III Manulife

Group Benefits Drug Prior Authorization Mounjaro (Tirzepatide)

The purpose of this form is to obtain the medical information required to assess your request for a drug on the Prior Authorization list under your drug plan benefit coverage. To avoid delays in processing your request, please ensure that all information, including contact information is complete. Completion of this form is not a guarantee of approval. If you have already purchased the drug, please attach all original receipts along with an **Extended Health Care Claim** form. All costs incurred to complete this form are the plan member's responsibility. If you are registered for the Plan Member Secure Site and have provided an email address, you will receive an email notification when the prior authorization decision is available on your claims statement. If you are not registered on the Plan Member Secure Site, you will be notified of the prior authorization decision by mail.

Important: Please ensure the most current unaltered version of the form is completed and signed. To download the most recent version of the Drug Prior Authorization form go to <u>www.manulife.ca</u>

Plan member and patient information	Plan contract number	Plan member certificate numb	ber	Plan sponsor				
	Plan member name (first, middl	e initial, last)				Date	e of birth (dd/	/mmm/yyyy)
To be completed by plan member								
	Plan member address (number,	street and apt.)	City or to	wn	Province	_	Postal code	
	Patient name (first, middle initia	al, last)	Patient	date of birth (dd/mn	nm/yyyy)	Relati	onship to pla	n member
	Patient's preferred daytime phor	ne number Patient's email addre	ess (option	al)				
	Does the patient have dru If <i>yes,</i>	ug coverage under any other	r group p	blan?			⊖ Yes	◯ No
	Name of insurance company							
	Plan contract number		Plan	member certificate n	umber			
	Is this drug covered unde	er the other group plan?					⊖ Yes	⊖ No
	If <i>no</i> , why was the drug declined by the other group plan? Please attach the other group (typically a letter or statement). We need this decline notice to see if this drug can be a If this is a renewal a current decline notice is required.							otice
	Did your plan sponsor ree	cently transfer your drug ber	nefits to	Manulife?			⊖ Yes	🔿 No
	Before joining Manulife, v insurance company?	were you receiving coverage	for this	drug through you	ur previou	IS	◯ Yes	\bigcirc No
	lf yes,							
		nt (a copy of a pharmacy rec s from the prior insurance co				insura	ance comp	any or an
	If <i>no</i> applies to any of the above two questions,							
	Proceed to section 2.							

2	To be completed by prescribing	Most provinces offer some form of drug coverage to their residents. Your Manulife drug plan supplements the coverage provided by provincial plans. It is important that you or your doctor (if required) apply to the applicable provincial program to ensure there are no delays in your drug reimbursement. Check with your doctor or login to the Manulife Provincial Drug Plans Resource Centre on our Plan Member Secure Site at <u>www.manulife.ca/planmember</u> to confirm if the drug you have been prescribed may be eligible for coverage under a provincial plan. If the drug you have been prescribed is listed under a provincial program, you will need to apply to the program before consideration can be given under your Manulife drug plan.						
	physician							
		Has application been made to the provincial program	for coverage?		⊖ Yes	🔿 No		
		If no, why?						
		Has the patient been approved for coverage by the pro-	ovincial program for this	drug?	⊖ Yes	◯ No		
		in no, dunise why the request was declined						
		In Ontario, for patients that qualify for coverage drug is an EAP drug, a copy of the approval or de Manulife can complete the assessment of this re	enial from EAP must b					
3	Patient Assistance Programs	Have you enrolled in the Patient Assistance Program?	,		⊖ Yes	◯ No		
	To be completed by plan member	If yes, please provide your Patient Assistance Prograr Case Manager name and contact details	n ID Number:					
4	Medical information	Drug strength and dosage						
	To be completed by prescribing	Where will the treatment be administered?						
	physician	○ Home ○ MD Office ○ Private Clinic	◯ Hospital/In-patier	nt 🔿 Ho	spital/Out	-patient		
		Is the MD office located in a hospital?			⊖ Yes	◯ No		
		Will the drug be administered in the MD office or in another area of the	he hospital? (describe below)					
		If the treatment is not being administered at home, please provide:						
		Name of private clinic/hospital	Telephone number					
		Address (sumber street and set)	City or town	Drovino -	Deats			
		Address (number, street and apt.)	City or town	Province	Postal code	2		

4 Medical information (continued)

To be completed by prescribing physician

Please select the diagnosis for which the drug has been prescribed and respond to the corresponding questions.

Type 2 Diabetes Mellitus

🔵 Initial Criteria

Does patient have a confirmed diagnosis of type 2 diabetes mellitus?	◯ Yes	🔿 No
Has patient achieved adequate glycemic control with the maximum tolerated dose of metformin and diet and exercise?	⊖ Yes	🔿 No
Does patient have documented intolerance or contraindication to metformin?	⊖ Yes	🔿 No
Will Mounjaro be used as an adjunct to diet and exercise?	⊖ Yes	🔿 No
Will Mounjaro be given in combination with other GLP-1 analogs?	◯ Yes	🔿 No
Will dose of Mounjaro exceed 15 mg once weekly?	⊖ Yes	🔿 No
Note: Initial approval is limited to 12 months. Additional information is required	after 12 m	onths in
order to assess for further coverage.		
🔿 Renewal Criteria		
Is there documented objective evidence of continued benefit for the patient (i.e., patient has a decrease in HbA1c)?	⊖ Yes	🔿 No
Will Mounjaro be used as an adjunct to diet and exercise?	⊖ Yes	🔿 No
Will Mounjaro be given in combination with other GLP-1 analogs?	⊖ Yes	🔿 No
Will dose of Mounjaro exceed 15 mg once weekly?	⊖ Yes	⊖ No
O Any other diagnosis		

Please provide the specific diagnosis and any Canadian clinical research that supports the use of this drug in your patient's context.

