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.
4. It is essential that you submit all required information correctly and timeously as incomplete forms will not be processed.
5. The information required is for the clinical assessment of this application as well as for Risk Equalisation Fund (REF) purposes.
6. You may contact the Pharmacy Benefit Management (PBM) Team at **(041) 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.**

B. MEMBER DETAILS

Scheme | Option

Membership Number

Surname | First Names

Title | Date of Birth (Y Y Y Y M M D D) | ID Number

Telephone number (Home) | (Work)

Fax number (Confidential) | Cellular

Email address (Confidential)

Postal Address | Code

C. PATIENT DETAILS (Beneficiary who requires Chronic Medication)

Surname | First Names

Title | Date of Birth (Y Y Y Y M M D D) | ID Number

Telephone number (Home) | (Work)

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 ☐

D. 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 Programme and that non-compliance may lead to the withdrawal of this benefit;
- 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 remain the responsibility of the of the beneficiary's health care provider irrespective of the funding decision made in terms of the Scheme rules, clinical critera and protocols.
- PROVIDENCE shall not accept responsibility for any act, errors or omissions, loss, damage or consequences of individual responses to the treatment authorised or not authorised for funding by the Scheme.

Patient Signature (or member if patient is a minor) _____ Date (Y Y Y Y M M D D)

E. PATIENT HEALTH INFORMATION (to be completed by doctor)

Weight (kg) | Height (m) | Hip/Waist ratio | Smoker? (Y N) | Ave per day

Exercise: Frequency (X per week) | Intensity (Please tick) Low ☐ Medium ☐ High ☐

Current blood pressure (mmHg) | Fasting Blood Glucose (If available) (mmol/L)

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Version 6 (March 2012)

Patient name	
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 Extended Chronic Benefit.*

Condition	Requirements
Addison's Disease	1. Serum Cortisol Test. 2. ACTH Stimulation Test. 3. Initial Specialist Application.
ADHD *	1. Initial Specialist Application . 2. Motivation if > 12 years.
Alzheimer's Disease*	1. Folstein's Mini Mental Examination State (MMSE) result. 2. Initial Specialist Application.
Ankylosing Spondylitis	1. Initial Specialist Application .
Asthma	1. Lung function test (8 yrs and older).
Benign Prostatic Hypertrophy*	1. Motivation for 2nd line agents (E.g. Avodart®, Flomax® and Xatral®).
Bipolar Mood Disorder	1. Specialist to complete Section J.
Bronchiectasis	1. Attach relevant radiology report. 2. Initial Specialist Application.
Cardiac failure	1. Please classify according to NYHA or ACC-AHA Classification. 2. Details of diagnosing specialist to be supplied.
Cardiomyopathy	1. Details of diagnosing specialist to be supplied.
Chronic Obstructive Pulmonary Disease	1. Lung function test including FEV1/FVC and FEV1 post bronchodilator.
Chronic Renal Disease	1. Serum Creatinine Clearance. 2. Initial Specialist (Nephrologist) Application.
Coronary Artery Disease	1. Stress ECG confirming diagnosis. 2. Attach history of previous cardiovascular disease event(s).
Crohn's Disease	1. Details of diagnosing specialist to be supplied.
Cystic Fibrosis	1. 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	1. Water deprivation test results. 2. Initial Specialist Application.
Diabetes Mellitus	1. Attach initial diagnostic report.
Dysrhythmias	1. Prescriber to clearly indicate ICD-10 code.
Epilepsy	1. EEG report confirming diagnosis . 2. Attach detailed seizure history .
Generalised Anxiety Disorder*	1. Specialist motivation required for treatment exceeding a 6 month period.
Glaucoma	1. Supply initial diagnostic intra-ocular pressure.
GORD*	1. Diagnostic Gastroscopy or Barium Meal Swallow report.
Haemophilia	1. Haemophilia A (Factor VIII as % of Normal). 1. Haemophilia B (Factor IX as % of Normal).
Hyperlipidaemia	1. Prescriber to complete Section G and I. 2. Please attach the diagnosing lipogram. The application cannot be reviewed if this is not submitted.
Hypertension	1. Prescriber to complete Section G and H. 2. Initial Specialist Application if younger than 30 years.
Hyperthyroidism	1. Attach report showing T3, T4 and TSH levels.
Hypothyroidism	1. Attach initial diagnostic report.
Menopause*	1. Motivation required for early-onset menopause (< 40yrs) and the prescription of Livifem ®.
Multiple Sclerosis	1. Extended Disability Status Score (EDSS). 2. Comprehensive disease history . 3. Initial Specialist Application.
Osteoporosis*	1. DEXA bone mineral density (BMD) scan and report on any additional risk factors.
Parkinson's Disease	1. Initial Specialist Application.
Rheumatoid Arthritis (RA)	1. Initial diagnostic test results confirming RA may be required where a "stepped therapy" approach has not been implemented. 2. Initial Specialist Application and motivation for Enbrel® and Revellex®.
Schizophrenia	1. Psychiatrist to complete Section J.
Systemic Lupus Erythematosus	1. Initial Specialist Application.
Ulcerative Colitis	1. Details of diagnosing specialist to be supplied.

