OLD MUTUAL

CHRONIC MEDICINE BENEFIT APPLICATION FORM

APPLICATION INSTRUCTIONS (please complete this application as follows)

1. **The application must be completed in black ink. Please print clearly and legibly.**
2. **One application form must be completed per patient.**
3. **Kindly take note of the clinical entrance criteria for the various chronic conditions. These are detailed on pages 6 to 8.**
4. **Certain entry requirements necessitate the completion of this form by a specialist.**
5. **The patient or principal member (where the dependant is below the age of 16) must complete Sections A, B and C.**
6. **Please forward pages 1 and 5 as well as those pages containing information pertaining to the relevant chronic condition/s, to Old Mutual Healthcare.**
7. **The completed and signed form can be faxed to (021) 509 8183 or a scanned copy, e-mailed to pbm@oldmutual.com.**
8. **Feel free to contact a consultant on 0860 102 102 for Oxygen Scheme or 0860 100 733 for other administered schemes.**
9. **The application will not be processed if the relevant sections are incomplete or if the required clinical tests are not submitted. (please use the checklist in Section C to ensure full completion)**

SECTION A: PRINCIPAL MEMBER'S DETAILS

Membership Number

Scheme and Option

Surname

Title Initials

Telephone Numbers (H) CODE (W) CODE

Fax Number (H) CODE (W) CODE

Cellular ID Number

Postal Address

SECTION B: PATIENT'S DETAILS

Title Identity number

Surname

Full First Names

Telephone Numbers (H) CODE (W) CODE

Fax Number (H) CODE (W) CODE

Cellular

E-mail address
(will be treated as private)

SECTION C: DECLARATION BY PATIENT

Checklist: (tick to indicate completion)

- Have Sections A, B and C been completed? ☐
- Have Sections J and K been completed by the relevant practitioner? ☐
- Have all the required supporting documents been included with this application? ☐
  (Please refer to the Clinical Entrance Criteria Requirements detailed on pages 6 to 8)
- Have the necessary sections pertaining to the chronic condition/s, been completed by the medical practitioner? ☐
  (Sections D, E, F, G, H and I)
- Does the medical aid provide chronic benefits for your chronic condition? Y ☐ N ☐
  (Refer to your member guide)

Please forward the relevant pages containing the completed sections to Old Mutual Healthcare. Please do not forward the entire application form.

I understand that the Scheme/Fund (or it's authorised representative) needs to access my/my minor child's personal medical information in order to assess the application. I hereby authorise my medical practitioner to provide the Scheme/Fund (or it's authorised representative) with all the relevant medical information required to assess my application. I hereby declare that the information provided on this application form is true and correct.

PATIENT SIGNATURE _____ **PRINCIPAL MEMBER SIGNATURE** _____ **DATE** DDMMYYYY

Patient name and surname	
Membership Number	

SECTION D: CARDIOVASCULAR RISK (to be completed by doctor when applying for PMB chronic medicine benefits for hypertension, hyperlipidaemias and diabetes mellitus type 2)

For patients younger than 30 years of age diagnosed with hypertension, a specialist must complete this section.

1. Weight in kg: _____ 2. Patient height in m: _____ 3. BMI: _____
4. Hip/waist ratio _____ 5. Waist Circumference _____ 6. Does the patient have a history of smoking? YES ____ , ____ per day (ave.) NO ____
7. Indicate the duration of smoking history _____ 8. If female, is the patient post-menopausal YES _____ NO _____
9. Is microalbuminuria present or is the GFR less than 60 ml/min YES _____ NO _____
10. How many times per week does the patient exercise _____
11. If there is target organ damage and/or cardiovascular disease please tick the appropriate box:

Angina	☐	Chronic Renal Disease	☐	Heart failure	☐	Retinopathy	☐
Hypertensive retinopathy	☐	Left ventricular hypertrophy	☐	Myocardial infarction	☐		
Peripheral arterial disease	☐	Prior CABG	☐	Stroke/TIA	☐		
Cardiomyopathy	☐	Prior stenting	☐	Nephropathy	☐		

For heart failure please provide either the NYHA classification: Class _____ , or the Stage of cardiac failure according to the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: Stage _____ .

SECTION E: APPLICATION FOR HYPERTENSION (please complete in conjunction with Section D)

For patients younger than 30 years of age have been diagnosed with hypertension, a specialist must complete this section.

