ALBERTA BLUE CROSS®

LIRAGLUTIDE / NALTREXONE + BUPROPION / SEMAGLUTIDE / TIRZEPATIDE for Weight Loss SPECIAL AUTHORIZATION REQUEST FORM FOR EMPLOYER PLANS

Please complete all required sections to allow your request to be processed.

Note: request may or may not be approved by Alberta Blue Cross.

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	INITIAL	BIRTHDATE (YYYY/MM/DD)

STREET ADDRESS	CITY	PROV	POSTAL CODE	COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other

STREET ADDRESS	REGISTRATION NUMBER

CITY, PROVINCE	PHONE	FAX

POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Drug Requested (choose ONE)

☐ Liraglutide (Saxenda) ☐ Naltrexone+bupropion (Contrave) ☐ Semaglutide (Wegovy) ☐ Tirzepatide (Zepbound)

Dosage and frequency

☐ **NEW request – FIRST trial of requested drug** ☐ **NEW request – SECOND trial of requested drug** ☐ **RENEWAL request**

Note: Maximum of two trials per drug per lifetime is allowed regardless of failure to respond or if the patient stops therapy prior to receiving sufficient therapy for a response.

Indication for use ☐ Chronic weight management ☐ Other, specify _____

Will the requested drug be used as an adjunct to a reduced calorie diet and increased physical activity? ☐ Yes ☐ No

Provide pre-treatment information for all INITIAL requests for treatment-naïve and treatment-experienced patients

1. Pre-treatment clinical assessment measures (taken just prior to initiation of the first/second trial of the requested drug)
   a) Body Mass Index (BMI) (kg/m^2) _____ Date _____
   b) Body weight (kg) _____ Date _____
2. For adult patients with a BMI greater than or equal to 27 kg/m^2 but less than 30 kg/m^2
   a) Please indicate if the patient has any weight-related comorbidities (check all that apply)
      ☐ Cardiovascular disease ☐ Dyslipidemia ☐ Hypertension ☐ Sleep apnea
      ☐ Type 2 Diabetes ☐ Other, specify _____
   b) Please specify the previous weight management intervention(s) the patient has failed
      _____
3. If a switch to a different drug is requested, please indicate response to previous drug
   _____

Provide the following for all RENEWAL requests and for INITIAL requests for treatment-experienced patients

For adult patients: Current body weight while on the requested drug (kg) _____ Date _____

For pediatric patients: a) Current BMI while on the requested drug (kg/m^2) _____ Date _____

b) Response to therapy _____

Additional information relating to request

Notice to Prescriber: the information in this statement will be kept in a life, health or disability benefits file with the insurer and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein.

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

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