

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2689 | Toll-free fax: 1 844 419-2689 | pac.bluecross.ca

- HOW TO COMPLETE THIS FORM:**
PLAN MEMBERS — Please complete RED portions of this form.
 Don't forget to sign *Part 6 — Member Consent and Declaration* before you submit your claim.
PHYSICIANS — Please complete BLACK portions of this form.

The patient is responsible for any fees charged by the physician for completion of this form. These fees are not eligible for reimbursement under your Pacific Blue Cross Extended Health Care plan.
 Completion of this form does NOT imply approval for this drug. Coverage is based on the provisions of your Extended Health Care plan and Pacific Blue Cross qualification criteria.

PART 1 — PLAN MEMBER TO COMPLETE

IMPORTANT NOTE: Wegovy® is not covered under all benefit plans. Please confirm coverage before submitting request. Members can check for eligibility on Member Profile or mobile app.

Plan member's name		Patient's name (if different than Plan member's name)			
Patient's birthdate (mm-dd-yyyy)		Policy number		ID number	
Street address		City		Province	Postal code
				Daytime phone number (10 digits)	

PART 2 — PHYSICIAN TO COMPLETE PART 2 TO PART 5

Physician's name			College ID		
Street address		City		Province	Postal code

I certify the medical information provided is accurate and current:

Physician's signature X	Date (mm-dd-yyyy)
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PART 3 — PATIENT INFORMATION – INITIAL REQUEST

Patient Information

- Age
☐ 18 years of age or older
- Reduced Calorie Diet and Increased Physical Activity
☐ Has tried reduced calorie diet and increased physical activity for at least 6 months (to be continued while on Wegovy) and has not reached target weight.
- Obesity Classification and Comorbidities
☐ BMI $\geq 40\text{kg/m}^2$ **OR**
☐ BMI $\geq 35\text{kg/m}^2$ **AND** at least one of: hypertension, dyslipidemia or obstructive sleep apnea
- ☐ No previous history of Ozempic being reimbursed by Pacific Blue Cross
 Please note that if the member has an existing approval for Ozempic from BC PharmaCare or Pacific Blue Cross, they will not qualify for Wegovy. Ozempic and Wegovy contain the same active ingredient, semaglutide, and it is not recommended that the two products be used together. For BC residents, Ozempic may count towards the BC PharmaCare deductible, further decreasing out-of-pocket costs and enhancing plan sustainability. Wegovy is not covered by BC PharmaCare and requires ongoing renewal. Ozempic is approved indefinitely and does not require renewal.

PART 4 — RENEWAL REQUEST

- ☐ Member has achieved and maintained weight loss of at least 5% from pre-treatment weight **AND**
☐ Member will continue to use Wegovy as an adjunct to a reduced calorie diet and increased physical activity.

PART 5 — ADDITIONAL INFORMATION

PART 6 — MEMBER CONSENT AND DECLARATION

! IMPORTANT: This section must be signed before submitting your form.

I declare that all information in this form is true and complete. I understand Pacific Blue Cross will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits and pay claims.

I acknowledge and agree that personal information about me and my eligible dependents may be collected, used and exchanged between Pacific Blue Cross and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by Pacific Blue Cross to my plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Member Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan. I authorize my physician to release my personal information to Pacific Blue Cross to obtain approval for prescription benefit.

Member's signature X	Date (mm-dd-yyyy)
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