MEDICINE MANAGEMENT
CHRONIC MEDICINE BENEFIT APPLICATION

Telephone 0860 100 608

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

self med medical scheme

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 Medicine Benefit.

PRINCIPAL MEMBER'S DETAILS

Member's surname | Title | First name

Medical scheme | Membership number

Option/Plan

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 Solutio Medicine Management will be kept confidential. Solutio Medicine Management will use this information to, inter alia, determine access to the Chronic Medicine Benefit for reimbursement of ongoing essential medication, promote optimal treatment and act in accordance with the rules of the schemes 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 Solutio Medicine Management, the Scheme and/or its administrator. I agree that this authorisation and request shall remain in force after my/their deaths. I indemnify the 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 ..... Date (ddmmyyyy)
(not required if patient is a minor)

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 the specific medical scheme/option 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 Solutio Medicine Management will rely on such particulars when making any recommendations regarding the payment of ongoing/chronic medication to the relevant medical scheme.

This refers specifically to patient:

Surname _____

First name _____

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

ONLY COMPLETE THIS FORM FOR PATIENTS WITH HYPERLIPIDAEMIA

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**

Medical scheme | **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

Ezetimibe is only considered for funding where very high risk patients have not reached an LDLC of ≤ 3.0mmol/l despite at least 2 months' compliance with standard therapy e.g. simvastatin/atorvastatin titrated to 80/40mg respectively. 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)