

Please refer to page 4 for instructions.

☐ **Renewal**

☐ **Initial claim**

PART 1 – TO BE COMPLETED BY THE PLAN MEMBER/PATIENT

Member name _____

Policy no. _____ Certificate no. _____

Patient name (if different) _____

Relationship to plan member: ☐ Spouse ☐ Dependent child Date of birth of the patient

Coordination of benefits

If the patient has his or her own drug plan or is registered with a provincial drug plan, the request must first be submitted to that plan.

Coverage by another drug plan	Is the patient covered by another drug plan? ☐ Yes – Provide a copy of the response received (approval or denial) ☐ No
Provincial plan coverage	Has a claim been submitted to the patient's provincial plan? ☐ Yes – Provide a copy of the response received (approval or denial) ☐ No
Patient support program	Is the patient enrolled in a patient support program? ☐ Yes ☐ No If yes – Name of program: _____ Contact name: _____ Telephone: _____ Extension: _____

I agree that the statements included in this form will serve as a basis to review my own or my dependent's drug claim.

If the drug claim being reviewed is for my dependent, I **confirm** that I have the authorization to discuss the information about him or her with respect to the request.

On behalf of myself and my dependent, **I authorize** my physician or healthcare provider to disclose and exchange with Industrial Alliance Insurance and Financial Services Inc. (iA Financial Group) the information requested in this form regarding the drug for myself or my dependent. **I consent** to the release of the information contained in this claim form to iA Financial Group, its employees, agents, reinsurers, service providers and other organizations working with iA Financial Group for the purposes of the underwriting, administration and processing of this request.

If my Social Insurance Number is used as my identification number, I **authorize** its use for the administration of my group benefits.

I agree that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature _____

Date | | Y | | M | | D | |

Address _____

Postal code

Daytime phone _____ Extension _____ Member email _____

PART 2 – TO BE COMPLETED BY PRESCRIBING PHYSICIAN

⚠ Please answer all the questions in every section, without exception.
Incomplete or missing information may delay the processing of your claim.

SECTION A – DRUG REQUESTED FOR EVALUATION

- ☐ Semaglutide injection (Ozempic) – Authorization will be given for a weekly initial maximum dose of 1 mg.
- ☐ Semaglutide tablet (Rybelsus) – Authorization will be given for an initial maximum dose of 14 mg per day.

Administration route (e.g. oral, etc.): _____

Treatment duration: _____

Will the drug be administered in a hospital? ☐ Yes ☐ No

☐ Yes (study end date) | Y M D | ☐ No

☐ Yes (date treatment started) _____ ☐ No

SECTION B – INITIAL REQUEST

Diagnosis / Therapeutic indication

- ☐ If other, please specify: _____

Administration of semaglutide in combination with metformin?

- ☐ No, please specify the reasons why semaglutide will not be administered in combination with metformin:

Previous drugs or treatments

Name of drug or treatment		Treatment duration																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
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For internal use:

⚠ Please answer all the questions in every section, without exception.
Incomplete or missing information may delay the processing of your claim.

INSTRUCTIONS AND IMPORTANT INFORMATION

Step 2: Prescribing physician must complete Part 2

- Any fees for the completion of the enclosed form are the responsibility of the plan member/patient.
- Your claims assessment will be delayed if the enclosed form is incomplete or contains errors.
- The purpose of the enclosed form is to obtain information required to assess your claim for a drug on iA Financial Group's Prior Authorization list. The drug must meet the criteria for coverage under your plan. In Quebec, drugs on the RAMQ Exception Drug list must also meet the criteria for coverage under your plan.
- Completion and submission of this form does not guarantee approval. You will receive reimbursement for the prior authorization drug only if the request has been reviewed and approved by iA Financial Group.
- You will be notified whether the request has been approved or denied. You can expect to receive notification within 10 days of when your request is received.
- To verify the status of the claim, log in to My Client Space.

All other provinces
Health and Dental Claims Department
PO Box 4643, Station A
Toronto ON M5W 5E3

Business hours: Monday to Friday, 8 am to 8 pm (ET)