1. Current blood pressure (to be completed for all patients) _____ / _____ mmHg.
2. When did this patient commence drug therapy for hypertension ☐☐☐☐☐☐☐☐
3. For all newly diagnosed patients and those diagnosed within the last six months, please supply the two initial blood pressure readings (before drug therapy) done at least two weeks apart in order to establish the **stage of hypertension***.

   i) Date ☐☐☐☐☐☐☐☐ ____ / ____ mmHg ii) Date ☐☐☐☐☐☐☐☐ ____ /____ mmHg

Drug therapy will be funded in accordance with the accepted algorithm and risk stratification as stated in the South African Hypertension Guideline 2006.

Please indicate risk factors of the patient: _____

Please provide additional clinical information, if there are compelling indications for use of drug classes that are not first or second line therapy:

Risk factors

• Smoking • Dyslipidaemia • Diabetes mellitus • Age > 60 years • Sex (men/postmenopausal women)
• Family history of early onset CVD (women aged < 65 years, men aged < 55 years) • obesity.

Patient name and surname

Membership Number

SECTION F: APPLICATION FOR HYPERLIPIDAEMIA (please complete in conjunction with Section D)

1. **Please attach a copy of a recent lipogram.**
2. **Does the patient suffer from familial hyperlipidaemia (FH)** YES_____ NO _____
3. If YES, please list signs of FH _____
4. Is there a family history of premature arteriosclerotic disease? YES_____ NO _____
   Please provide the following details if the answer is YES:

	Father	Mother	Sibbling
Description of event			
Age at time of first event/death			

5. When did your patient commence drug therapy for hyperlipidaemia? D D M M Y Y Y Y
6. In terms of the European Guidelines adopted by South African Heart Association, the following categories' patients are not required to be risk scored.
   1. Established atherosclerosis
      a. Coronary Heart Disease
      b. Cerebrovascular atherosclerotic disease
      c. Peripheral vascular disease
   2. Diabetes Type 2
   3. Diabetes Type 1 with microalbuminuria or proteinuria

   Please provide supporting clinical evidence or pathology results to confirm the health status of the patient to indicate that the patient falls within the aforementioned categories.

   _____

   _____

   _____

7. For patients with primary hyperlipidaemia please risk rate your patient using the following table and indicate your patient's score by marking the appropriate percentage risk.

Estimate of 10-year risk for **MEN**: (Framingham point scores)

Age (yr)	Points
20-34	-9
35-39	-4
40-44	0
45-49	3
50-54	6
55-59	8
60-64	10
65-69	11
70-74	12
75-79	13

Total Cholesterol (mmol/l)	Age: 20-39	40-49	50-59	60-69	70-79
	Points				
<4	0	0	0	0	0
4.10 - 5.00	4	3	2	1	0
5.10 - 6.20	7	5	3	1	0
6.21 - 7.20	9	6	4	2	1
≥7.2	11	8	5	3	1

	Age: 20-39	40-49	50-59	60-69	70-79
	Points				
Nonsmoker	0	0	0	0	0
Smoker	8	5	3	1	1

HDL (mmol/l)	Points
≥1.6	-1
1.30 - 1.59	0
1.00 - 1.29	1
<1	2

Systolic BP (mmHg)	Points: If untreated	If treated
<120	0	0
120 - 129	0	1
130 - 139	1	2
140 - 159	1	2
≥160	2	3

Estimate of 10-year risk for **WOMEN**: (Framingham point scores)

Age (yr)	Points
20-34	-7
35-39	-3
40-44	0
45-49	3
50-54	6
55-59	8
60-64	10
65-69	12
70-74	14
75-79	16

Total Cholesterol (mmol/l)	Age: 20-39	40-49	50-59	60-69	70-79
	Points				
<4	0	0	0	0	0
4.10 - 5.00	4	3	2	1	1
5.10 - 6.20	8	6	4	2	1
6.21 - 7.20	11	8	5	3	2
≥7.2	13	10	7	4	2

	Age: 20-39	40-49	50-59	60-69	70-79
	Points				
Nonsmoker	0	0	0	0	0
Smoker	8	5	3	1	1

