



GROUP BENEFITS PRIOR AUTHORIZATION FORM - GLP-1 RECEPTOR AGONISTS

CONTACT INFORMATION

Mail: MDM Insurance Services Inc.
P.O. BOX 970, GUELPH, ON, N1H 6N1

Email: Pharmacy@mdm-insurance.com

Fax: (519) 836-4909

INSTRUCTIONS

Complete and submit this form using one of the three methods provided in the Contact Information section.

If previous coverage for your prescription drugs was not provided by your Benefits Plan, please submit a 24 month pharmacy history including all medication and glucose monitoring technology claims.

GLP-1 agonists are approved for use as an adjunct to diet, exercise, and metformin to improve glycemic control in adult patients with type 2 diabetes mellitus when diet and exercise plus maximal tolerated dose of metformin do not achieve adequate glycemic control.

Note: Use in weight loss/obesity without the diagnosis of type 2 diabetes mellitus will not be considered.

PART 1 - PATIENT INFORMATION

Group _____ Account _____ Certificate _____

Plan Member _____
First Name Initial Last Name

Telephone (_____) _____

If you prefer email notification for the results of your prior authorization, please provide your email address _____

You acknowledge that data transmitted over the internet may be intercepted and that such transmission is at your own risk. If you no longer wish to communicate with MDM Insurance Services Inc. by email, please send notification to Pharmacy@mdm-insurance.com

Patient _____
First Name Initial Last Name

Address _____
Street City Province Postal Code

Date of Birth _____ Relationship to Plan Member _____
MMM/DD/YYYY

PART 2 - CO-ORDINATION OF BENEFITS

In order to ensure you are receiving benefits to which you may be entitled, please answer the following questions. An incomplete response will result in processing delays.

Are you currently on, or have previously been on this medication? ☐ Yes ☐ No

If yes, start date _____ Coverage provided by _____
MMM/DD/YYYY

Are you currently receiving disability benefits (short-term or long-term) for the condition for which this medication has been prescribed? ☐ Yes ☐ No

Please indicate below if you have applied for coverage or received any financial assistance or other support related to this drug.

For patients that have coverage under a private insurance plan, the request for coverage must be submitted to that plan first. Once you have received the decision document from that plan, please submit a copy of the decision document along with this form completed by the physician, so that we may further review your request.

a. Does the patient have coverage under any group or individual benefit plan? ☐ Yes ☐ No

If yes, was coverage for this drug approved or declined under that group or individual benefit plan? ☐ Approved ☐ Declined

The decision document resulting from this application for coverage must be attached to this form.

If coverage was approved, please indicate coverage effective dates _____
MMM/DD/YYYY

If coverage was approved, please provide full name of covered family member _____

Relationship to Covered Member _____

Name of Insurance Company _____

Plan Number _____ Plan Member ID Number _____

For patients eligible for coverage through any provincial drug program, such as SK Special Support Program, Manitoba Pharmacare, BC Pharmacare, Exceptional Drug Status, Ontario Drug Benefit, etc., please ensure that you or your physician have applied for coverage through the applicable provincial program(s) first. Once you have received the decision document from the applicable program(s), please submit a copy of the decision document along with this form so that we may further review your request.

b. Does the patient have coverage under a provincial program? ☐ Yes ☐ No

If yes, name of provincial program _____

If coverage was approved, the decision document resulting from this application for coverage must be attached to this form

If application has not been made, please explain why not _____

PART 2 - CO-ORDINATION OF BENEFITS (CONTINUED)

c. Does the patient have coverage under a patient assistance program or any other source? ☐ Yes ☐ No

If yes, name of program or other source

Patient Assistance Program ID Number

Patient Assistance Contact Name

Phone Number (.....) Email

PART 3 - PATIENT/GUARDIAN AUTHORIZATION (TO BE COMPLETED BY PATIENT)

I authorize MDM (a) to use the personal information disclosed on this form, and any other personal information known to MDM regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact and to obtain any such personal information from and to disclose any such personal information to any physician, pharmacist, or other health care professional having knowledge of such patient's health relevant to this request and any related claim, and (c) to share and disclose personal information, including healthcare information, with RXI Health Solutions. (RXI Health Solutions provides reimbursement navigation services that optimize funding outcomes for patients requiring specialized high cost medications). I acknowledge MDM reserves the right to exhaust alternative coverage options, including but not limited to, provincial and public drug programs and manufacturer coverage prior to rendering a funding decision.

I hereby certify that the information provided in this request is true, complete, and accurate.

Patient/Legal Guardian Name Telephone (.....)

Signature of Patient/Legal Guardian Date MMM/DD/YYYY

PART 4 - MEDICAL INFORMATION (TO BE COMPLETED BY PHYSICIAN)

PRESCRIBER INFORMATION

Physician First Name Initial Last Name Specialty

Address Street City Province Postal Code

Telephone (.....) Fax (.....) Registration Number

MEDICATION REQUESTED

GLP-1 agonists are approved for use as an adjunct to diet, exercise, and metformin to improve glycemic control in adult patients with type 2 diabetes mellitus when diet and exercise plus maximal tolerated dose of metformin do not achieve adequate glycemic control.

Note: Use in weight loss/obesity without the diagnosis of type 2 diabetes mellitus will not be considered.

Name of Requested Drug DIN

Directions for use

CLINICAL INFORMATION

Date of initial diagnosis MM/YYYY

Diagnosis and stage of disease

Anticipated duration for treatment Patient's current weight ☐ lbs ☐ kg

Patient calculated BMI kg/m². Anticipated monthly cost: \$

Does patient have any relevant drug allergies? ☐ Yes ☐ No

If yes, nature of allergy

Has the patient tried, or is the patient currently taking metformin? ☐ No ☐ Yes If yes, please specify:

1. Maximally tolerated metformin dose used:

2. Dates of maximally tolerated metformin used from: to: MMM/DD/YYYY MMM/DD/YYYY

If metformin was discontinued or not trialed, please justify why not, and describe the nature of the intolerance or contraindication, if applicable:

PART 4 - MEDICAL INFORMATION (CONTINUED)

RELEVANT CURRENT/PREVIOUS THERAPIES

Please list all medications and therapies that have been used to treat this condition, including strength of drug, frequency of dosing and duration of each treatment with an official pharmacy claims history for both drugs used to treat diabetes as well as technology used to measure (example – blood glucose test strips).

Medication Name	Dosing Regimen	Start Date (MM/YYYY)	End Date (MM/YYYY)	Patient Response Please provide details of intolerance, therapeutic failure, or contraindication

ADDITIONAL INFORMATION REQUIRED

Applications must include an official pharmacy claims history. Applications that do not include an official pharmacy claims history will not be considered.
If drugs or technology are contraindicated or not tolerated, provide objective evidence (example: blood work reports, adverse drug/technology reaction reports)
Attach the current HgbA1C report from an accredited lab.

I certify that the information provided is true, correct, and complete.
Please be advised further information may be requested if needed to facilitate determination of coverage.

Prescribing Physician's Signature _____ Date _____
MMM/DD/YYYY

PART 5 - PRIVACY

MDM Insurance Services Inc. ("MDM") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.