

# **DRUG SPECIAL AUTHORIZATION REQUEST FORM, SPECIALTY CARE PROGRAM, AND ADHERENCE SUPPORT SERVICES INFORMATION**



## **COMPLETING YOUR FORM...**

To ensure prompt processing of your request, please complete the following Special Authorization Request Form in full. Note that there are sections that must be completed by you, the patient, and sections that must be completed by your prescriber. Once completed, submit the form to GreenShield via your method of choice:

**By email:** [drugspecial.autho@greenshield.ca](mailto:drugspecial.autho@greenshield.ca)

**By fax:** 1.866.797.6483

**By mail:** GreenShield, Drug Special Authorization Department,  
P.O. Box 1606, Windsor ON N9A 6W1

## **Note that submission of an incomplete form may result in delays.**

Your request will be reviewed and evaluated by our Drug Special Authorization Department who will share the results with you. Should you have any questions, call GreenShield's Contact Centre at 1.888.711.1119.

## **OTHER DRUG COVERAGE...**

If you are eligible for coverage by another plan (public or private), indicate that in Section 1B of the authorization form.

If you have provincial drug coverage, please ensure that your prescriber has applied for coverage under your primary provincial drug plan. The result of that application must be attached to the completed Special Authorization Request Form.

## **SPECIALTY CARE PROGRAM (not applicable in Quebec)**

If your request for coverage is approved, you may be required to obtain your special authorization drug at a partnering pharmacy. If this applies to your benefits plan, a care coordinator working on behalf of GS will contact you to help you find a convenient pharmacy near you. The care coordinator will also work with you and your physician to arrange to have your prescription sent to the pharmacy you select. Should you choose not to speak with the care coordinator, and you obtain your special authorization drug at a non-partner pharmacy, your claim may not be paid under your benefits plan.

## **ADHERENCE SUPPORT SERVICES**

Some drug treatment plans are complicated, and patients can sometimes find it difficult to follow their prescriber's instructions when taking their medication. If your special authorization drug is approved, you may be eligible for adherence support services. A medication management specialist can work with you to ensure that you have the support necessary to take your medication as instructed and adhere to your drug treatment plan. This is a voluntary program, offering you coaching, resources, and ongoing monitoring by a registered nurse during your treatment.



## PREScription DRUG SPECIAL AUTHORIZATION REQUEST FORM

Please note: Incomplete information may delay your request for processing.

### SECTION 1A – PATIENT INFORMATION

|                |                            |               |                    |
|----------------|----------------------------|---------------|--------------------|
| First Name     | Certificate ID             | Employer Name |                    |
| Last Name      | Date of Birth (YYYY/MM/DD) | Email Address |                    |
| Street Address | Telephone (Home)           |               |                    |
| City           | Province                   | Postal Code   | Telephone (Mobile) |

### SECTION 1B - COORDINATION OF BENEFITS

|                                |  |                      |                            |
|--------------------------------|--|----------------------|----------------------------|
| <b>Patient Support Program</b> | Is the patient enrolled in any assistance program for the requested drug? <input type="checkbox"/> Yes <input type="checkbox"/> No                               |                      |                            |
|                                | Program Name   |                      | Patient Identifier         |
|                                | Contact First Name   | Contact Last Name    | Contact Phone              |
| <b>Drug Access Navigator</b>   | Is the patient in contact with an alternate drug access navigator (i.e., hospital)? <input type="checkbox"/> Yes <input type="checkbox"/> No                     |                      |                            |
|                                | Organization Name  |                      |                            |
|                                | Contact First Name   | Contact Last Name    | Contact Phone              |
| <b>Provincial Coverage</b>     | Has the patient applied for reimbursement under a provincial plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA          |                      |                            |
|                                | What is the coverage decision? (Attach decision outcome letter) <input type="checkbox"/> Approved <input type="checkbox"/> Denied                                |                      |                            |
| <b>Other Private Coverage</b>  | Is this patient covered by any other plan? (If yes answer below) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA            |                      |                            |
|                                | Planholder First Name  | Planholder Last Name | Date of Birth (YYYY/MM/DD) |
|                                | Relationship to Planholder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant <input type="checkbox"/> Other _____ |                      |                            |
|                                | What is the coverage decision? (Attach outcome letter if received) <input type="checkbox"/> Approved <input type="checkbox"/> Denied                             |                      |                            |

