

CHRONIC MEDICATION BENEFIT APPLICATION FORM

A. IMPORTANT INFORMATION

- 1. One application must be completed per beneficiary applying for chronic medication.
- 2. Allow **5 working** days for the processing of your application.
- 3. The original prescription must be given to the provider who dispenses your medication.

| 5. Aproval of chronic medication is subject to the rules of the Scheme and PROVIDENCE Chronic Protocols 5. Avour may contact the Pharmacy Benefit Management (PBM) Team at (N41) 395 4482 or email pbm@providence.co.za. 7. Send completed forms via fax 086 680 8855, mail PO Box 1672, Port Elizabeth, 6000 or e-mail pbm@providence.co.za. **MEMBER DETAILS** **Cheme** Option** Option** Arembership Number** Option** Arembership Number** Date of Birth | | | | | | | | | | | | | | |
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| 7. Send completed forms via fax 086 680 8855, mail PO Box 1672, Port Elizabeth, 6000 or e-mail pbm@providence.co.za. **MEMBER DETAILS** Scheme | | | | | | | | | | | | | | |
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| Fax number (Confidential) Cellular | | | | | | | | | | | | | | |
| Email address (Confidential) The outcome of this application must be communicated to me via my email address: Yes No OR fax number Yes No PATIENT DECLARATION By signing below, I hereby give permission for, acknowledge and/or agree to the following: My (or my minor dependant's) doctor may provide clinical information regarding my/minor's condition to the PBM Team; Any information concerning this application will remain confidential at all times; It may be a pre-condition to the approval of the Chronic Medication Benefit that I register and comply with the requirements of a Disease Management | | | | | | | | | | | | | | |
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| My (or my minor dependant's) doctor retains the responsibility for my (or my minor dependant's) condition, based on the understanding that I (or my | | | | | | | | | | | | | | |
| minor dependant) also has a responsibility towards my (or my minor dependant's) own health concerns, irrespective of the outcome of this application. | | | | | | | | | | | | | | |
| This funding authorisation is at all times subject to the Scheme rules even if a member's circumstances change after the authorisation is provided. | | | | | | | | | | | | | | |
| This authorisation is not a guarantee of payment. | | | | | | | | | | | | | | |
| This funding authorisation is based on the most appropriate clinical criteria in terms of the Scheme rules and protocols. All treatment decisions | | | | | | | | | | | | | | |
| reaminn the responsibility of the of the beneficiary's health care provider irrespective of the funding decision made in terms of the Scheme rules, | | | | | | | | | | | | | | |
| clinical criteria and protocols. PROVIDENCE shall not accept responsibility for any act, errors or omissions, loss, damage or consequences of individual responses to to the | | | | | | | | | | | | | | |
| treatment authorised or not authorised for funding by the Scheme. | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| atient Signature (or member if patient is a minor) Date Y Y Y M M D D PATIENT HEALTH INFORMATION (to be completed by doctor) | | | | | | | | | | | | | | |
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| Veight kg Height m Hip/Waist ratio Smoker? Y N Ave per day Exercise: Frequency X per week Intensity (Please tick) Low Medium High | | | | | | | | | | | | | | |
| Application interiority (Fields (Ich) | | | | | | | | | | | | | | |

| Patient name | | | | | | | | | | | | | | | | |
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| Membership number | | | | | | | | | | | | | | | | |

F. CLINICAL CRITERIA

The following information is required when applying for a new chronic condition

Certain conditions which do not appear on the form below may be considered for approval on the Chronic Benefit, although not all long-term conditions, which a doctor may define as chronic, will fulfill the criteria for approval.

