INFORMATION DRUG REQUEST
DRUG REQUIRING PRIOR AUTHORIZATION

Weight loss medication

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 (AAAA/MM/JJ):	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: _____

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 analysis of my request for prior authorization for that drug.

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

SECTION 4 - DRUG COVERED BY THE APPLICATION

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

Medication will be administered at the following location:

☐ Home ☐ Health and 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 drugs and/or treatments used to date to control this condition:

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

☐ Chronic weight problem

☐ Other. Specify: _____

CHRONIC WEIGHT PROBLEM

Evaluation before starting treatment

Date of the evaluation : _____

Patient weight: _____kg or _____pounds Patient height: _____cm or _____inches BMI: _____kg/m2

☐ BMI is 30kg/m3 or more ☐ BMI is 27kg/m2 or more and present with at least one comorbidity

Weight-related comorbidities

☐ High blood pressure ☐ Dyslipidemia ☐ Type 2 Diabetes ☐ Sleep apnea ☐ Clinically manifest cardiovascular disease

☐ Other (please precise) : _____

Will this drug be accompanied by a reduced-calorie diet and increased physical activity? ☐ Yes ☐ No

Does the patient have a failure with a weight management intervention program followed for at least 3 months? ☐ Yes ☐ No

SECTION 8 - CLINICAL INFORMATION REGARDING RENEWAL

Has the patient lost > 5% of his initial weight? ☐ Yes ☐ No

Actual Weight : _____kg or _____pounds **Actual BMI :**_____ Date of measurement (YYYY-MM-DD) :_____

SECTION 9 – ADDITIONAL INFORMATION (optional)

SECTION 10 – SIGNATURE OF AUTHORIZED PRESCRIBER

Print name of authorized prescriber:	Physician speciality:	
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 to 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 email : **exceptions@aga.ca** By fax: (514) 935-1147	By mail : AGA Benefit Solutions 3500 de Maisonneuve Blvd. W, suite 2200 Westmount (QC) H3Z 3C1