Desjardins Insurance
Life • Health • Retirement

C. P. 3950
Lévis (Québec) G6V 8C6
desjardins.com/planmember
1-844-410-6485

PRIOR AUTHORIZATION REQUEST

Contrave (naltrexone/bupropion)
Saxenda (liraglutide)
Wegovy (semaglutide)
Xenical (orlistat)
Zepbound (tirzepatide)

PLEASE READ THE INSTRUCTIONS ON THE LAST PAGE.

PRINT NEW REQUEST

Section A. Patient identification (to be completed by the plan member)

Patient's last and first name	Relationship to plan member	Patient's date of birth (YYYY MM DD)
	☐ Plan member ☐ Spouse ☐ Dependent child	

Plan member's last and first name	Group No.	Certificate No.

No., street, apartment	City	Province	Postal code

Telephone Nos. - Home	Office	Extension	Email

The response to this request includes confidential information. Indicate how you would like to be informed of the decision:

☐ By mail (the response to your request will be sent to the address indicated in this section) ☐ By fax _____

Coordination of benefits: If the patient has private or provincial drug coverage, submit the request to that plan first. Then, send us the decision notice and this completed form.

Private plan – Is the patient covered by another private drug insurance plan?

☐ **Yes** – Provide a copy of the notice of approval or refusal. → ☐ **Copy attached to this form.**

☐ **No** Specify: Name of the insurer _____ Group No. _____ Certificate No. _____

Provincial plan – Has a request for reimbursement been submitted to your provincial plan?

☐ **Yes** – Provide a copy of the notice of approval or refusal. → ☐ **Copy attached to this form.**

☐ **No** – Explain:

Patient support program – Is the patient enrolled in a patient support program?

☐ **Yes** – Program name _____

Contact person _____ Telephone No. _____ Extension _____

☐ **No**

Section B1. Declaration and authorization for the collection, use and communication of personal information

All the information I have provided on this form is accurate and complete. I acknowledge having read the Personal Information Management section on the last page. I authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, strictly for the purposes of managing my file and processing this request to: a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes healthcare professionals or facilities, insurance companies; b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; c) when necessary, use the personal information it may have about me in existing files that are now closed. To achieve the purposes described above and to provide you support, your information, on a depersonalized basis, may be used for analysis, statistics and development of predictive models. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to this request.
A photocopy of this authorization is as valid as the original.

Signature of plan member _____ **Date** _____

Last name and first name of parent/legal guardian (if applicable) _____

Signature of patient or parent/legal guardian (if applicable) _____ **Date** _____

Section B2. Optional consent to communicate personal information to a third party

Consent to communicate the decision on the prior authorization request

To ensure the request is processed efficiently, I authorize Desjardins Insurance to communicate the reasons for the decision to the healthcare professionals involved in the file and, if applicable, the drug manufacturer's patient support program.

☐ Yes

☐ No

My consent can be withdrawn at any time by contacting the program or Desjardins Insurance. I understand that my consent is optional and doesn't affect the processing of my request by Desjardins Insurance. My consent also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my request.

Signature of plan member _____ **Date** _____

Last name and first name of parent/legal guardian (if applicable) _____

Signature of patient or parent/legal guardian (if applicable) _____ **Date** _____

Section C. Attending physician section (to be completed by the attending physician)

Physician's last and first name (PLEASE PRINT)	License No.	Specialty

No., street, suite	City	Province	Postal code

Telephone No.	Fax No.

Signature of physician _____ **Date** _____

Drug name	Formulation	Strength	Dosage	Patient's weight	Scheduled duration of treatment

Where is the drug administered?

☐ Home ☐ Physician's office ☐ Private clinic ☐ Hospital – Inpatient ☐ Hospital – Outpatient

☐ Other (please specify) _____

Disability

Is the patient currently on disability?

☐ Yes ☐ Total ☐ Partial For what reason? _____

☐ No

- To avoid processing delays, make sure all sections are completed: otherwise, the request will be returned to the plan member.
- For us to consider a diagnosis that is not listed below, provide supporting documents (clinical practice guidelines, clinical studies, etc.) that justify the drug's use in the given context.

Diagnosis

☐ Obesity

☐ Other therapeutic indications (please specify) _____

Section C. Attending physician section (continued)

Information relating to obesity

Describe the intended therapeutic goals ______________________________

____

____

____

Provide the following values:

Weight ____________ ☐ lb ☐ kg

Height ____________ ☐ in ☐ cm

BMI ____________ kg/m²

Waist circumference at the navel ____________ ☐ in ☐ cm

Indicate all comorbidities that apply to the patient:

- ☐ Cardiovascular disease, explain the nature of the disease ____________ Date of diagnosis ____________ (YYYY MM DD)
- ☐ Dyslipidemia
- ☐ High blood pressure
- ☐ Obstructive sleep apnea
- ☐ Type II diabetes
- ☐ Others, please explain ____________

