# MEDICINE MANAGEMENT
# CHRONIC MEDICINE BENEFIT APPLICATION

**FEDHEALTH**

**Telephone 0860 100 608**

**Please FAX completed form where possible to : 0800 223 670 / 680**
**or mail to Medscheme, P O Box 38632, Pinelands, 7430**

## A TO BE COMPLETED BY THE APPLICANT (PLEASE PRINT USING BLOCK LETTERS)

Please book at least 30 minutes with your doctor in order for him/ her to examine you and complete this form. The ideal person to do this is the registered practitioner who regularly prescribes your medication. Please keep a copy of the completed form for your records. **Member/ patient signature is essential to process this application.**

Should you be accepted onto the Chronic Medicine Management programme, you will be informed in writing. You will receive a medicine "Access Card", which lists the medicine to be paid from the Chronic Disease Benefit.

### PRINCIPAL MEMBER'S DETAILS

**Member's surname** ______ **Title** ______ **First name** ______

**Membership number** ______

**Option** ______

### PATIENT'S DETAILS

**Patient's surname** ______ **Title** ______ **First name** ______

**ID number** ______ **Date of birth** (ddmmyyyy) ______ **Beneficiary code** ______

**Telephone numbers and code** **(H)** (   ) ______ **(W)** (   ) ______

**Fax** (   ) ______ **Cell** ______

**Postal address** ______ **Code** ______

**E-mail address** ______

- I/ we understand that all personal and clinical information supplied to Chronic Medicine Management will be kept confidential. Chronic Medicine Management will use this information to, inter alia, determine access to the Chronic Disease Benefit for reimbursement of ongoing essential medication, promote optimal treatment and act in accordance with the rules of the scheme and the provisions of the Medical Schemes Act, Act 131 of 1998 (as amended). Medical staff will review this information in order to make informed recommendations regarding the provision of these benefits. Your medical practitioner, however, retains the ultimate responsibility for his or her patient, irrespective of benefits so authorised.
- I/ we therefore authorise any health care professional, hospital, clinic and/or medical facility in possession of, or may hereafter acquire, any medical information regarding myself, the applicant, and any dependant, whether such information relates to the past or future, to disclose such information to Chronic Medicine Management, Fedhealth Medical Scheme and/or its administrator. I agree that this authorisation and request shall remain in force after my/ their deaths. I indemnify Fedhealth Medical Scheme and its trustees, agents and administrator against any claim, of whatsoever nature, which may be made against them as a result of or arising out of the disclosure of any test results or medical information.
- I/ we confirm that the information contained in this Chronic Medicine Benefit Application Form is correct.

**MEMBER'S SIGNATURE** ............................................ **PATIENT'S SIGNATURE** ............................................
(not required if patient is a minor) **Date** (ddmmyyyy) ______

## B TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (PLEASE PRINT USING BLOCK LETTERS)

### DETAILS OF THE ATTENDING MEDICAL PRACTITIONER

**Doctor's surname** ______ **Initials** ______ **Qualifying degree** ______

**Practice number** ______ **HPCSA Reg.No.** ______

**Postal address** ______ **Code** ______

**E-mail address** ______

**Telephone number and code** (   ) ______ **Cell** ______ **Fax** (   ) ______

**PLEASE ENSURE THAT YOUR PATIENT IS APPLYING FOR THE FIRST TIME AS THE COMPLETION OF ONLY ONE APPLICATION WILL BE PAID FOR.**

### CLINICAL EXAMINATION GENERAL INFORMATION (TO BE COMPLETED FOR ALL APPLICANTS)

**Gender** M | F **Weight** ______ kg **Height** ______ cms **Blood pressure** (sitting, having rested for 5 minutes) ___ / ___ mmHg

**Smoking** yes | no **Physical activity** little | regular | very active **TIA/ Stroke** yes | no

**Please indicate if the patient has a history of the following:** **Ischaemic Heart Disease** yes | no **Peripheral Vascular Disease** yes | no

**First degree relative with premature heart disease (PREMATURE = MI IN FEMALES <65 YEARS; MALES <55 YEARS)** yes | no

**If the patient has diabetes, please provide the most recent HbA1c results.** ______

## C TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (PLEASE PRINT USING BLOCK LETTERS)

### DIAGNOSIS AND MEDICINES FOR WHICH AUTHORISATION IS REQUESTED

**Please note: Prescribed Minimum Benefit rules, chronic disease lists and medicine formularies applicable to Fedhealth Medical Scheme will apply.**
As per the requirements of the Government Risk Equalisation Fund (REF), in order to register patients on the chronic medicine programme, documentation from a relevant specialist and/ or test results verifying the diagnosis, is required for the following diagnoses:

