PRIOR AUTHORIZATION PROGRAM FORM

Anti-Obesity – Xenical® (Orlistat), Meridia® (Sibutramine)

Instructions:

1. Section 1 to be completed by Plan Member/ Patient
2. Section 2 to be completed by Physician/ Pharmacist (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by the Pharmacist.
4. Please fax completed form to Formulary Management at 647-722-3054 (Toronto Area) / (Toll Free Fax) 1-866-262-0007 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario, M8Z 5M4.

Section 1:
Patient Information

Cardholder's Name: (Last , First)	Certificate Number:	
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)	Relationship to Cardholder: Employee Spouse Dependent
Contact Information: Pharmacy Name: Number ( ) OR Patient / Legal Guardian Name: Number ( )		

Signature of Patient/ Legal Guardian: _____ Date (dd/mm/yy): _____

Section 2:
Prescribed Drug Information

Drug Name:	Drug Strength:	Dosage Instructions:

Eligibility for drug coverage is determined if the patient meets at least one of the qualifying criteria listed below. In the case where the patient has another drug plan, prior authorization may cover a portion that is not paid by the primary plan.
Please indicate if the patient meets one of the qualifying criteria for drug coverage:

- ❑ Patient with a BMI ≥ 30 kg/m^2
- ❑ Patient with a BMI ≥ 27 kg/m^2 in the presence of other risk factors (e.g. hypertension, diabetes, dyslipidemia, excess visceral fat)
- ❑ Reducing the risk of weight regain in obese patients after prior weight loss

Physician's Name: (Last, First)	License Number:
Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -

Signature of Physician:_____ Date (dd/mm/yy): _____

Section 3:
Pharmacist Information

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -

Signature of Pharmacist: _____ Date (dd/mm/yy): _____

Pharmacist Name: (Print Last, First) _____

Internal Office Use Only:

Date Received:	DIN Number:	HICL:	Date Approved:
Effective Date:	Termination Date:	Approved: YES or NO	Approved by:
Notified: Pharmacy Member	Notification Date		