

PRIOR AUTHORIZATION PROGRAM FORM

MOUNJARO (tirzepatide)

Instructions:

Section 1 to be completed by Plan Member / Patient
 Section 2 and 3 to be completed by Physician
 Section 4 to be completed by Physician and Pharmacist

Please submit the completed form to:

NexgenRx Formulary Management
 145 The West Mall P.O. Box 110 U,
 Toronto, Ontario, M8Z 5M4
by Fax: 1-877-639-4369
by email: PriorAuthSupport@nexgenrx.com

The costs incurred to complete this form are the responsibility of the patient. The costs are not eligible for reimbursement under the plan

ALL FIELDS ARE MANDATORY: INCOMPLETE FORMS MAY RESULT IN YOUR APPLICATION BEING DECLINED

SECTION 1A: POLICY INFORMATION

Carrier ID: Policy Group Number : Certificate Number : Patient Code :
 98

SECTION 1B: PATIENT INFORMATION

First Name: Last Name: Date of Birth (DD MMM YYYY): Gender: ☐ Male ☐ Female
☐ Prefer not to disclose
 Street Address: City: Province: Postal Code:
 Preferred Phone: Email: Relationship to Member:
☐ Employee ☐ Spouse ☐ Dependent

SECTION 1C: PLAN MEMBER INFORMATION

First Name: Last Name: Employer:
 Preferred Phone: Email:

SECTION 1D: COORDINATION OF BENEFITS - PROVINCIAL COVERAGE

Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No
 What is the coverage decision? (Attach decision outcome letter) ☐ Approved ☐ Denied

SECTION 1E: COORDINATION OF BENEFITS - PRIVATE COVERAGE

Is the patient covered by any other drug plan? ☐ Yes ☐ No
 What is the coverage decision? (Attach decision outcome letter) ☐ Approved ☐ Denied
 Plan Member First Name: Plan Member Last Name: Date of Birth (DD MMM YYYY): Relationship to Member:
☐ Employee ☐ Spouse ☐ Dependent

Coverage provided by: Carrier ID: Policy Group Number: Certificate Number:

SECTION 1F: COORDINATION OF BENEFITS - PATIENT SUPPORT PROGRAM

Is the patient enrolled in a Patient Support Program? ☐ Yes ☐ No
 Patient consents to NexgenRx contacting Patient Support Program? ☐ Yes ☐ No
 Program Name: Program Patient Identifier: Program Fax:

Contact First Name: Contact Last Name: Phone: Email:

SECTION 1G: COORDINATION OF BENEFITS – DISABILITY

Is the patient currently on disability benefits for the condition being treated? ☐ Yes ☐ No



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SECTION 1H: COORDINATION OF BENEFITS – DRUG ACCESS NAVIGATOR

Is the patient currently being supported by a Drug Access Navigator?

☐ Yes

☐ No

Patient consents to NexgenRx contacting Drug Access Navigator

☐ Yes

☐ No

Organization Name:

Patient Identifier:

Fax:

Contact First Name:

Contact Last Name:

Phone:

Email:

Results of this request to be communicated to

☐ Patient

☐ Plan Member

☐ Patient Support Program *

☐ Drug Access Navigator *

☐ Pharmacy*

For each preferred recipient, email and patient consent **MUST** be provided in their respectful sections. Patient, Plan Member, Patient Support Program, and Drug Access Navigator details are found in Section 1. Pharmacy details are found in Section 4.

☐ Legal Guardian

Consent Provided:

E-MAIL (mandatory):

☐ Yes ☐ No

SECTION 1I: CONSENT

I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of participating in this clinical patient support program and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist, other health care professional or agent having knowledge of such patient's health relevant to this request and any related claim. You give the authorization to have this form provided to a Licensed Authorized Supplier your Employer has agreed to upon request.

I consent to be contacted by any outside companies other than NexgenRx via phone, text or email and to the transfer of personal information by phone, fax or email between the Licensed Authorized Supplier, my insurer, and my health care provider(s) for the purpose of determining my eligibility for the program and the delivery of program services. Email and text may be used during the course of my participation in the program to inform me about my status in the program, program services, and to provide notifications and reminders. I acknowledge that neither email nor text is a secure method of communication. Information in emails and texts has the potential to be accessed and read by a third party. Electronic communication is at my option and I may withdraw this option to communicate electronically at any time.

* If the patient has another drug plan, this application may cover some or all of the portion not paid by the primary plan.

By signing below, you certify that all the information referred to in this form are genuine and that the information provided is true and complete and if any such claim concerns your spouse or any dependent that you have their consent to disclose their personal information to us for purpose referred to above. You also authorize us to obtain and exchange information with respect to this claim with any person having such relevant information including any health care provider, insurer, claims adjudicator or administrator or any privately or publicly funded benefit plan or program.

