claimsecure
when precision matters

SPECIAL AUTHORIZATION REQUEST
For Anti-Obesity Medications

www.claimsecure.com

Fax Requests to **905-949-3029**
OR Mail Requests to **Clinical Services, ClaimSecure Inc., Suite 620, 1 City Centre Drive, Mississauga, Ontario, L5B 1M2**
OR Email **Special.Authorization@Claimsecure.com**
INCOMPLETE FORM MAY RESULT IN DELAYS OR A DENIAL

TO BE COMPLETED BY PATIENT

Plan Member	Group Number	Certificate Number

Patient Name	Relationship to Member: ☐ Self ☐ Spouse ☐ Other

Street Address	City

Province	Postal Code	Telephone Number	Patient Date of Birth (YYYY/MM/DD)
		( )	

If you would like a response/letter via email, please type your email address to ensure accuracy, otherwise, we will reply by mail.

Email Address

OR If you are registered with eProfile and would like your response/letter sent to you by email, please check "yes" below and we will use the email you provided for your eProfile account.

☐ **Yes, please email the response/letter to the email I provided in my eProfile account**
☐ **No, I do not wish to receive an email response at this time.**

(Please be advised, all response/letters that are emailed will not be followed up by a mailed response.)

I hereby authorize:

1. Any licensed physician, healthcare provider, hospital, clinic, medically related facility, insurance company, patient assistance program administration company and ClaimSecure to exchange personal information relating to my health and this Special Authorization request for the evaluation of the eligibility for this drug, adjudication of claims and to ensure continuity of care.

2. ClaimSecure to exchange personal information with the above parties and service providers, including case management program and/or preferred pharmacy network (PPN) partners, working with ClaimSecure for the administration of my health benefit program, and where applicable, the administration of the case management program and pharmacy preferred provider network on my behalf.

I understand that personal information is needed for the above purposes and that refusing to consent may result in delay or denial of my request.

I understand that personal information may be subject to disclosure to those authorized under applicable law within Canada.

I certify that the information given is true, correct, and complete to the best of my knowledge. 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 _____ **Date (YYYY/MM/DD)** _____

SPOUSAL COVERAGE

If you are a spouse applying for Special Authorization and have your own primary drug coverage, please be advised that you must first inquire about coverage of the requested drug with your primary drug plan.

How is the requested drug covered under your primary drug plan?

☐ **GENERAL BENEFIT** ☐ **Require SPECIAL or PRIOR AUTHORIZATION** ☐ **EXCLUDED**

If your primary drug plan requires you to apply for Special or Prior Authorization for the requested drug, please answer the following:
Have you applied for coverage through Special or Prior Authorization? ☐ **YES or** ☐ **NO**
What is the coverage decision for the requested drug? ☐ **APPROVED or** ☐ **DECLINED**

Please provide documents.

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PROVINCIAL COVERAGE (TO BE COMPLETED BY PLAN MEMBER)
Please be advised that some medications may be covered under the provincial plans. If your drug is listed on the formulary it is important that you and your physician apply for coverage under the provincial plan first to avoid delays in your Special Authorization request.

Have you applied for provincial coverage? ☐ **YES or** ☐ **NO**

Has your request been approved? ☐ **YES or** ☐ **NO**

Please provide documents.

PATIENT ASSISTANT PROGRAM (TO BE COMPLETED BY PLAN MEMBER)
Are you registered with a patient assistant program for your prescribed medication? ☐ **YES or** ☐ **NO**

If yes, please provide:
a) Case/File #:_____
b) Case worker contact information - Name: _____ Telephone: _____

TO BE COMPLETED BY PHYSICIAN

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

☐ **NEW REQUEST** ☐ **RENEWAL** ☐ **DOSE INCREASE** ☐ **OTHER**

Product Name	Strength	Regimen

Diagnosis	Date of Diagnosis	Expected Duration of Therapy

Body Mass Index (BMI)	Height	Weight
kg/m²	☐ **m** ☐ **ft in**	☐ **kg** ☐ **lbs**

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 _____

_____

_____

_____

☐ **YES or** ☐ **NO - The patient has been prescribed lifestyle therapy (diet and exercise) for 6 or more months prior to requesting approval.**

☐ **YES or** ☐ **NO - The patient is continuing with lifestyle therapy (diet and exercise) while on medication for weight reduction.**