HDL (mmol/l)	Points
≥1.6	-1
1.30 - 1.59	0
1.00 - 1.29	1
<1	2

Systolic BP (mmHg)	Points: If untreated	If treated
<120	0	0
120 - 129	1	3
130 - 139	2	4
140 - 159	3	5
≥160	4	6

Patient name and surname	
Membership Number	

Estimate of 10-year risk for **MEN**: (Framingham point scores)

Point total	10-year risk %
<0	<1
0	1
1	1
2	1
3	1
4	1
5	2
6	2
7	3
8	4
9	5
11	8
12	10
13	12
14	16
15	20
16	25
≥17	≥30

10-year risk ____ %

Estimate of 10-year risk for **WOMEN**: (Framingham point scores)

Point total	10-year risk %
<9	<1
9	1
10	1
11	1
12	1
13	2
14	2
15	3
16	4
17	5
18	6
19	8
20	11
21	14
22	17
23	22
24	27
≥25	≥30

10-year risk ____ %

Framingham scoring system for calculating the 10-year risk of major coronary events in adults without diabetes.
HDL denotes high-density lipoprotein cholesterol & BP blood pressure. All age ranges are given in years.

Reprinted from National Institues of Health, National Heart, Lung & Blood Institute. Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation and Treatment of High blood Cholesterol in Adults (Adult Treatment Panel III), Executive Summary. NIH Publication No. 01-3670; May 2001.

8. Based on the information supplied in Section F.
   - For patients below 60 years of age: does your patient have a 20% or greater chance of a coronary event in the next ten years? YES____ NO____
   - For patients above 60 years of age: does your patient have a 30% or greater chance of a coronary event in the next ten years? YES____ NO____

We acknowledge that there are limitations to the Framingham Risk Assessment Score Chart. In order to assist with the funding decision, please motivate if you feel that your patient is negatively impacted by these limitations.

The PMB chronic benefit will not provide cover in patients with less than a 20%/30% risk of a coronary artery event within the next ten years. This is based on local and international treatment guidelines and is in line with the Medical Scheme Council Clinical Algorithm. This is a funding decision and does not in anyway question your clinical decision. This funding decision is to ensure the long-term sustainability of this benefit.

SECTION G: APPLICATION FOR DIABETES TYPE 2 (please complete in conjunction with Section D)

1. Please attach a laboratory report confirming the diagnosis of type 2 diabetes.
2. Medication will be funded from the chronic benefit if the WHO criteria are met:
   - Fasting plasma glucose > 7.0mmol/l
   - Random plasma glucose > 11 mmol/l
   - 2 hours post prandial glucose load > 11.1 mmol/l during an Oral Glucose Tolerance Test (OGTT)
3. A motivation is required from an endocrinologist or specialist physician to authorize chronic benefits for glitazones and nateglinide. The motivation must indicate the advantage of these medications over conventional therapy.
4. When did your patient commence drug therapy for type 2 diabetes? D D M M Y Y Y Y

SECTION H: APPLICATION FOR PSYCHIATRIC BENEFITS (to be completed by medical practitioner)

A psychiatrist must complete this form if benefits are required for the following conditions:
• Anorexia • Bulimia • Bipolar mood disorder • Insomnia • Narcolepsy • Obsessive Compulsive Disorder • Panic Disorder • Post Traumatic Stress Disorder • Schizophrenia

1. Please indicate diagnosis (DSM1V)_____
2. Please indicate the number of relapses_____
3. Applications for depression will be assessed as follows:

   - Applications from General Practitioners will be approved for six months pending a motivation from a psychiatrist.
   - Generic Fluoxetine or Citalopram will be funded as first line therapy from a general practitioner.
   - Motivation or psychiatrist referral is required to fund other chronic medication indicated for treating depression.

SECTION I: MEDICAL/SURGICAL HISTORY/RISK FACTORS (to be completed by medical practitioner)

Osteoportic fracture YES____ NO____	Date of most recent fracture
Please indicate fracture location/s:	
Has patient had a hysterectomy? YES____ NO____	Has patient had a Thyroidectomy? YES____ NO____
Has patient had an Oophorectomy? YES____ NO____	Date of Oophorectomy

Patient name and surname

Membership Number

SECTION J: MEDICAL PRACTITIONER'S DETAILS

Title | Initials | BHF Practice Number

Surname

Qualification

Practice Postal Address

CODE

Telephone Number CODE | Fax Number CODE

E-mail Address

SECTION K: DISEASE AND MEDICATION DETAILS (Please print clearly and legibly to avoid delays in processing.)