Patient / Legal Guardian Name:

Signature of Patient / Legal Guardian:

Date (DD MMM YYYY):

SECTION 2: MEDICATION REQUESTED (to be completed by a Physician)

DRUG NAME, STRENGTH AND DOSE																												
Drug Identification Number (DIN)																												
Indication	☐ Type 2 Diabetes Mellitus ☐ OFF-LABEL USE: (Please note that only the "Indications" published in the Product Monograph submitted to Health Canada will be considered) ☐ Type 1 Diabetes Mellitus ☐ Obesity and Chronic Weight Management: Weight: _____ Height: _____ BMI: _____ ☐ Other (please specify): _____																											
Quantity prescribed or attach a copy of a prescription	Quantity Prescribed / Dose: _____ ☐ Weekly ☐ Monthly ☐ Other frequency (please specify): _____																											
Start Date:																												
Anticipated Duration of Treatment																												
Treatment Administration Site (Specify where the medication will be Administered)	☐ HOME (administered by patient) ☐ Clinic (administered by health care professional) ☐ Hospital ☐ Other (please specify) _____																											
Has the patient previously used this medication?	☐ Yes, Renewal. Start of treatment date: _____ ☐ No. New drug Therapy																											
FOR RENEWAL: Clinical response:	☐ Improved ☐ Stable ☐ No response																											
FOR RENEWAL: Any adverse effects?	☐ Yes ☐ No																											
Concurrent medications with the requested drug, if any:	<table border="1"> <thead> <tr> <th></th> <th>DRUG & DOSE</th> <th>SIG</th> </tr> </thead> <tbody> <tr><td>1</td><td>_____</td><td>_____</td></tr> <tr><td>2</td><td>_____</td><td>_____</td></tr> <tr><td>3</td><td>_____</td><td>_____</td></tr> <tr><td>4</td><td>_____</td><td>_____</td></tr> </tbody> </table>				DRUG & DOSE	SIG	1	_____	_____	2	_____	_____	3	_____	_____	4	_____	_____										
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1	_____	_____																										
2	_____	_____																										
3	_____	_____																										
4	_____	_____																										
If alternative therapies have previously been considered or initiated, please list the treatments that have been trialed, including the clinical response or outcomes observed, as well as the reasons for discontinuation (e.g., lack of efficacy, adverse effects, or patient preference).	<table border="1"> <thead> <tr> <th></th> <th>DRUG & DOSE</th> <th>DURATION</th> <th>CLINICAL RESPONSE</th> <th>REASON FOR DISCONTINUATION</th> </tr> </thead> <tbody> <tr><td>1</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>2</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>3</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>4</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>				DRUG & DOSE	DURATION	CLINICAL RESPONSE	REASON FOR DISCONTINUATION	1	_____	_____	_____	_____	2	_____	_____	_____	_____	3	_____	_____	_____	_____	4	_____	_____	_____	_____
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2	_____	_____	_____	_____																								
3	_____	_____	_____	_____																								
4	_____	_____	_____	_____																								
Baseline testing completed:	☐ Yes (please attach results) ☐ No - Please provide Reason: _____ _____ _____																											
*** Please ensure that the most recent supporting laboratory results and/or test reports are attached ***																												

SECTION 3: CLINICAL INFORMATION

Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying criteria listed below. If the patient has another drug plan, prior authorization may cover some or all of the excess not paid by the primary plan.

Please indicate if the patient meets at least one of the following qualifying criteria for drug coverage:

MOUNJARO (Tirzepatide injection) is indicated for once-weekly administration as an adjunct to diet and exercise to improve glycemic control for:

- ☐ **Treatment of adult patients with TYPE 2 Diabetes Mellitus.**
 - ☐ As monotherapy when metformin is inappropriate due to contraindication or intolerance.
 - ☐ In combination with metformin.
 - ☐ In combination with metformin and a sulfonylurea.
 - ☐ In combination with metformin and a sodium-glucose cotransporter 2 inhibitor (SGLT2i).
 - ☐ In combination with basal insulin with or without metformin.
- ☐ **Treatment of pediatric patients aged 10 to less than 18 years with type 2 diabetes mellitus in combination with:**
 - ☐ Metformin, or
 - ☐ Basal insulin with or without metformin

Target HbA1C	
Baseline HbA1C	
Most recent HbA1C	
Maximally tolerated Metformin dose used:	
Date Metformin Was Initially Initiated:	
If Metformin was discontinued or not tried, please justify	

Please provide any additional clinical information to support the request:

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MOUNJARO (tirzepatide)

SECTION 4A: MEDICAL PRACTITIONER'S INFORMATION

Physician First Name:	Physician Last Name:	License Number:	Specialty:
Clinic / Organization Name:			
Street Address:	City:	Province:	Postal Code:
Phone:	Fax:	Email:	
Signature of Physician:		Date (DD MMM YYYY):	

SECTION 4B: PHARMACIST'S INFORMATION

Pharmacist First Name:	Pharmacist Last Name:	License Number:
Pharmacy Name:	Provider Number:	
Street Address:	City:	Province: Postal Code:
Phone:	Fax:	Email:
Patient consents to NexgenRx contacting the Pharmacy? ☐ Yes ☐ No		
Signature of Pharmacist:	Date (DD MMM YYYY):	

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INTERNAL OFFICE USE

Date Received (DD/MM/YYYY):	Start Date (DD/MM/YYYY):	End Date (DD/MM/YYYY):	Date Approved (DD/MM/YYYY):