* Chronic conditions only available on the Challenger option of Suremed Health.

| Condition | Requirements | |
|---------------------------------------|--|-----|
| Addison's Disease | 1. Serum Cortisol Test. 2. ACTH Stimulation Test. 3. Initial Specialist Application. | |
| Ankylosing Spondylitis | Initial Specialist Application . | |
| Asthma | 1. Lung function test (8 yrs and older). | |
| Bipolar Mood Disorder | Specialist to complete Section J. | |
| Bronchiectasis | Attach relevant radiology report. Initial Specialist Application. | |
| Cardiac failure | Please classify according to NYHA or ACC-AHA Classification. | |
| | Details of diagnosing specialist to be supplied. | |
| Cardiomyopathy | Details of diagnosing specialist to be supplied. | |
| Chronic Obstructive Pulmonary Disease | Lung function test including FEV1/FVC and FEV1 post bronchodilator. | |
| Chronic Renal Disease | Serum Creatinine Clearance. Initial Specialist (Nephrologist) Application. | |
| Coronary Artery Disease | Stress ECG confirming diagnosis. 2. Attach history of previous cardiovascular disease event(s). | |
| Crohn's Disease | Details of diagnosing specialist to be supplied. | |
| Cystic Fibrosis | Details of diagnosing specialist to be supplied. | |
| Depression* | 1. Funding for first line therapy will be allowed for 6 months only. Further funding will only be considered on motivation from a | |
| | psychologist and/or prescription from a psychiatrist. 2. Prescriber to complete Section J. | |
| Diabetes Insipidus | Water deprivation test results. Initial Specialist Application. | |
| Diabetes Mellitus | Attach initial diagnostic report. | |
| Dysrhythmias | Prescriber to clearly indicate ICD-10 code. | |
| Epilepsy | EEG report confirming diagnosis . 2. Attach detailed seizure history . | |
| Glaucoma | Supply initial diagnostic intra-ocular pressure. | |
| Haemophilia | 1. Haemophilia A (Factor VIII as % of Normal). 1. Haemophilia B (Factor IX as % of Normal). | |
| Hyperlipidaemia | Prescriber to complete Section G and I. | |
| | 2. Please attach the diagnosing lipogram. The application cannot be reviewed if this is not submitted. | |
| Hypertension | Prescriber to complete Section G and H. Initial Specialist Application if younger than 30 years. | |
| Hyperthyroidism | 1. Attach report showing T3, T4 and TSH levels. | |
| Hypothyroidism | Attach initial diagnostic report. | |
| Multiple Sclerosis | Extended Disability Status Score (EDSS). Comprehensive disease history . Initial Specialist Application | 'n. |
| Osteoporosis* | DEXA bone mineral density (BMD) scan and report on any additional risk factors. | |
| Parkinson's Disease | Initial Specialist Application. | |
| Rheumatoid Arthritis (RA) | Initial diagnostic test results confirming RA may be required where a "stepped therapy" approach has not been implemented. Initial Specialist Application and motivation for Enbre® and Revellex®. | |
| Schizophrenia | Psychiatrist to complete Section J. | |
| Systemic Lupus Erythematosus | Initial Specialist Application. | |
| Ulcerative Colitis | Details of diagnosing specialist to be supplied. | |

