SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

# CHRONIC WEIGHT MANAGEMENT PRESCRIPTION DRUG SPECIAL AUTHORIZATION REQUEST

**PLEASE NOTE:**

- Failure to complete the form in its entirety may cause delays and/or a request for additional information.
- Submit the completed form and any accompanying documents to the above address (Attn: Claims Department) or via an approved online submission method.

## MEMBER INFORMATION

Policy Number | ID Number

First Name | Last Name

Street Address/Box No.

City/Town | Province | Postal Code

Email Address

Phone Number

## COORDINATOR INFORMATION

**To be filled out by the professional coordinating the request on behalf of the patient (Patient Support Program, Physician or Pharmacist).**

Program/Pharmacy Name

Physician's Name

Phone Number

Fax Number

Communication Preference:

☐ Fax ☐ Phone ☐ Email _____

## PATIENT INFORMATION

First Name | Last Name | Relationship to Member | Date of Birth (YYYY-MM-DD)

**Does the patient have healthcare coverage in current province of residence?** ☐ Yes ☐ No

## COORDINATION OF BENEFITS INFORMATION

**Do you or your dependents have coverage for this drug under any other plan?** ☐ Yes ☐ No

*If* **yes,** *please complete the questions below:*

Name of Insurance Company | Policy Number

**Has the patient applied and/or been approved for special access coverage through a provincial drug plan?** (e.g., Exception Drug Status under the Saskatchewan Drug Plan) ☐ Yes — Applied ☐ Yes — Approved ☐ No

**Has the patient applied for cost assistance through a provincial government program?** ☐ Yes ☐ No

*If* **yes,** *please provide program name below:*

Program Name

*If* **no,** *please provide explanation below:*

## CONSENT & AUTHORIZATION

I authorize my healthcare provider(s) to release any information or records requested in respect of this claim to Blue Cross or its agents and certify that the information given is true, correct and complete to the best of my knowledge.

I understand that the personal information I have provided, as well as any other personal information currently held or collected in the future by Saskatchewan Blue Cross and/or its agents may be collected, used, maintained and disclosed for the purposes of determining eligibility for coverage, underwriting, claims adjudication and payment, administering products and services, audit and investigation, confirming my identity, maintaining my relationship with Saskatchewan Blue Cross, and to help develop and recommend suitable products and services to me. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, and/or its authorized agents/advisors, representatives, licensed physicians and/or any other health care professionals or institutions, life and health insurers and reinsurers, government and regulatory authorities, the member of any benefit plan or policy under which I am a participant and other third parties only when needed for a purpose stated above.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time in writing; however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policies of Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1.800.667.6853.

Name of Member/Patient (Print) | Signature of Member/Patient | Date (YYYY-MM-DD)

**COMPLETE FORM ON NEXT PAGE FOR SPECIALTY DRUG DETAILS AND PHYSICIAN STATEMENT**

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## PATIENT SUPPORT PROGRAM (PSP) ENROLMENT

**Is the patient in a manufacturer patient support program?** ☐ Yes ☐ No
*If* **yes,** *please complete the below section:*

Program Name | Program Number

Phone Number | Fax Number

## SPECIALTY DRUG DETAIL

**List the details about the specialty drug prescribed to the patient:**

Trade Name: _____ Strength: _____ Dosage: _____

Frequency: _____ Diagnosis: _____

Expected duration of therapy: _____ BMI: _____ kg/m² Weight: _____ ☐ lb ☐ kg

**Is the patient following a reduced calorie diet for the purposes of weight reduction?** ☐ Yes ☐ No

**Is the patient engaging in increased physical activity for chronic weight management?** ☐ Yes ☐ No

**Comorbidities (check all that apply):**

☐ Arthritis ☐ Dyslipidemia ☐ Heart Disease ☐ Hypertension ☐ Obstructive Sleep Apnea ☐ Type II Diabetes

☐ None

**Please indicate any additional information that you feel would be beneficial to assist our team in reviewing this request.**

## PHYSICIAN STATEMENT

Physician's Name (Print) | Physician's Specialty

Address

City/Town | Province | Postal Code

Telephone Number | Fax Number

Physician's Signature | Date (YYYY-MM-DD)

## HOW TO SUBMIT A SPECIALTY DRUG AUTHORIZATION REQUEST

**By email:** ProviderRelations@sk.bluecross.ca

**By fax:** 306-667-5860

**By mail:** Attn: Claims Department
Saskatchewan Blue Cross
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2