

Prior Authorization Request

ZEPBOUND (tirzepatide)

Instructions

Please complete Part A and have your physician complete Part B. Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the plan member does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. Please note that plan members have the right to appeal the decision made by Express Scripts Canada.

Part A – Patient

Patient information

First Name:		Last Name:	
Insurance Carrier Name/Number:			
Group Number:		Client ID:	
Date of Birth (YYYY/MM/DD):		Relationship: ☐ Employee ☐ Spouse ☐ Dependent	
Language: ☐ English ☐ French		Gender: ☐ Male ☐ Female	
Address:			
City:	Province:	Postal Code:	
Email address:			
Telephone (home):	Telephone (cell):	Telephone (work):	

Coordination of benefits

Patient Assistance Program	Is the patient enrolled in any patient assistance program? ☐ Yes ☐ No Contact Name: _____ Fax: _____
Provincial Coverage	Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied *Attach decision letter*
Primary Coverage	Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied *Attach decision letter*

Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof. This service uses AI-enabled Optical Character Recognition (OCR) technology provided by a third-party vendor to process submitted documents; all Prior Authorization related decisions are made by a human. To exercise your rights of access or rectification, please contact ExpressScriptsCanada_Privacy@Express-scripts.com.

Plan Member Signature

Date

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Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

SECTION 1 – DRUG REQUESTED

ZEPBOUND (tirzepatide)		☐ New request	☐ Renewal request*
Dose	Administration (ex: oral, IV, etc)	Frequency	Duration
Site of drug administration:			
☐ Home	☐ Physician's office/Infusion clinic	☐ Hospital (outpatient)	☐ Hospital (inpatient)

* Please submit proof of prior coverage if available

SECTION 2 – ELIGIBILITY CRITERIA**1. Please indicate if the patient satisfies the below criteria:****Chronic Weight Management – Adult**INITIAL

- ☐ For chronic weight management as an adjunct to a reduced calorie diet and increased physical activity in an adult, AND
- ☐ The patient has a body mass index (BMI) of 30kg/m² or greater. *Please indicate patient's weight and BMI below, OR*

Date (YYYY-MM-DD)	Weight	BMI

- ☐ The patient has a BMI of 27kg/m² or greater in the presence of at least one weight-related comorbidity (e.g. hypertension, type 2 diabetes, or dyslipidemia). *Please indicate patient's weight and BMI below:*

Date (YYYY-MM-DD)	Weight	BMI

RENEWAL

- ☐ The patient has demonstrated a 5% or greater loss in body weight. Please indicate patient's baseline and current weight below:

BASELINE		CURRENT	
Date (YYYY-MM-DD)	Weight	Date (YYYY-MM-DD)	Weight

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Obstructive Sleep Apnea

- ☐ For the treatment of moderate to severe obstructive sleep apnea (OSA) in an adult, AND
- ☐ Used as an adjunct to a reduced calorie diet and increased physical activity, AND
- ☐ The patient has a body mass index (BMI) of 30kg/m² or greater. *Please indicate patient's weight and BMI below:*

Date (YYYY-MM-DD)	Weight	BMI

OR

- ☐ None of the above criteria applies.

Relevant additional information:

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2. Please list previously tried therapies

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate response	Allergy/Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

SECTION 3 – PRESCRIBER INFORMATION

Physician's Name:	
Address:	
Tel:	Fax:
License No.:	Specialty:
Physician Signature:	
Date:	

Please fax or mail the completed form to
Express Scripts Canada®

Fax: Express Scripts Canada Clinical Services
1 (855) 712-6329

Mail: Express Scripts Canada Clinical Services
6985 Financial Drive, Suite 300
Mississauga, ON, L5N 0G3