APPLICATION FORM – CHRONIC MEDICINE BENEFIT 2019

1. Medication for all chronic conditions that are covered may be registered telephonically on **0800 132 345** (doctors and pharmacists only).
2. Alternatively, please complete this form to apply for Chronic Medicine Benefits. One form must be completed per patient.
3. Once the form has been completed, please email it to chronic@medikredit.co.za
4. Forms not completed in full will not be processed.
5. Section 1 of the application form must be completed by the member.
6. Sections 2 and 3 are for information purposes only and must not be sent back to us.
7. Sections 4-8 must be completed by your doctor.
8. Approval of any chronic condition and medicine is subject to clinical entry criteria and drug utilisation review.
9. Please attach copies of any reports to support the diagnosis of chronic conditions, where applicable.

1. PATIENT INFORMATION

Surname ______________________ Initials ______

Full Name(s) ______________________

RSA Identity No. ______________________ Gender (M=Male; F=Female) ___

Date of Birth ______________

Telephone:

Home Code ______ No. ______________ Cell No. ______________

Work Code ______ No. ______________ Fax Code ______ No. ______________

E-mail Address ______________________

I understand that my application will not be processed if the information on this form is incomplete or the relevant diagnostic results are not provided to Performance Health. I give permission to my doctor to provide Performance Health with my diagnosis and other relevant clinical information to review my application.

Patient Signature (unless a minor)	Principal Member Signature (only if patient is a minor)	Date

INSTRUCTION: To be taken to your doctor for information

These conditions are reimbursed on all options provided the Clinical Entry Criteria is met as indicated below.

2. CLINICAL ENTRY CRITERIA FOR THE PRESCRIBED MINIMUM BENEFITS (PMB) CHRONIC DISEASES

CDL Condition	Clinical Entry Criteria (*please include the ICD 10 code*)
Addison`s Disease	Diagnosis to be confirmed by an Endocrinologist, Paediatrician or Specialist Physician
Asthma	1. Diagnosis to be confirmed by a Pulmonologist, Paediatrician or Specialist Physician 2. Diagnostic Lung Function Test (pre- & post-bronchodilator) for children ≥7 years old and for all adults
Bipolar Mood Disorder	Diagnosis to be confirmed by a Psychiatrist
Bronchiectasis	Diagnosis to be confirmed by a Pulmonologist or Specialist Physician
Cardiac Failure	New York Heart Association stage required – please capture in Section 6
Cardiomyopathy	Subtype required – please capture in Section 6
Chronic Obstructive Pulmonary Disease (COPD)	1. Diagnosis to be confirmed by a Pulmonologist or Specialist Physician 2. Diagnostic Lung Function Test reflecting both pre- and post-bronchodilator FEV1 3. Motivation for oxygen use: FEV1 with oxygen saturation (arterial blood gas) & hours of oxygen needed /day
Chronic Renal Failure	1. Diagnostic Creatinine Clearance or estimated Glomerular Filtration Rate (eGFR) 2. Hb results and Iron studies required when applying for Erythropoietin
Coronary Artery Disease	Report with diagnostic findings required – e.g. ECG (exercise/stress), echocardiography, angiography, or details of cardiac event (ACS/MI/PCI/CABG, including date) – please use Section 6 to capture detail
Crohn`s Disease	Diagnosis to be confirmed by a Gastroenterologist, Surgeon or Specialist Physician
Diabetes Insipidus	Diagnosis to be confirmed by an Endocrinologist, Paediatrician or Specialist Physician
Diabetes Mellitus Type 1 & 2	Fasting Blood Glucose, and either the 2hr –OGTT, HbA1c (DCCT) or Random Blood Glucose result are required (laboratory report); motivation required if only one test result provided - please use Section 6
Dysrhythmias	Diagnosis to be confirmed by a Cardiologist or Specialist Physician
Epilepsy	Diagnosis to be confirmed by a Neurologist, Specialist Physician or Paediatrician, alternatively the seizure history or abnormal EEG report to be provided
Glaucoma	Diagnosis to be confirmed by an Ophthalmologist
Haemophilia (A & B)	1. Diagnosis to be confirmed by a Specialist Physician or Haematologist 2. Pathology report indicating factor VIII or IX levels
HIV/AIDS	Pathology report with positive ELISA result, $CD4^+$ count and Viral load (note that RNA Viral load is not diagnostic, as it is not specific to HIV)
Hyperlipidaemia – Refer to Section 5	1. Diagnostic Lipogram required – Should include Total Cholesterol, LDL, HDL and Triglyceride values 2. Familial Hyperlipidaemia requires an Endocrinologist diagnosis 3. Most recent Lipogram required should the dose increase or medicine change
Hypertension – Refer to Section 4	1. Two Diagnostic BP readings (3 or more months apart) required for newly diagnosed patients, unless diagnostic BP is ≥160/100 or significant CV risk factors present 2. Patients younger than 30 years must be diagnosed by a Cardiologist
Hypothyroidism	Diagnostic Thyroid function test results: TSH and FT4; Thyroid antibody tests in case of sub-clinical results
Multiple Sclerosis	1. Diagnostic confirmation from a Neurologist or Specialist Physician 2. The following information is required when applying for interferon beta / immunomodulators a. MRI reports b. Relapsing-remitting history(clinical presentation and dates) – please capture in Section 6 c. Extended Disability Status Score (EDSS) – please capture in Section 6 d. Relapses requiring cortisone therapy - please capture in Section 6
Parkinson's Disease	Diagnosis confirmation from a Neurologist or Specialist Physician, otherwise the diagnostic motor signs applicable to the patient to be listed in Section 6
Rheumatoid arthritis	1. Diagnosis confirmation from a Rheumatologist, Paediatrician or Specialist Physician 2. Alternatively, supporting pathology report (CRP/ESR and Rheumatoid factor) to be provided and clinical history confirming diagnosis, as well as treatment history, to be captured in Section 6
Schizophrenia	Diagnosis confirmation from a Psychiatrist
Systemic Lupus Erythematosus	Diagnosis confirmation from a Specialist Physician or Rheumatologist
Ulcerative Colitis	Diagnosis to be confirmed by a Gastroenterologist, Specialist Physician or Surgeon