### SECTION 1C – CONSENT

I hereby authorize any licensed physician/dentist, medical practitioner, hospital, patient assistance program, clinic, or medically related facility to provide to GreenShield information regarding my health as it relates to this request. I hereby authorize GreenShield to obtain and exchange my personal information with other parties as required, including any health care provider, patient assistance program and/or Specialty Care Program vendor working with GreenShield for the purpose of administering this benefit, and to any prescribed entity as defined by the Personal Health Information Protection Act, 2004, for analysis or statistical purposes related to managing, evaluating, or planning for all or part of the health system, including resource allocation and the delivery of health services. I acknowledge that my personal information is needed to assess eligibility for this drug, to administer the group benefits plan, and where applicable, to the Specialty Care Program and patient support services on my behalf. I acknowledge that my personal information may be exchanged and transferred between these parties for these purposes and may include information about my drug claims, diagnosis, medical condition, treatment, and other health related information. I acknowledge that providing my consent will help GreenShield to assess my claim and that refusing to consent may result in delay or denial of my claim. This consent may be revoked by me at any time by sending written instructions to that effect at the address indicated below. I understand that personal information may be subject to disclosure to those authorized under applicable law within Canada only when the information is needed to administer this benefit and/or to confirm the accuracy of this information. I certify that the information given is true, correct, and complete to the best of my knowledge.

|                      |                   |
|----------------------|-------------------|
| Signature of Patient | Date (YYYY/MM/DD) |
|----------------------|-------------------|

If under 16 years of age (14 years of age in Quebec), the signature of the parent / guardian is required.

**PREScription DRUG SPECIAL AUTHORIZATION REQUEST FORM  
SEMAglutide (Ozempic)**

**SECTION 2A DRUG REQUESTED FOR EVALUATION**

Product Name and Strength

|                            |                             |
|----------------------------|-----------------------------|
| Dose                       | Frequency of Administration |
| Route (ex. oral, IV, etc.) | Therapy Duration            |

Is the patient currently on the requested therapy?  
(If yes provide therapy start date)  Yes  No Therapy Start Date (YMD)

If already established on therapy, please attach proof of payment and details of prior coverage. Individuals established on therapy through compassionate coverage will only be considered if they met this plan's criteria on initiation of therapy.

**SECTION 2B LOCATION OF ADMINISTRATION**

|   |  |          |             |
|---|--|----------|-------------|
| <input type="checkbox"/> Home<br><input type="checkbox"/> Physician's Office<br><input type="checkbox"/> Hospital (In-Patient)<br><input type="checkbox"/> Hospital (Out-Patient)<br><input type="checkbox"/> Infusion Center | For Infusion Centers please complete information below |          |             |
|   | Name and Address of Infusion Center                    |          |             |
|   | City   | Province | Postal Code |

**SECTION 2C DRUG REQUESTED FOR EVALUATION**

**For use of Ozempic at a dose of up to 1mg weekly**

For use as an adjunct to diet, exercise, and metformin or another antihyperglycemic agent to improve glycemic control in adult patients with type 2 diabetes mellitus when diet and exercise plus maximal tolerated dose of metformin do not achieve adequate glycemic control.

Please note that use in obesity without the diagnosis of type 2 diabetes mellitus will not be considered.  
Combination therapy with other GLP-1 receptor agonists will not be eligible for consideration.

Diagnosis: \_\_\_\_\_

Please confirm you are requesting approval for dosing of up to 1mg per week.  YES  NO

Dates of maximally tolerated metformin use: \_\_\_\_\_

Dose of maximally tolerated metformin use: \_\_\_\_\_

Response to metformin therapy:

Target HbA1c: \_\_\_\_\_

Baseline HbA1c: \_\_\_\_\_

Most recent HbA1c (within the last 3 months): \_\_\_\_\_

**PREScription DRUG SPECIAL AUTHORIZATION REQUEST FORM  
SEMAglutide (Ozempic)**



If metformin was discontinued or not trialed, please provide specific rationale as to the nature of the intolerance or contraindication:

Has the patient trialed any additional antihyperglycemic therapies?  YES  NO

If YES, please include name/dose/duration and the outcome of prior treatment(s).

1) Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_

Outcome: \_\_\_\_\_

2) Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_

Outcome: \_\_\_\_\_

3) Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_

Outcome: \_\_\_\_\_

**\*\*\*Note: Restrictions will enforce a maximum dosing of 1mg per week\*\*\***

**For use of Ozempic at a dose of up to 2mg weekly**

**Initial approval (12 months):**

For use as an adjunct to diet, exercise, metformin, and a second antihyperglycemic agent to improve glycemic control in adult patients with type 2 diabetes mellitus when diet, exercise, plus maximal tolerated dose of metformin, a second antihyperglycemic medication, and Ozempic 1mg weekly for a minimum of 6 months do not achieve adequate glycemic control.

Please note that use in obesity without the diagnosis of type 2 diabetes mellitus will not be considered. Combination therapy with other GLP-1 receptor agonists will not be eligible for consideration.

Diagnosis: \_\_\_\_\_

Please confirm you are requesting approval for dosing of up to 2mg per week.  YES  NO

Dates of Ozempic 1mg weekly use: \_\_\_\_\_

Target HbA1c: \_\_\_\_\_

If target is not < 7%, please provide rationale: \_\_\_\_\_

Current HbA1c (must be drawn at least 6 months after initiation of Ozempic 1mg weekly)

\*\*Note: a copy of the bloodwork MUST be attached\*\*: \_\_\_\_\_

**PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST FORM  
SEMAGLUTIDE (OZEMPI)****Metformin use:**

Dose: \_\_\_\_\_ Duration: \_\_\_\_\_

Outcome: \_\_\_\_\_

Will metformin be used in combination with Ozempic 2mg weekly therapy?

 YES    NO

If NO, please explain why: \_\_\_\_\_

**Second Antihyperglycemic agent used:**

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_

Outcome: \_\_\_\_\_

Will this agent be used in combination with Ozempic 2mg weekly therapy?  YES    NO

Note: Continued use of a second, non-metformin antihyperglycemic agent in combination with Ozempic 2mg weekly is required for consideration.

Has the patient trialed any additional antihyperglycemic therapies?  YES    NO

If YES, please include name/dose/duration and the outcome of prior treatment(s).

1) Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_

Outcome: \_\_\_\_\_

Will this agent be used in combination with Ozempic 2mg weekly therapy?  YES    NO

If NO, please explain why: \_\_\_\_\_

2) Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_

Outcome: \_\_\_\_\_

Will this agent be used in combination with Ozempic 2mg weekly therapy?  YES    NO

If NO, please explain why: \_\_\_\_\_

3) Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_

Outcome: \_\_\_\_\_

Will this agent be used in combination with Ozempic 2mg weekly therapy?  YES    NO

If NO, please explain why: \_\_\_\_\_

**\*\*\*Note: Restrictions will enforce a maximum dosing of 2mg per week\*\*\*****Renewal for 2mg weekly dose only (open-ended):**

Subsequent renewals will only be considered in patients who have demonstrated a decrease in HbA1c after 12 months.

Baseline HbA1c (prior to the increase to 2mg weekly): \_\_\_\_\_

Current HbA1c \*\*Note: a copy of the bloodwork MUST be attached\*\*: \_\_\_\_\_

**PREScription DRUG SPECIAL AUTHORIZATION REQUEST FORM**  
Please note: Incomplete information may delay your request for processing.



**SECTION 3A – PRESCRIBER INFORMATION AND SIGNATURE**

|                |                |                   |
|----------------|----------------|-------------------|
| First Name     | License Number | Specialty         |
| Last Name      | Telephone      | Fax               |
| Street Address |                |                   |
| City           | Province       | Postal Code       |
| Signature      |                | Date (YYYY/MM/DD) |

**SECTION 3B – SUBMISSION INSTRUCTIONS**

Return request form to:

|   |   |
|---|---|
| <b>Fax</b> : 1.519.739.6483 or<br>1.866.797.6483  | <b>Mail:</b> GreenShield<br>Drug Special Authorization Department,<br>P.O. Box 1606, Windsor ON N9A 6W1 |
| <b>Email</b> : <a href="mailto:drugspecial.autho@greenshield.ca">drugspecial.autho@greenshield.ca</a> |   |

**COST OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.**