5	Drug history	If no previous therapies have been tried for the selected diagnosis, please specify the rationale:							
	To be completed by prescribing physician	Risk of drug interaction Please provide medical rationale	Patient has cont	raindicatio	n 🔿 Oth	ier			
		For the selected diagnosis, please provide all previous and current drug therapies in the area below.							
		Drug name			Start date (yyyy,	′mmm)	End date (yyyy/n	nmm)	
		Please specify the outcome: Intolerance (Allergy/Adverse Event) Inadequate/Suboptimal Response							
	Will the patient be continuing on this medication in addition to				new therapy?		○ Yes ○ No		
	Drug name Please specify the outcome: Intolerance (Allergy/Adverse)				Start date (yyyy/mmm)		End date (yyyy/mmm)		
				Intolerance (Allergy/Adverse Event)		Inadequate	e/Suboptimal Response		
		Will the patient be continuin	g on this medication in a	ddition to r	new therapy?		◯ Yes ◯ No		
		Drug name			Start date (yyyy,	/mmm)	End date (yyyy/n	nmm)	
		Please specify the outcome: Intolerance (Allergy/Adverse Event) Inadequate/Suboptimal Response							
		Will the patient be continuing on this medication in addition to new therapy? \[Yes \] No							
6	Physician information	Prescribing physician's name			Spec	cialty			
	To be completed by prescribing physician	Address (number, street and suite)		City or town		Province	Postal code		
		Telephone number	Extension	Fax num	ber				
	Physician authorization	I certify that the information in this form is true and complete to the best of my knowledge. The information in this statement will be kept in a Group Benefits health file with Manulife 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.							
		Physician's signature			Date signed (dd/mmm/yyyy)				
7	Authorization and Plan member signature	I certify that I, my spouse and/or my dependents of minor or major age ("Dependents") require the drug named on this form (or an equivalent drug that Manulife proposes).							
	To be signed by plan member	 Lauthorize: Manulife and/or its service providers, its reinsurers, and their service providers to collect, use, maintain and disclose my personal information related to this application ("Personal Information") for the purposes of: The assessment of the drug authorization request. Managing my Group Benefits plan. Assessing and processing claims. Auditing and investigation of claims. Patient assistance programs, if applicable. And/or other purposes identified in the Personal Information Statement for Employers' Group Benefits plans (collectively, the "Purposes"). Any person or organization who has Personal Information about me that is required for Manulife to assess 							
		this drug authorization request, including any medical and health care professionals, institution, pharmacy or any other medical or health care related facility, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any other administrators of other benefits programs to collect, use, maintain, disclose and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes.						macy p plan o collect,	

 7 Authorization and Plan member signature (continued) To be signed by plan member 	 pharmacy or provider, a case manager arrange to have my prescription(s) tran That except where there are contractual service providers and reinsurers are loce Personal Information may be subject to be subject to the laws of those jurisdict I may withdraw my consent for certain the restrictions. If I do so, Manulife may treaterminate my claim. I agree: A photocopy or electronic version of thi I have the right to access and verify my any factually inaccurate Personal Inform Requests can be sent to: Privacy Office N2J 4C6 or Canada_Privacy@manulife For more information, I can review the Felans and the Canadian Privacy Policy. I confirm that: The information I have given in this require By signing, I give permission to and/or collection, use, disclosure or otherwise 	If my Manulife plan recommends purchasing a drug that requires prior authorization from a preferred pharmacy or provider, a case manager may contact me, my doctor and/or patient assistance program to arrange to have my prescription(s) transferred to the preferred pharmacy or provider. That except where there are contractual restrictions, Manulife employees, authorized organizations, service providers and reinsurers are located both within Canada and outside of Canada. Therefore, my Personal Information may be subject to interprovincial or cross-border transfers for the Purposes and ma be subject to the laws of those jurisdictions. I may withdraw my consent for certain uses of my Personal Information, subject to legal and contractual restrictions. If I do so, Manulife may treat my withdrawal of consent as a request to dismiss, rescind or terminate my claim. ee: A photocopy or electronic version of this consent is valid. I have the right to access and verify my Personal Information maintained in Manulife's files and to request any factually inaccurate Personal Information be corrected, if appropriate. Requests can be sent to: Privacy Officer Manulife, P.O. Box 1602, Del Stn 500-4-A, Waterloo, Ontario N2J 4C6 or Canada_Privacy@manulife.ca. For more information, I can review the Personal Information Statement for Employers' Group Benefits Plans and the Canadian Privacy Policy. firm that: The information I have given in this request is true and accurate. By signing, I give permission to and/or confirm that I have obtained the individual's consent for the collection, use, disclosure or otherwise processing of the individual's Personal Information for the Purposes (as these terms are defined above).				
	 Protecting your personal information is important to us. People who can see your personal information are: Manulife employees who need to see your information to do their jobs. People you've given permission to. To find out more about Manulife's privacy policy please see manulife.ca 					
8 Mailing instruction	Use the Submit a Claim Feature on the Plan Member Secure Site OR mail or fax your completed form to the appropriate address:					
	If you live in Quebec:	If you live outside Quebec:				
	Manulife Group Benefits Health Claims Attention Prior Authorization Team PO BOX 2580, STATION B MONTREAL QC H3B 5C6	Manulife Group Benefits Health (Attention Prior Authorization Tea PO BOX 1653 WATERLOO ON N2J 4W1				

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