Sun Life Financial | YOU FLEX | MHCSI The Pharmacy Benefits Specialists

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:____
(STREET/MAILBOX) (CITY)

____
(PROVINCE) (POSTAL CODE)

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

I hereby authorize my physician/nurse practitioner and/or pharmacist to provide the information necessary to complete this form on my behalf for request of coverage of medication for weight management by my drug plan.

SIGNATURE:____ DATE:______________________

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 physician-approved recognized and personalized physical activity program
5. Physician assessment has deemed the individual a good candidate for use of a weight management medication.

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TO BE COMPLETED BY THE PHYSICIAN/NURSE PRACTITIONER (NP) and/or PHARMACIST IN CONSULTATION WITH THE PHYSICIAN/NURSE PRACTITIONER

Dear Doctor/Nurse Practitioner/Pharmacist: 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 ❑ Patient will enroll in Xenical BodyWellness Program ❑ Patient has enrolled in Xenical BodyWellness Program	❑ 120 mg	❑ 02240325
Meridia (sibutramine) capsules	❑ 10 mg ❑ 15 mg	❑ 02243163 ❑ 02243164
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	**Waist to Hip Ratio**	
Co-morbidities *(check any/all that apply)*	_____ None _____ Hypertension Current Blood Pressure: Medication *(if applicable)*: _____ Diabetes Current Blood Glucose/Glycated Hemoglobin: Medication *(if applicable):* _____ Dyslipidemia Current Lipid levels - Total Chol/ LDL/HDL/Triglycerides: Medication *(if applicable)*: _____ Gastrointestinal Esophageal Reflux Disease (GERD) _____ Osteoarthritis _____ Sleep Apnea _____ 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)*	_____ Physician/NP-based monitoring program _____ Dietician/Nutritionist Consult _____ Commercial programs (e.g. Weight Watchers, TOPS, etc.) *Please specify:* ____No concurrent nutritional support programming planned	
Concurrent physician/NP -approved physical activity programming *(please specify)*		
Physician/NP Name/Signature:	**Phone:**	**Date:**
Pharmacist Name/Signature:	**Store # & Location/ Phone # :**	**Date:**

OFFICE USE ONLY			
Approval	❑ **Accepted** ❑ **Declined**	**Date** **Approved by**	**Quantity** **and/or End date**
Extension possible	❑ **Yes**	❑ **No**	