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Patient name

Membership number

G. CARDIOVASCULAR (to be completed by doctor when applying for hypertension, hyperlipidaemia or diabetes mellitus)

Is the patient (if female) post-menopausal? Y N

Is Microalbuminuria present? Y N

Is GFR less than 60ml/min? Y N

Please indicate which of the following co-morbidities/risk factors apply to this patient?

- ☐ Peripheral arterial disease
- ☐ Nephropathy
- ☐ Retinopathy
- ☐ Heart Failure
- ☐ Left ventricular hypertrophy
- ☐ Chronic renal disease
- ☐ Cardiomyopathy
- ☐ Prior stroke/TIA
- ☐ Prior myocardial infarction
- ☐ Prior Coronary Artery Bypass Graft (CABG)
- ☐ Prior Stent
- ☐ Angina

If Heart failure is present, please indicate classification below:

NYHA/ACC-AHA Classification ☐ A ☐ B/I(Mild) ☐ C/II(Mild)-III(Moderate) ☐ D/IV(Severe)

Ref: De Marco T, Delgado RM III, Agocha A. et al. J Cardiac Fail. 2004;10

H. HYPERTENSION (to be completed by doctor when applying for hypertension)

Please supply two blood pressure readings, performed at least two weeks apart before initiating drug therapy, for newly diagnosed patient

1) Y Y Y Y M M D D ____ mmHg 2) Y Y Y Y M M D D ____ mmHg

I. HYPERLIPIDAEMIA (to be completed by doctor when applying for hyperlipidaemia)

Please attach the diagnosing lipogram. The application cannot be reviewed if this is not submitted.

Is there a family history of early-onset arteriosclerotic disease? Y N

If yes, please provide details below:

Does the patient suffer from familial hyperlipidaemia? Y N

If yes, please indicate the signs below?

- ☐ Family history of disorder/ heart attack at early age
- ☐ High LDL levels (Treatment resistant)
- ☐ Tendon Xanthoma

Other

Please rate your patient as per the Framingham coronary prediction algorithm ____ %

J. PSYCHIATRIC CONDITIONS (to be completed by doctor when applying for psychiatric disorders)

Please indicate DSM IV Diagnosis

Please indicate number of relapses

K. ADDITIONAL NOTES

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Patient name

Membership number

L. MEDICAL PRACTITIONER DETAILS

Surname | Initials

Practice number | Speciality

Telephone number | Cellular

Fax number (Confidential)

Email address (Confidential)

The outcome of this application must be communicated to me via my email address: Yes ☐ No ☐ **OR** fax number Yes ☐ No ☐

M. CONDITION AND MEDICATION DETAILS (to be completed by doctor)

ICD-10 Code	Medication prescribed (Name, strength & dosage)	Date Medication initiated & prescriber details	Repeats

Signature of Medical Practitioner _____ Date Y Y Y Y M M D D

N. HOW THE CHRONIC BENEFIT WORKS

The Chronic Benefit includes cover for medication from a specified list of chronic conditions which is in accordance with the scheme option.
These conditions have been selected according to clinical and actuarial criteria.

Chronic Disease List - The Prescribed Minimum Benefit regulations require that medical schemes cover the diagnosis, medical management and medication for a specified list of 27 chronic conditions known as the Chronic Disease List.
All such ailments meeting approval criteria will be authorised under the PMB Chronic Medication benefit.

Extended Chronic Disease List - Certain medical scheme options provide cover for an Extended Disease List which includes some 46 additional chronic conditions. All approved medication will be paid up to the benefit limit on the respective plan.
All such ailments meeting approval criteria will be authorised under the Extended Chronic Medication benefit.
The PROVIDENCE PBM (Pharmacy Benefit Management) team will authorise a value for all approved chronic conditions.
The approved value (PCV – PROVIDENCE Chronic Value) is determined based on the treatment protocols for all levels of treatment for each condition.
The PCV is the maximum Rand value that will be approved for the class/category of each drug that is authorised.

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