

Strictly Confidential
WEIGHT MANAGEMENT MEDICATION Prior Authorization Form

Fax completed form to 1-902-481-7114
Or Mail to: MHCSI, 201 Brownlow Avenue, Unit 20
Dartmouth, NS B3B 1W2

This form must be completed **IN FULL** and submitted to MHCSI to permit authorization for coverage of a weight management medication on your employer-sponsored drug plan. Coverage will be granted if criteria are met and weight management medications are benefits of your plan. Approvals may be subject to quantity or dollar limits as per plan design.

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH _____
(PLEASE PRINT)

ADDRESS: _____ (CITY)
(STREET/MAILBOX)

(PROVINCE) (POSTAL CODE)

MHCSI CARD NUMBER: _____ / _____
(GROUP #) (CERTIFICATE OR CLIENT#)

Coordination of benefits (COB): <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, Name of Coordinating Plan _____	
If MHCSI, please provide: _____ / _____ (GROUP #) (CERTIFICATE OR CLIENT#)	
Is this drug being covered by the coordinating plan? <input type="checkbox"/> NO <input type="checkbox"/> YES	

I hereby authorize any licensed prescriber, other healthcare professional, institution, insurance company, patient access program, plan sponsor/administrator and MHCSI to exchange information in connection with this claim for the purpose of Prior Authorization evaluation, adjudication of claims, and administration of my drug benefit program. A photocopy of this authorization shall be as valid as the original. I certify that the information in this form is true and complete.

Signature X	Date(YYYY/MM/DD)
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CRITERIA FOR COVERAGE

Patients are eligible for coverage of approved weight management medications if they meet the following criteria:

1. Body Mass Index (BMI) of 30 or more (obese) or between 27 and 30 (overweight) with co-morbidities such as hypertension, diabetes, dyslipidemia, sleep apnea, osteoarthritis or other defined weight-related co-morbidity.
2. Provide evidence of previous treatment attempt(s) with failure(s) to achieve weight loss goal with non-pharmacological management (including diet, exercise, and behaviour modification) of at least 6 months duration, or evidence of the need for an urgent, medically-necessary weight loss which would preclude an attempt at a 6-month, non-pharmacological weight management approach.
3. Provide evidence of concurrent participation in a recognized and personalized nutritional and behavioral weight management support program or consultation.
4. Provide evidence of concurrent participation in a medical practitioner -approved recognized and personalized physical activity program
5. Medical practitioner assessment has deemed the individual a good candidate for use of a weight management medication.

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TO BE COMPLETED BY MEDICAL PRACTITIONER

Dear Prescribing Medical Practitioner: We appreciate you providing information on this patient's medical condition and medication history which is required by the drug plan sponsor for authorization of claims for weight management medications. Please complete the following sections of this form IN FULL. Any costs incurred in the completion of this form are the responsibility of the patient.

Medication Requested: -generic brand may be used where available

Drug Name	Strength	DIN
Xenical (orlistat) capsules <input type="checkbox"/> Patient will enroll in Xenical BodyWellness Program <input type="checkbox"/> Patient has enrolled in Xenical BodyWellness Program	<input type="checkbox"/> 120 mg	<input type="checkbox"/> 02240325
Other, please specify:		

Is this request for a ___ first time use, ___ continuation or ___ re-trial of therapy?

INFORMATION SUPPORTING REQUIREMENT FOR THIS MEDICATION

Patient/Treatment Parameters & Description			
Height	Weight	BMI	Waist Circumference
Co-morbidities (check any/all that apply)		<input type="checkbox"/> None <input type="checkbox"/> Hypertension Current Blood Pressure: Medication (if applicable): <input type="checkbox"/> Diabetes Current Blood Glucose/Glycated Hemoglobin: Medication (if applicable): <input type="checkbox"/> Dyslipidemia Current Lipid levels - Total Chol/ LDL/HDL/Triglycerides: Medication (if applicable): <input type="checkbox"/> Gastrointestinal Esophageal Reflux Disease (GERD) <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other, please specify:	
Details of previous weight loss/management strategies, including duration of attempt(s) & results			
Current Therapeutic Goal (e.g. % reduction of baseline weight over 6 months; target BMI)			
Planned concurrent personalized nutritional & behavioral weight management support programming (check any/all that apply)		<input type="checkbox"/> Medical practitioner- based monitoring program <input type="checkbox"/> Dietician/Nutritionist Consult <input type="checkbox"/> Commercial programs (e.g. Weight Watchers, TOPS, etc.) Please specify: <input type="checkbox"/> No concurrent nutritional support programming planned	
Concurrent medical practitioner-approved physical activity programming (please specify)			
Prescriber Name/Signature: /		Phone:	Date:
Pharmacist Name/Signature: /		Store # & Location/ Phone # :	Date:
OFFICE USE ONLY			
Approval <input type="checkbox"/> Accepted <input type="checkbox"/> Declined	Date	Quantity	
	Approved by	and/or End date	Processing Number
Extension possible		<input type="checkbox"/> Yes	<input type="checkbox"/> No