| Patient name | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|-------|--------|-----------|-------|---------|--------|-----------|---------------|----------|--------|-------------|--------|------------|-----------|---------|----|---|-----|-----------|------|----|---|------|--|----------|
| Membership number | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. CARDIOVASCULAR (| to be | comp | oleted by | y doc | ctor wh | nen ap | pplying f | or h | yperte | nsion | ı, hyperlip | idaen | nia or dia | betes me | llitus) |) | | | | | | | | | |
| Is the patient (if female) | post | -men | opausa | al? | | | Υ | ١ | N | | | | | | | | | | | | | | | | |
| Is Microalbuminuria pres | ent? | • | | | | | Υ | N | N | | | | | | | | | | | | | | | | |
| Is GFR less than 60ml/m | in? | | | | | | Υ | ١ | N | | | | | | | | | | | | | | | | |
| Please indicate which of | the | follow | ving co | -mo | rbiditi | ies/ri | isk fact | ors | apply | to th | nis patie | nt? | | | | | | _ | | | | | | | |
| Peripheral arterial dis | ease | | | | | Nep | hropathy | / | | | | Re | tinopathy | | | | | Не | art Failu | re | | | | | |
| Left ventricular hyper | troph | у | | | | Chr | onic rena | al dis | sease | | | Ca | rdiomyopa | ithy | | | | Pri | or stroke | e/TI | A | | | | |
| Prior myocardial infaro | | | | | | | | | rtery B | ypass | Graft (CA | BG) | | Prior S | tent | | | An | gina | | | | | | |
| If Heart failure is present | , ple | ase i | ndicate | e cla | assific | ation | below | : | | | | | | | | | | 7 | | | | | | | |
| NYHA/ACC-AHA Classification | | | | _ A | | | E | 3/I(1 | Mild) | | C | II(M | ild)-III(N | loderate | e) | | | D/ | IV(Se | /er | e) | | | | |
| Ref: De Marco T, Delgado RM III, Agoch. H. HYPERTENSION (to b | | | | | | applyi | ing for h | ypei | rtensio | n) | | | | | | | | | | | | | | | |
| Please supply two blood pressu | | | | | | | | | | | g drug the | apy, f | or newly o | liagnosed | patie | nt | | | | | | | | | |
| 1) Y Y Y Y | М | M [| D D | | | | | mm | nHg | | 2) | | Y Y | Y Y | М | М | D | D | | | | n | nmHg | | |
| I. HYPERLIPIDAEMIA (to | be c | omple | eted by | docto | or whe | n app | lying for | r hy p | perlipio | daemi | ia) | | | | | | | | | | | | | | |
| Please attach the diagr | | | _ | | _ | | | | not be | e rev | iewed i | this | s is not | submi | ted. | | | | | | | | | | |
| Is there a family history of the state of th | | - | | terio | scler | otic o | disease | ? | | | | Υ | N | | | | | | | | | | | | |
| n yes, piease provide de | tano | DOIO | *** | | | | | | | | | | | | | | | | | | | | | | |
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| object the patient suffer from familial hyperlipidaemia? yes, please indicate the signs below? | | | | | | | | | | | | | | | | | | | | | | | | | |
| Family history of disorder/ heart attack at early age High LDL levels (Treatment resistant) Tendon Xanthoma | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | | | | | _ | | | |
| Please risk your patient as per the Framingham coronary prediction algorithm % | | | | | | | | | | | | | | | | | | | | | | | | | |
| J. PSYCHIATRIC COND | ITIO | NS (| to be co | mple | eted by | / doc | tor when | арр | plying | for ps | sychiatric | disor | ders) | | | | | | | | | | | | |
| Please indicate DSM IV | Diag | nosis | 3 | | | | | | | | | | | | | | | | | | | _ | | | |
| Diagon indicate number | af | lanaa | | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate number of K. ADDITIONAL NOTES | oi re | iapse | 98 | | | | | | | | | | | | | | | | | | | | | | <u> </u> |
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| Membershi | p number | , [| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. MEDICAL | PRACTI | TION | IER | DE1 | AIL | LS | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Surname | | | | | | | | | | | | | | | | | | | | | | | | | | In | itials | | | | | | |
| Practice nu | mber | | | | | | | | | | | | | | | Sp | ecia | lity | | | | | | | | | | | | | | | |
| Telephone | number | | | | | | | | | | | | | | | Ce | ellula | r | | | | | | | | | | | | | | | |
| Fax number | r (Confide | ntial) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email addre | ess (Confi | denti | al) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The outcom | ne of this a | applic | atio | on m | ust l | be o | comr | mun | icate | d to | me | via ı | ny e | emai | il ac | ddres | s: Y | es | | | | No | | OR | ≀ fa | ıx nı | umbe | er Y | 'es | | N | o |] |
| M. CONDITI | ON AND | MED | IC/ | ATIOI | N D | ETA | AILS | (to I | be co | mple | ted b | y doc | tor) | | | | | | | | | | | | | | | | | | | | |
| ICD-10 Code | | | | N | ledi | icat | ion p | pres | crib | ed (| Nan | ne, s | trei | ngth | & | dosa | ge) | | | | | | | | | | on ir er de | | | | Rep | eats | |
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| that is author | J.100u. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |