AGA BENEFIT SOLUTIONS

INFORMATION DRUG REQUEST
DRUG REQUIRING PRIOR AUTHORIZATION

Continuous glucose monitor (CGM)

SECTION 1 – INFORMATION ON THE MEMBER

Member name:	Group number:	Certificate number:
Address (No. / Street / Apt.):		
City :	Province :	Postal Code :
Phone number :	E-mail address :	
Employer name / Policy holder: :	Group / Division number:	

SECTION 2 – INFORMATION ON THE PATIENT

Patient name:	
Patient Date of Birth (YYYY/MM/DD):	Relationship to member:

Have you applied for coverage with a provincial program? ☐ YES ☐ NO

Has your application for coverage with the provincial program for this drug or supply been approved? ☐ YES ☐ NO

If you have applied for coverage with a provincial program, please provide us with a copy of the refusal or acceptance letter.

Are you enrolled in a drug manufacturer's patient assistance program? ☐ YES ☐ NO

If yes, please provide your patient assistance program identification number: _____

If this concerns a device replacement, please indicate the initial purchase date (YYYY-MM-DD) and provide us with the proof of purchase :

Date of initial purchase (YYYY-MM-DD) : _____

SECTION 3 - AUTHORIZATION TO SHARE PERSONAL INFORMATION

I authorize any health professional (doctor, pharmacist, dentist), any person (service provider), any other insurance company, any public or private health institution, any government agency in relation to health or social services, to disclose and exchange requested information by the insurer or AGA Benefits Solutions, necessary for the evaluation of my request for prior authorization for that drug.

Patient signature:	Date:
Signature of the subscriber when patient is a minor:	Date:

SECTION 4 - DRUG COVERED BY THE APPLICATION

Drug Name:			
Dosage:			
Pharmaceutical Form:		Content / Strength:	
Anticipated duration of treatment:	From (YYYY/MM/DD) :	To (YYYY/MM/DD) :	
Diagnosis:		Initial date of diagnosis (YYYY-MM-DD):	

Medication will be administered at the following location:

☐ Home ☐ Health an social service center ☐ Long-term care center ☐ Private clinic

☐ Hospital - internal patient ☐ Hospital - external patient ☐ Elsewhere. Specify : _____

If the treatment is not administered at home, please provide the following information:

Name of the location where the drug will be administered:		Telephone:	
Address (No. / Street / Apt.):	City :	Province:	Postal Code :

SECTION 5 - TYPE OF APPLICATION

☐ Initial request	☐ Continued treatment	☐ Modification of treatment

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SECTION 6- SUMMARY OF PREVIOUS TRIALS OR CONTRAINDICATIONS

Please provide a list of medicines and/or treatments used to date to control this condition:

Name of drug/treatment currently or previously prescribed	Content - strength / Dosage	Trial Period From (YYYY-MM-DD)	Trial Period To (YYYY-MM-DD)	Reason for Discontinuation
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify:
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify:
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify:

SECTION 7 - CLINICAL INFORMATION SPECIFIC TO THIS APPLICATION

Diagnosis

☐ Type 1 Diabetes ☐ Type 2 Diabetes

☐ Date of initial diagnosis (YYYY/MM/DD) : _____

Diabetes control

Select all criteria applying to the patient

☐ Non optimal value of hemoglobin A1c (HbA1c) adapted to the patient despite adequate care of the condition

☐ Frequent episodes of hypoglycemia during the last year, despite the glycemic management plan in place

☐ Inability to recognize symptoms of hypoglycemia.

Specify : _____

☐ Other. Specify : _____

Other information

Does patient use an insulin pump? ☐ YES ☐ NO

Is the patient insulin dependant? ☐ YES ☐ NO

SECTION 8 - CLINICAL INFORMATION REGARDING RENEWAL

The patient uses the CGM as effectively as possible, at least 70% of the time

☐ Yes

☐ No. Specify : _____

SECTION 9– ADDITIONAL INFORMATION (optional)

SECTION 10 – SIGNATURE OF AUTHORIZED PRESCRIBER

Print name of authorized prescriber:	Specialty of the physician:	
Signature of authorized prescriber:	License Number:	Date :

SECTION 11 - IMPORTANT PATIENT INFORMATION

Fees may be charged to complete this form, it is the patient's responsibility to pay them.
Ensure all required sections of the form have been completed and signed before returning it.
Attach any additional documents required on this form.
Your request may be delayed if we do not have all the necessary information.
The drug will be eligible only if it meets the criteria established by the insurer.

HOW TO RETURN THE FORM

By fax: (514) 935-1147 By email: exceptions@aga.ca	By mail : AGA Benefit Solutions 3500 de Maisonneuve Blvd. W, suite 2200 Westmount (QC) H3Z 3C1