1. **Please note that a formulary will be applied. Funding for medication prescribed outside this formulary will require a motivation. This is a funding decision to ensure the long-term sustainability of this benefit and does not question your clinical judgement.**

Ailment/ Diagnosis Code ICD10	Name of medication prescribed	Strength	Dosage/ Quantity per month	Name of currently authorised medication that is to be discontinued? (if applicable)	How long has the patient been on this medication?		How many repeat prescriptions would you like your patient to receive? *(months)*
					Years	Months	

SIGNATURE OF MEDICAL PRACTITIONER

DATE DDMMYYYY

KINDLY COMPLETE AND FORWARD TO PBM

SECTION L: PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC MEDICINE BENEFIT

All Schemes/Funds administered by Old Mutual Healthcare Pharmacy Benefit Management provide chronic medicine benefits for the 25 chronic diseases, called the Prescribed Minimum Benefit (PMB) chronic diseases.

Government regulates the PMB and allows Schemes/Funds to apply managed healthcare principles to ensure the provision of cost effective health services within the constraints of what is affordable. The Medical Scheme Act prescribes that a Scheme/Fund can apply clinical entry criteria, treatment guidelines, treatment algorithms and formularies to determine whether a member is eligible for a benefit and also the extent of the benefit available.

A formulary is a list of cost effective medication that will be covered by the PMB chronic disease benefit. The formulary has been developed using evidence-based medicine. Please check your current member guide to determine whether your Scheme/Fund applies a formulary. The Old Mutual Healthcare formulary is referred to as the Medicine Benefit List (MBL).

Schemes/Funds are also allowed to appoint Designated Service Providers (DSP) for the provision of medicines authorised for the PMB chronic diseases. Members who voluntarily use the services of a non-DSP will be required to make a co-payment on their PMB chronic medication. Please check your current member guide to determine whether your Scheme/Fund has a DSP arrangement.

SECTION M: MEDICAL MANAGEMENT OF THE PMB CHRONIC DISEASES

The Prescribed Minimum Benefits also cover the cost of the medical management of the PMB chronic diseases. Medical management refers to certain consultations and diagnostic tests used by your medical practitioner. Certain Schemes/Funds require members to register for medical management of their PMB disease to ensure that they receive cover for quality, appropriate and cost effective health care. Please refer to your current member guide to obtain information about the medical management benefits, the registration process and DSP arrangements for your Scheme/Fund.

SECTION N: PRESCRIBED MINIMUM BENEFITS: CLINICAL ENTRY CRITERIA

Please take note of the following:

1. Your application cannot be processed if the information is not supplied.
2. The entrance criteria may require that the form be completed by a specialist.
3. The following information is required each time you register for a new chronic disease. Once registered for a chronic disease you are not required to complete an application form, unless you are diagnosed with a new chronic disease. Once registered for a disease you may be required to submit further documentation if your medication is changed. You will be informed if your doctor is required to provide this documentation. **Your doctor or pharmacist may contact the PBM clinical call centre on 0860 024 766 to update chronic medication authorisations**.

PMB CONDITION	CLINICAL ENTRANCE CRITERIA REQUIREMENTS
Addison's disease	1. Serum cortisol levels. 2. ACTH stimulation test to distinguish primary from secondary adrenal insufficiency. The PMB is only applicable to primary Addison's disease. 3. A specialist physician, paediatrician or endocrinologist must make diagnosis.
Asthma	1. A lung function test for children, who are eight years and older, as well as for adults. 2. The South African Treatment Guidelines for Asthma will be used to assess all applications. 3. Applications for leukotriene inhibitors (e.g. Singulair ®) must be supported by a pre and post lung function test to substantiate the additional benefit.
Bipolar Mood Disorder	A psychiatrist must complete Section H.
Bronchiectasis	Please attach a report based on the findings of a radiological examination (X-ray or CT scan).
Cardiac failure	Please indicate the level of functional incapacity as per: 1. The New York Heart Association's Classification, and/or 2. The stage of Cardiac Failure according to the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (February 2002). Level/Stage to be recorded in Section D.
Cardiomyopathy	A specialist physician or cardiologist must confirm the diagnosis.
Chronic obstructive pulmonary disease (COPD)	1. Please attach a lung function test. (The REF entry criteria are in line with the GOLD classification). 2. Applications for oxygen must be supported by the following; oxygen saturation levels off oxygen therapy, hours of oxygen use per day and FEV1 level
Chronic renal disease	1. A specialist physician must complete the application form. 2. Indicate the serum creatinine clearance. 3. A report indicating haemoglobin, Tsat and ferritin levels must be provided when applying for erythropoietin. The report must indicate if the patient is currently on or off drug therapy. 4. A report indicating the Tsat and Ferritin must be provided when applying for Ion supplementation
Coronary artery disease	Please attach a copy of the stress or exercise ECG report confirming the diagnosis of coronary artery disease.

