"We Care"
MEDICAL BENEFITS BOARD
ST.JOHN'S, ANTIGUA

P.O.Box 424
Nevis Street,
St. John's, Antigua

Telephone: (268) 481-6200 / 6413
(268) 481-6216 - 9
Fax: (268)481-6330
Email: mbs@candw.ag
Website: www.mbs.gov.ag

SPECIALLY AUTHORIZED DRUG (SAD)
REQUEST APPLICATION FORM

Please complete the form LEGIBLY and in its ENTIRETY. Incomplete forms will be RETURNED to the requesting physician.

*Requests for GLP-1 Agonists submitted for and on behalf of **NON-DIABETIC** patients **WILL NOT BE APPROVED***

D___M___Y___

PHYSICIAN: _____ **PHYSICIAN'S SPECIALITY:** _____

TEL: _____ **OFFICE ADDRESS**: _____

Patient/ Beneficiary: _____ **MBS Beneficiary #** _____

Application Request Type (√): 1st ___ 2nd ____ 3rd ____ other (specify) _____

Date of Birth: D___M___Y___ **Current Age** (years): _____ **Sex** (√): Male_____ Female_____

Current Address: _____

Previous Address (where lived in past 12 months): _____

Tel: _____

Next of Kin: _____ Tel: _____

Diagnosis (Please provide relevant clinical details and indication for SAD including type, grade & stage of condition where applicable):

_____
_____
_____

Age at Diagnosis of Condition (years):_____ **Year of Diagnosis/Presentation**: _____

Height (inches): _____ Weight (lbs): _____ Waist (inches): _____ Hip (inches): _____

Co-morbidities (including year of diagnosis/presentation with condition):

(i)_____ Year _____

(ii)_____ Year _____

(iii)_____ Year _____

The Medical Benefits Act, 2010, Part IV (55) Offences
(1) A person who for the purpose of obtaining a benefit or other payment under this Act, whether for himself or some other person, or for any other purpose connected with this Act—
(a) knowingly makes any false statement or false representation; or
(b) produces or furnishes or causes or knowingly allows to be produced or furnished, any document or information which he knows to be false in any material particular; commits an offence and except as is otherwise provided under this Act, is liable on summary conviction to a fine of five thousand dollars and to imprisonment for a term of two years.

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Medication(s) previously used for the diagnosed condition (include dosage regimen & duration):

_____

_____

Reason(s) for discontinuation of previously used medication(s):

_____

_____

Current Medications (include dosage regimen & duration):

_____

_____

_____

_____

_____

SAD Request (Please include dosage and duration):

_____

_____

_____

_____

_____

Treatment Option(s) (including alternative drug/drug regimen should patient not respond to requested SAD)

(1)_____

_____

(2)_____

_____

_____

(3)_____

_____

Does patient have private insurance (yes/no): _____

If answer is **yes**, state name and address of insurance provider: _____

.....

(Physician's signature and stamp)

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THE INFORMATION ON PAGE 3 OF THIS FORM MUST BE PROVIDED FOR DIABETIC PATIENTS REQUIRING GLP-1 AGONISTS ONLY

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FOR PATIENTS REQUIRING GLUCAGON-LIKE PEPTIDE-1 (GLP-1) AGONISTS

(For example, Dulaglutide, Liraglutide, Semaglutide, Tirzepatide)

IN ADDITION TO THE INFORMATION REQUIRED ABOVE, THE SPECIALIST PHYSICIAN MUST PROVIDE THE BELOW REQUESTED INFORMATION ONLY IF PATIENT HAS A CONFIRMED DIAGNOSIS OF DIABETES MELLITUS

1. **DOCUMENTED EVIDENCE OF A CONFIRMED DIAGNOSIS OF DIABETES MELLITUS. (please attach to application form)**
2. **DOCUMENTED EVIDENCE OF PATIENT'S COMPREHENSIVE PRIOR TREATMENT HISTORY, SUPPORTED BY PROOF OF TREATMENT FAILURE WITH ALTERNATIVE THERAPIES. (please attach to application form)**
3. **APPROPRIATE CLINICAL JUSTIFICATION FOR THE REQUESTED GLP-1 AGONIST. (please attach to application form)**

THIS INFORMATION IS A REQUIREMENT FOR MEDICAL AND ADMINISTRATIVE REVIEW BY THE MEDICAL BENEFITS SCHEME.

SPECIAL AUTHORIZED DRUG APPLICATIONS THAT LACK THE ABOVE REQUESTED INFORMATION WILL BE RETURNED TO THE REQUESTING SPECIALIST PHYSICIAN.

NB: REQUESTS FOR GLP-1 AGONISTS SUBMITTED FOR & ON BEHALF OF NON-DIABETIC PATIENTS WILL NOT BE APPROVED

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EVIDENCE OF A CONFIRMED DIAGNOSIS OF DIABETES MELLITUS. (Please submit supporting evidence along with this application form)

The Medical Benefits Act, 2010, Part IV (55) Offences
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A WRITTEN COMPREHENSIVE, PRIOR TREATMENT HISTORY, SUPPORTED BY PROOF OF TREATMENT FAILURE WITH ALTERNATIVE THERAPIES. (Please submit all supporting evidence along with this application form)
Prior Treatment History:
Previously Tried Treatment (including list of alternative therapies):

The Medical Benefits Act, 2010, Part IV (55) Offences
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CLINICAL JUSTIFICATION FOR THE REQUESTED GLP-1 AGONIST. (Please submit all supporting evidence along with this application form)
Clinical Justification Explained:

……

(Specialist Physician's Signature and Stamp)