| Diagnosis | Requirement |
|---|---|
| Hyperlipidaemia | Documentation of lipogram results and risk criteria. Please complete Section D. |
| Chronic Renal Disease | Documentation of creatinine clearance or Glomerular Filtration Rate (GFR) estimate. *(Most recent)* |
| COPD | Documentation of lung function test. *(Most recent)* |

| Diagnosis & ICD-10 code | Medicine trade name | Strength e.g. 10 mg | Directions e.g. 1 TDS | Special investigations / motivations | Specialist's details (name & practice no.) | Treatment on previous medical aid for diagnosis | |
|---|---|---|---|---|---|---|---|
| | | | | | | Yes* | No |
| | | | | | | Yes* | No |
| | | | | | | Yes* | No |
| | | | | | | Yes* | No |
| | | | | | | Yes* | No |
| | | | | | | Yes* | No |

*** If yes indicated:** **Medical aid name** ______________________ **Date** (ddmmyyyy) ____________

### DRUG ALLERGIES

Please specify ______________________

### Acknowledgement by examining doctor

Having conducted a personal examination and/ or procured the tests and/ or other diagnostic investigations referred to, I certify that the particulars are, to the best of my knowledge and belief, true and accurate. I acknowledge that Chronic Medicine Management will rely on such particulars when making any recommendations regarding the payment of ongoing/ chronic medication to Fedhealth Medical Scheme.

**This refers specifically to patient:**

**Surname** ______________________

**First name** ______________________

**DOCTOR'S SIGNATURE** ........................................ **Date** (ddmmyyyy) ____________

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ONLY COMPLETE THIS FORM FOR PATIENTS WITH HYPERLIPIDAEMIA

D

## TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (PLEASE PRINT USING BLOCK LETTERS)

## Motivation for a Lipid Modifying Agent for the treatment of Hyperlipidaemia

***In line with the requirements of the Government Risk Equalisation Fund (REF), the application can only be assessed on receipt of the completed form and copies of the relevant lipograms.***

***The reimbursement of lipid modifying therapy for primary prevention is reserved for patients with a greater than 20% risk of an acute clinical coronary event in the next 10 years. This funding decision is in accordance with local and international guidelines for the management of hyperlipidaemia.***

***Registered starting doses of lipid modifying drugs and incremental dosage increases will be considered. Higher dosages will be considered on motivation. Kindly consider a less costly alternative, e.g. generic simvastatin.***

### PATIENT'S DETAILS

**Patient's surname** ______ **Title** ______ **First name** ______

**Membership number** ______

**Date of birth** (ddmmyyyy) ______ **Gender** M F

**Height** ______ **cms** **Weight** ______ **kg** **Calculated BMI** ______ **Latest BP** / **mmHg** (sitting, having rested for 5 minutes)

**Requested drug and dose** ______

***Funding of Ezetimibe is limited to those very high risk patients not reaching an LDLC of ≤ 3.0mmol/l despite at least 2 months' compliance with maximum dose standard therapy e.g. rosuvastatin titrated to 40mg daily. Requests for the funding of ezetimibe must be accompanied by a motivation.***

**Risk factors** *(please indicate by ticking the appropriate box)*

| | Yes | No | Comment |
|---|---|---|---|
| Smoker | | | |
| Diabetes Mellitus | | | |
| Ischaemic Heart Disease (e.g. angina, myocardial infarct [MI]) | | | |
| Peripheral Vascular Disease (e.g. aortic aneurism) | | | |
| Stroke/ Transient Ischaemic Attacks (TIA) | | | |
| Renal Artery Stenosis | | | |

**History of fasting lipogram laboratory results** *(please indicate if the following results are pre-treatment or on treatment)*

| | Diagnosing lipogram (attach copy) | Lipogram on treatment (attach copy) | Lipogram on treatment (attach copy) |
|---|---|---|---|
| **Date** | | | |
| Lipid modifying drug & dosage | | mg/day | mg/day |
| Total cholesterol | | | |
| S-HDL | | | |
| S-LDL | | | |
| Total triglyceride | | | |
| TSH (where LDLC ≥ 4mmol/l) | | | |

### Familial hyperlipidaemia (FH)

**Diagnosed by an endocrinologist** yes no **Doctor's name** ______ **Practice number** ______

**Signs of FH (e.g. tendon xantomata)** ______

**Family history of premature atherosclerotic event in 1st degree relative** yes no

| | | |
|---|---|---|
| **Relative (e.g. father/ sister)** | | |
| **Description (e.g. MI/ stroke)** | | |
| **Age at time of event/ death** | | |

**DOCTOR'S SIGNATURE** ..................................................................................... **Date** (ddmmyyyy) ______