



**PRIOR AUTHORIZATION REQUEST FORM**  
**Liraglutide (Saxenda®), Bupropion/Naltrexone (Contrave®), Orlistat**  
**(Xenical®) /Treatment of obesity**

**DECLARATION OF THE INSURED PERSON**

Section 1: Information about the participant and the patient			
Name of Participant	Insurance Policy / Certificate	Name of Employer	
Name of Patient	Date of Birth (YYYY/MM/DD)	Telephone	
Address (house number and street name)	City/Town	Province	Postal Code

Section 2: Other prescription drug insurance			
Do you have other prescription drug insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If so, please answer the following:			
What type of plan is it?	<input type="checkbox"/> Private	<input type="checkbox"/> Public	
Have you ever submitted a claim for this drug to the other insurer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
What is the status of the claim?	<input type="checkbox"/> Accepted	<input type="checkbox"/> Refused	<input type="checkbox"/> Under review
Did this insurer ask you to complete a prior authorization request?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If so, what is the status of the prior authorization request?	<input type="checkbox"/> Accepted	<input type="checkbox"/> Refused	<input type="checkbox"/> Under review
<b><i>Please enclose acceptance or refusal documents, if applicable</i></b>			

Section 3: Authorization to disclose personal information	
I certify that the information in this prior authorization request is complete, accurate and true.	
I authorize physicians and other health care professionals, medical, paramedical or clinical institutions, care coordinators, members of SSQ's Preferred Pharmacy Network (outside Quebec only) and any public or parapublic organization, including Régie de l'assurance maladie du Québec, to disclose to SSQ, Life Insurance Company Inc. (SSQ) any of my personal information including and without limitation, any medical information and medical evaluations in connection with the processing of this request. I hereby waive their confidentiality obligation and authorize them to disclose the requested information to SSQ. In addition, I authorize SSQ to disclose to the previously named third parties any of my personal information including and without limitation any medical information and medical evaluations in connection with the processing of this request.	
Photocopies of this document have the same value as the original.	
Signature of <b>patient</b> (parent/legal guardian) _____	Date _____

**IMPORTANT:**  
All correspondence concerning this form will be sent to the address indicated in the participant's file.

**Send us this duly completed form by mail or by fax at: 1-855-453-3942.**  
Telephone: 418-651-2588/1-800-380-2588 – Fax: 1-855-453-3942. Address: 2525 Laurier Blvd, P.O. Box 10500, Quebec City, QC G1V 4H6



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**DECLARATION OF THE PHYSICIAN**

Section 4: Information about the prescribing physician		
Name of Physician	Speciality	Licence No.
Telephone	Fax	
I hereby certify that the information in this request is accurate:		
Signature of <b>Physician</b> _____		Date _____

Section 5: Drug covered by the authorization			
Drug name	Pharmaceutical form	Strength	<b>Dosage</b> Dose: _____ Frequency of administration: _____
Type of request	<input type="checkbox"/> <b>First request</b> Complete section 6		<input type="checkbox"/> <b>Continuation of treatment</b> Complete section 7 Also complete section 6 if this is the first authorization requested from SSQ



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Section 6: Clinical information (first request)

**Assessment immediately prior to the beginning of treatment**

Date of assessment: \_\_\_\_\_

Patient's weight: \_\_\_\_\_ kg

Patient's height: \_\_\_\_\_ cm

BMI: \_\_\_\_\_ kg/m<sup>2</sup>

Waist circumference: \_\_\_\_\_ cm

**Comorbidity:**

- Hypertension
- High cholesterol
- Type 2 diabetes
- Sleep apnea
- Clinical manifestation of cardiovascular disease
- Other, specify: \_\_\_\_\_

**Failure to complete a weight management program of at least 3 months**

- Yes
- No, specify: \_\_\_\_\_

**Associated with a diet plan**

- Yes
- No, specify

**Associated with an exercise program**

- Yes
- No, specify



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**Section 7: Clinical information (continuation of treatment)**

**Information needed to assess response to treatment**

The drug covered by this request form was started on: \_\_\_\_\_(YYYY-MM-DD)

**Observed clinical benefits**

Date of last assessment: \_\_\_\_\_

Patient's weight: \_\_\_\_\_ kg      Patient's height: \_\_\_\_\_ cm

BMI : \_\_\_\_\_ kg/m<sup>2</sup>      Waist circumference: \_\_\_\_\_ cm

Other clinical benefits observed, specify :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 8: Additional information**

\_\_\_\_\_  
\_\_\_\_\_  
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