



SPECIAL AUTHORIZATION REQUEST For Anti-Obesity Medications

Fax Requests to 905-949-3029

OR Mail Requests to Clinical Services, ClaimSecure Inc., Suite 620, 1 City Centre Drive, Mississauga, Ontario, L5B 1M2

TO BE COMPLETED BY PATIENT (forms without a certificate # will delay processing)

Plan Member		Group Number		Certificate Number (10 Digits)	
Patient Name		Relationship to Member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other		Street Address	
City		Province		Postal Code	
				Telephone Number ()	
Patient Date of Birth (YYYY/MM/DD)					

I hereby authorize any physician, hospital, insurance company, other healthcare professional and ClaimSecure to exchange information in connection with this claim for the purpose of special authorization/patient exception evaluation, adjudication of claims, and administration of my health benefit program. I assume responsibility for any cost required for the completion of this form. A photocopy of this authorization shall be as valid as the original.

Signature X		Date (YYYY/MM/DD)
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TO BE COMPLETED BY PHYSICIAN ONLY (please print clearly)

Physician Name		Specialty Qualification		Date (YYYY/MM/DD)	
Street Address				Physician Signature X	
City		Province		Postal Code	
				Telephone Number ()	
				Fax Number ()	

DRUG REQUESTED FOR SPECIAL AUTHORIZATION

Product Name		Strength
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Body Mass Index (BMI)	kg/m ²	Height	<input type="checkbox"/> m <input type="checkbox"/> ft in	Weight	<input type="checkbox"/> kg <input type="checkbox"/> lbs
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PLEASE SUBMIT A COPY OF YOUR PHARMACY MEDICATION CLAIMS HISTORY FROM LAST YEAR

Patient suffers from obesity and has the following risk factors and/or medical conditions:

- Hypertension and is on medication. Name of medication(s) _____
- Diabetes mellitus and is on medication or insulin
- Hyperlipidemia and is on medication. Name of medication(s) _____
- A cardiac disease not stated above. Please name _____
- A disease state or risk factor not stated above. Please name _____

INCOMPLETE FORMS WILL DELAY PROCESSING

- Yes No The patient has been prescribed lifestyle therapy (diet and exercise) for 6 or more months prior to requesting approval.
- Yes No The patient is continuing with lifestyle therapy (diet and exercise) while on medication for weight reduction.
- Yes No If you have already purchased the product, please attach receipts.

INTERNAL USE ONLY

Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date (YYYY/MM/DD)	Expiry Date (YYYY/MM/DD)	Reviewer
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