PMB CONDITION	CLINICAL ENTRANCE CRITERIA REQUIREMENTS
Crohn's disease	A specialist physician, paediatrician, gastro-enterologist or surgeon must complete the application form. If a general practitioner manages the condition, the medical practitioner indicated above must confirm the diagnosis.
Diabetes insipidus	1. An endocrinologist, specialist physician, paediatrician, neurologist or neurosurgeon must complete the application form. 2. The results of a water deprivation test are required.
Diabetes Type 1	The medical practitioner that currently manages the patient must complete the application form.
Diabetes Type 2	The medical practitioner must complete Sections D and G of the application form.
Dysrhythmias	The medical practitioner must indicate the ICD10 code. The PMB chronic disease benefit only provides cover for Chronic Atrial Fibrillation and Flutter (I48) and Ventricular Tachycardia (I47.2).
Epilepsy	1. Please attach a detailed seizure history. 2. Please attach an EEG report confirming the diagnosis of epilepsy. 3. The REF entry criteria is as follows: • the occurrence of two or more unprovoked seizures within a 12 month period; or • the occurrence of a single unprovoked seizure with focal neurological abnormality on clinical examination or cerebral imaging, or EEG epileptiform activity.
Glaucoma (open and closed angle)	Please provide the intra-ocular pressure at diagnosis. This is only required for newly diagnosed patients.
Haemophilia	Haemophilia A: Please provide the factor V111 level as a % of normal. Haemophilia B: Please provide the factor 1X level as a % of normal.
HIV	**Please do not complete this form. To register, or request information on the HIV programme, please call our HIV programme manager. Refer to your member guide for the contact number.**
Hyperlipidaemia	The medical practitioner must complete Sections D and F of the application form.
Hypertension	The medical practitioner must complete Sections D and E of the application form
Hypothyroidism	Please attach the diagnostic report that confirms the initial diagnosis of hypothyroidism.
Multiple sclerosis	1. A specialist physician or neurologist must complete the application form and indicate the specific type of MS. 2. Please provide the following information when applying for chronic medicine benefits for interferon; • extended disability status score (EDSS) • relapsing-remitting history • relapses requiring IV cortisone treatment
Parkinson's disease	Applications for certain medicines will only be considered if prescribed by a neurologist, or if the application is supported by a neurologist's motivation. Please refer to the formulary. For Schemes/Funds that do not have a formulary this restriction will only apply to Pramipexole dihydrochloride and Entacapone.
Rheumatoid arthritis	1. PMB only covers rheumatoid arthritis and excludes other closely related conditions. We therefore require copies of the relevant blood test reports and supportative clinical history confirming the diagnosis of rheumatoid arthritis. The diagnostic criteria for RA are those proposed by the American College of Rheumatology (ACR) for classification of the disease. 2. Applications for COXIB's must be supported by a motivation indicating the risk factors considered for their use over conventional anti-inflammatories. 3. Applications for anti-inflammatories as monotherapy must be supported/motivated by a rheumatologist.
Schizophrenia	A psychiatrist must complete Section H.
Systemic lupus erythematosus (SLE)	1. A rheumatologist, specialist physician or paediatrician must complete the application form. 2. The REF recommends that the diagnostic criteria for SLE are those of the American Rheumatism Association (ARA).
Ulcerative colitis	A specialist surgeon, physician or gastro-enterologist must complete the application form. If the condition is managed by a general practitioner, a specialist surgeon, physician or gastro-enterologist must confirm the diagnosis.

