iA Financial Group

REQUEST FOR PRIOR AUTHORIZATION
OZEMPIC®, RYBELSUS® (semaglutide)

GROUP INSURANCE

Please refer to page 2 for instructions

PART 1 - TO BE COMPLETED BY THE PLAN MEMBER/PATIENT

Member name _____

Policy no. _____ Certificate no. _____

Patient name (if different) _____

Relationship to plan member: ☐ Spouse ☐ Dependent child Date of birth of the patient Y M D

Is the patient covered by another group plan for the drug for which you are requesting authorization? ☐ No ☐ Yes

Are you receiving or have you applied for any financial assistance from another source (e.g. provincial or patient assistance program)? **If yes, please provide copy of response. If no, please provide reason** _____

I agree that the statements included in this form will serve as a basis to review my own or my dependent's drug claim.

If the drug claim being reviewed is for my dependent, I confirm that I have the authorization to discuss the information about him or her with respect to the request.

On behalf of myself and my dependent, I authorize my physician or healthcare provider to disclose and exchange with Industrial Alliance Insurance and Financial Services Inc. (iA Financial Group) the information requested in this form regarding the drug for myself or my dependent. I consent to the release of the information contained in this claim form to iA Financial Group, its employees, agents, reinsurers, service providers and other organizations working with iA Financial Group for the purposes of the underwriting, administration and processing of this request.

If my Social Insurance Number is used as my identification number, I authorize its use for the administration of my group benefits.

I agree that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature _____ Date Y M D

Address _____ Postal code

Daytime phone _____ Extension _____ Member email _____

PART 2 - TO BE COMPLETED BY PRESCRIBING PHYSICIAN

1. Drug
   - ☐ **OZEMPIC (semaglutide)** - Authorization will be given for a weekly initial maximum dose of 1 mg.
   - ☐ **RYBELSUS (semaglutide)** - Authorization will be given for an initial maximum dose of 7 mg per day.
2. Diagnosis
   - ☐ Type 2 diabetes
   - ☐ If other, please specify: _____
3. Administration of semaglutide in combination with metformin?
   - ☐ Yes
   - ☐ No, please specify the reasons why semaglutide will not be administered in combination with metformin:

_____

_____

_____

Physician's first and last name (please print) _____

Address _____ Postal code

Telephone _____ Fax _____

Physician's email _____ License number _____

☐ General practitioner ☐ Specialist ☐ Other, specify _____

Signature _____ Date Y M D

For internal use:

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INSTRUCTIONS AND IMPORTANT INFORMATION

How to fill out the form

Step 1: Plan member / patient must complete Part 1
Step 2: Prescribing physician must complete Part 2

IMPORTANT INFORMATION

- Any fees for the completion of the enclosed form are the responsibility of the plan member/patient.
- Your claims assessment will be delayed if the enclosed form is incomplete or contains errors.
- The purpose of the enclosed form is to obtain information required to assess your claim for a drug on iA Financial Group's Prior Authorization list. The drug must meet the criteria for coverage under your plan. In Quebec, drugs on the RAMQ Exception Drug list must also meet the criteria for coverage under your plan.
- Completion and submission of this form does not guarantee approval. You will receive reimbursement for the prior authorization drug only if the request has been reviewed and approved by iA Financial Group.
- You will be notified whether the request has been approved or denied. You can expect to receive notification within 10 days of when your request is received.
- To verify the status of the claim, log in to My Client Space.

How to submit your form

By fax (according to your province of residence):

Quebec	**All other provinces**
1-855-884-9811	1-877-780-7247

By mail (according to your province of residence):

Quebec	**All other provinces**
Health and Dental Claims Department	Health and Dental Claims Department
PO Box 800, Station Maison de la poste	PO Box 4643, Station A
Montreal QC H3B 3K5	Toronto ON M5W 5E3

By Secure Messaging: Log in to the My Client Space website.

If you have any questions, please contact Customer Service at 1-877-422-6487.

Business hours: Monday to Friday, 8 am to 8 pm (ET)