Indicate if the weight management plan includes a reduced-calorie diet:

☐ Yes, indicate start date ____________ (YYYY MM DD) ☐ No, please explain ____________

Indicate if the weight management plan includes an increase in physical activity:

☐ Yes, indicate start date ____________ (YYYY MM DD) ☐ No, please explain ____________

Indicate the reference values below:

Measurements	Reference values
Blood pressure	
LDL	
HbA1C	
Framingham Risk Score (FRS)	
Other, please specify:	

Prior medication or treatment

Has the patient ever used medication or received treatment for this medical condition? ☐ Yes ☐ No

If not, explain ____________

If so, list any medication used or any treatment received:

MEDICATION OR TREATMENT NAME	OUTCOME	TREATMENT PERIOD
Name:	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication	From: YYYY MM DD
Dose:	Specify:	To: YYYY MM DD
Name:	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication	From: YYYY MM DD
Dose:	Specify:	To: YYYY MM DD
Name:	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication	From: YYYY MM DD
Dose:	Specify:	To: YYYY MM DD
Name:	☐ Ineffectiveness ☐ Intolerance ☐ Contraindication	From: YYYY MM DD
Dose:	Specify:	To: YYYY MM DD

Section C. Attending physician section (continued)

Prescription renewal

Treatment of obesity

Provide the information required to assess the evolution of the response to the treatment and the intended therapeutic goals:

Measurements	Values at initiation of treatment	Values at the most recent evaluation Date:
Blood pressure		
LDL		
HbA1C		
Framingham Risk Score (FRS)		
Weight ☐ lb ☐ kg		
Height ☐ in ☐ cm		
BMI (kg/m^2)		
Waist circumference at the navel ☐ in ☐ cm		

Describe the beneficial effect of the therapy observed in relation to the therapeutic goals intended at the initiation of treatment _____

The following question only applies to patients with associated comorbidities at the initiation of treatment.

Indicate any changes to concomitant medication (change in dosage, addition or discontinuation of a therapy) _____

Section D. Instructions – How to complete and return this form

- Complete sections A and B.
- Ask your physician to complete section C. The plan member is responsible for assuming any costs incurred to complete this form or to obtain additional information.
- To obtain a reimbursement once the drug has been approved, please use your payment card at the pharmacy or submit your original receipts by mail. Eligible drugs must be dispensed by a pharmacist or a physician, if there is no pharmacist.
- Choose one of the following options to send us this form or any other required documents.

Online:

1. Go to desjardins.com/planmember and click on **Log in to your account**.
2. Enter your user ID and password to log in to your group insurance file.
3. In the **Tools and resources** tab, select *Send documents*, then click on **Start**.
4. In the **Type of insurance** drop-down menu, select *Health insurance*.
5. In the **Type of document** drop-down menu, select *Forms*.
6. In the list under **Document Name**, select *Prior Authorization Request – Drugs.*
7. Attach your documents and complete your submission.

By fax: 418-838-2134 or 1-877-838-2134 (toll-free)

By mail: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6

Under its prior authorization program, Desjardins Insurance authorizes the reimbursement of certain drugs that meet criteria that are based, in particular, on clinical practice guidelines and recommendations issued by health technology assessment organizations. The drug will be eligible for reimbursement if it meets the insurer's criteria, if it's not administered in a hospital and if it's not eligible under a government program. If the information on your form is complete, your request will normally be processed within 5 business days.

When the request is received, it will be assessed in the strictest confidence. In some situations, additional diagnostic or clinical information may be required.

If the treatment continues beyond the authorized period, you will be asked to submit a new request form and provide information that justifies the extension of treatment. If you have a payment card, your pharmacist will be advised that the authorization period is coming to an end. The insurance must be in force and the patient still covered on the date expenses are incurred. This prior authorization is subject to change if, at the time expenses are incurred, the contract has been modified.

When Desjardins Insurance declines a prior authorization request, it is because we need to uphold conditions set out in the contract. It does not mean we are questioning the physician's opinion. If you have any questions, please contact our Client Relations Centre at the number indicated on page 1 of this form.

Personal information management

To serve you effectively every day and fulfill our legal obligations, we need to collect, use and disclose information about you. You can read Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy for full details on how your personal information is processed. Specific consents may be required to begin and maintain a business relationship with Desjardins Insurance. These steps will be taken in compliance with Desjardins Group's Privacy Policy. Desjardins Insurance handles the personal information it has on you in a confidential manner. Access to your file is limited to authorized personnel who need it to access it to perform their duties. Desjardins Insurance may also communicate with plan members to provide them with optimal health management (management claim tools, informative health documentation, etc.) and offer its clients an insurance product following the termination of their group insurance. You have the right to review your personal information in our files and correct anything that is incomplete, ambiguous or not relevant. To do so, please consult our Privacy Policy.