SECTION O: NON-PRESCRIBED MINIMUM BENEFIT CHRONIC DISEASES

Your Scheme/Fund may cover one or more of the non-Prescribed Minimum Benefit chronic diseases. Please refer to your current member guide before applying for chronic benefits for the following diseases. Your Scheme/Fund may also cover chronic diseases that are not listed below. For further information on the diseases covered by your Scheme/Fund, please contact the Pharmacy Benefit Management call centre. The authorisation notes are a summary of the authorisation requirements and PBM may request additional information to authorise certain medicines.

CHRONIC CONDITION	CLINICAL ENTRY CRITERIA/AUTHORISATION NOTES
Acne (cystic nodular)	For isotretinoin therapy the weight of the patient, date treatment commenced and duration of therapy is required. For certain Schemes/Funds a photograph with masked eyes is required. A dermatologist must initiate therapy.
Acne vulgaris	For isotretinoin therapy the weight of the patient, date of treatment commencement and duration of therapy is required. A dermatologist must initiate therapy
ADHD or ADD	A paediatrician, psychiatrist or neurologist must complete the application form.
Allergic rhinitis	A motivation or a specialist prescription is required to fund the combined used of inhaled nasal corticosteroids and antihistamines. Generic fluticasone, beclomethasone and budesonide will be funded as first line therapy. Motivations must be submitted to fund other medication as first line therapy.
Alzheimer's type dementia	Please submit results of a mini mental state examination (MMSE) if the following drugs are prescribed: Aricept®, Exelon® and Reminyl®.
Ankylosing spondylitis	1. A rheumatologist must complete the application form. 2. Applications for COXIB's must be supported by a motivation indicating the risk factors considered for their use over conventional anti-inflammatories
Benign prostatic hypertrophy	Doxazosin generics will be funded as first line therapy. A motivation is required to fund alternative products. Avodart, Flomax, Proscar and Xatral will not be funded as first line therapy unless prescribed by an Urologist.
Depression	Section H of the application form must be completed. Applications from GP's will be approved for six months only pending a motivation from a psychiatrist. Generic Fluoxetine or Citalopram will be funded as first line therapy from a general practitioner. Motivation or psychiatrist referral is required to fund other chronic medication indicated for treating depression.
GORD	Generic omeprazole is the only PPI that will be funded as first line therapy. A motivation is required to fund other medicines as first line therapy, unless prescribed by a gastro-enterologist. Alternative medicines will be funded if a motivation is submitted indicating that generic omeprazole has been ineffective.
Gout	Only preventative medication will be funded from the chronic benefit.
Hypoparathyroidism	A specialist physician or endocrinologist must complete the application form.
Hypotension	Submit a pre and post medication blood pressure reading.
Hyperthyroidism	Submit T3, T4 and TSH levels. Funding will be authorised for six months pending review.
Meniere's disease	Generic cyclizine, prochlorperazine and cinnarazine will be covered as first line agents. Betahistine (Serc®) will be funded after successful motivation.
Menopause (HRT)	A motivation for HRT in patients less than 40 years of age is required. A motivation is required to authorise Tibolone.
Migraine	The benefit will only cover preventative medication.
Oncology	**Please do not complete this form. To register, or request information on the Oncology programme, please call our Oncology programme manager on 021 509 2273.**
Organ transplant	Proposed transplants need to be pre-authorised. Please refer to your member guide for details. Pharmacy Benefit Management will authorise post transplant medication.
Osteoarthritis	Applications for COXIB's must be supported by a motivation indicating the risk factors considered for their use over conventional anti-inflammatories.
Osteoporosis	a. applications must include a DEXA bone mineral density scan (BMD) report. b. a short report on additional risk factors (e.g. previous fractures, family history, long term oral corticosteroids use) must be included, if applicable. c. An endocrinologist motivation is required for males, females < 30 years and children.
Stroke	Applications for clopidrogel (Plavix ®) must be accompanied by a motivation from a specialist indicating the additional benefit for use over aspirin therapy.
Systemic sclerosis	A rheumatologist or specialist physician must complete the application form.
Tourette's syndrome	A psychiatrist or neurologist must complete the application form.
Zollinger-Ellison Syndrome	A gastro-enterologist or specialist physician must complete the application form.