CHRONIC MEDICATION BENEFIT APPLICATION FORM

A. IMPORTANT INFORMATION

1. One application must be completed per beneficiary applying for chronic medication.
2. Allow **1 working** day 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. Approval of chronic medication is subject to the rules and chronic protocols of the Scheme.
6. You may contact the Pharmacy Benefit Management (PBM) Team at (**041) 395 4482** or e-mail **chronic@rumed.co.za**
7. Send completed forms via fax **086 680 8855**, mail **PO Box 1672, Port Elizabeth, 6000** or e-mail **chronic@rumed.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 ☐

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 (or my minor dependant'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 (or my minor dependent) register and comply with the requirements of a Disease Management Programme.
- 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 beneficiary'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 beneficiary's health care provider irrespective of the funding decision made in terms of the Scheme rules, clinical criteria and protocols.
- The Scheme and its Administrator 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) | Available Blood Glucose result (mmol/L) Fasting ☐ Random ☐

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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. Initial Specialist Application. 2. ACTH Stimulation Test. 3. Serum Cortisol Test.
ADHD*	1. Initial Specialist Application. 2. Specialist motivation if > 12 years of age.
Alzheimer's Disease*	1. Initial Specialist Application. 2. Folstein's Mini Mental Examination State (MMSE) result.
Ankylosing Spondylitis*	1. Initial Specialist Application.
Asthma	1. Lung function test (8 years of age and older).
Benign Prostatic Hypertrophy*	1. Motivation for 2nd tier agents (e.g. Alfuzosin) and Hormone inhibitors.
Bipolar Mood Disorder	1. Specialist to complete Section K.
Bronchiectasis	1. Initial Specialist Application. 2. Attach relevant radiology report.
Cardiac failure	1. Specialist to complete section G.
Cardiomyopathy	1. Initial Specialist Application.
Chronic Obstructive Pulmonary Disease	1. Lung function test including FEV1/FVC and FEV1 post bronchodilator.
Chronic Renal Disease	1. Initial Specialist (Nephrologist) Application. 2. Serum Urea, Creatinine and GFR.
Coronary Artery Disease	1. Stress ECG confirming diagnosis. 2. Attach history of previous cardiovascular disease event(s).
Crohn's Disease	1. Initial Specialist Application. 2. Diagnostic reports to be supplied
Cystic Fibrosis*	1. Initial Specialist Application.
Depression*	1. Prescriber to complete Section K.
Diabetes Insipidus	1. Initial Specialist Application. 2. Water deprivation test results.
Diabetes Mellitus	1. Prescriber to complete Section G and H. 2. Please attach the diagnostic Fasting/Random Blood Glucose results. The application cannot be reviewed if this is not submitted.
Dysrhythmias	1. Prescriber to clearly indicate ICD-10 code. 2. ECG confirming diagnosis.
Epilepsy	1. EEG report confirming diagnosis. 2. Attach detailed seizure history.
Generalised Anxiety Disorder*	1. Prescriber to complete Section K.
Glaucoma	1. Initial Specialist Application. 2. Supply initial diagnostic intra-ocular pressure/s.
Haemophilia	1. Initial Specialist Application. 2. Haemophilia A (Factor VIII as % of Normal). 2. Haemophilia B (Factor IX as % of Normal).
HIV & AIDS (Call 0860103228 for more information)	1. HIV application available on website or complete section L. 2. Eliza test result. 3. Baseline blood tests. 4. Crag test if CD4 count is below 100. 5. TB screening.
Hyperlipidaemia	1. Prescriber to complete Section G and J. 2. Please attach the diagnosing Lipogram. The application cannot be reviewed if this is not submitted.
Hypertension	1. Prescriber to complete Section G and I. 2. Initial Specialist Application if younger than 18 years of age.
Hyperthyroidism	1. Attach initial diagnostic report.
Hypothyroidism	1. Attach initial diagnostic report.
Menopause*	1. Motivation required for early-onset menopause (< 40 years of age) and the prescription of Tibolone.
Multiple Sclerosis	1. Initial Specialist Application. 2. Comprehensive disease history. 3. Extended Disability Status score (EDSS).
Myasthena Gravis*	1. 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 for Leflunomide and Specialist Motivation for Biologic DMARDs. 3. Baseline Disease Acitvity Scores.
Schizophrenia	1. Psychiatrist to complete Section K.
Systemic Lupus Erythematosus	1. Initial Specialist Application. 2. Comprehensive disease history
Ulcerative Colitis	1. Initial Specialist Application. 2. Diagnostic reports to be supplied

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Patient name

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

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 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)

H. DIABETES MELLITUS

Please attach the laboratory diagnostic Fasting or Random Blood Glucose results. The application cannot be reviewed if this is not submitted.

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

Please supply two blood pressure readings, performed on two different occasions, before initiating drug therapy, for a newly diagnosed patient.

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

J. 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 Has this been verified by an Endocrinologist? Y N

If yes, please provide details below:

Please risk your patient as per the Framingham coronary prediction algorithm %

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

Please indicate DSM IV diagnosis

Please indicate number of relapses

L. HIV &AIDS

Date of HIV Diagnosis Y Y Y Y M M D D Viral Load on Diagnosis CD4 count on Diagnosis

Previous ARV regimen	Date Started	Date Stopped	Reason for Change
	Y Y Y Y M M D D	Y Y Y Y M M D D	
	Y Y Y Y M M D D	Y Y Y Y M M D D	

Please describe any abnormality on examination or previous significant illness

All Baseline Investigations to be attached to application: Current Viral load & CD4 count Creatinine Hep B sAg

U & E FBC LFT RPR Pap Smear CrAg Random Cholesterol & Glucose

TB Screen: Symptomatic Y N Investigations: CXR Y N Sputum Y N Is member a candidate for IPT? Y N

Alternate contact Relationship Cellular

M. ADDITIONAL NOTES

SABS ISO 590

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Patient name

Membership number

M. MEDICAL PRACTITIONER DETAILS

Surname | Initials

Practice number | Speciality

Telephone number | Cellular

Fax number

Email address

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

N. 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

P. 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 - RUMed provides cover for an Extended Disease List.
All such ailments meeting approval criteria will be authorised under the Extended Chronic Medication benefit.
The PBM team will authorise an amount for all approved chronic conditions. The approved amount (Chronic Drug Amount - CDA) is determined based on the treatment protocols for all levels of treatment for each condition.
The CDA is the maximum Rand amount that will be approved for the class/category of each drug that is authorised.

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