INSTRUCTION: To be taken to your doctor for information

3. CLINICAL ENTRY CRITERIA FOR THE ADDITIONAL CHRONIC CONDITIONS (Only Option A eligible)	
Additional Chronic Condition	**Clinical Entry Criteria (*please include the ICD 10 code*)**
Acne	1. Diagnosis to be confirmed by a Dermatologist or GP 2. For Roaccutane and its generics the script must be from a Dermatologist
Allergic rhinitis	Diagnosis to be confirmed by an ENT, Paediatrician, Pulmonologist or Specialist Physician
Alzheimer's Disease	Diagnosis to be confirmed by a Psychiatrist or Neurologist. Mini mental (MMSE) report required.
Ankylosing Spondylitis	Diagnosis to be confirmed by a Specialist Physician or Rheumatologist
Attention Deficit Hyperactivity Disorder (ADHD)	Diagnosis to be confirmed by a Paediatrician, Psychiatrist or Neurologist
Cushing's Disease	Diagnosis to be confirmed by an Endocrinologist, Specialist Physician or Paediatrician
Cystic Fibrosis	Diagnosis to be confirmed by a Pulmonologist, Paediatrician or Specialist Physician
Gastro-Oesophageal Reflux Disease (GORD)	1. Standard dose PPIs only for 3 months, thereafter only low dose PPIs or H2-antagonists will be considered for maintenance treatment 2. Diagnostic gastroscopy reports required for double dose PPIs, and new / follow-up gastroscopy required for continuation of standard dose PPIs beyond 3 months
Gout – prophylaxis only	No colchicine, cortisone, NSAIDs or analgesics will be considered from the Chronic benefit
Hyperthyroidism	Thyroid Function Tests including TSH and T4 level required
Interstitial Fibrosis	1. Diagnosis to be confirmed by a Pulmonologist or Specialist Physician 2. Lung Function Test results required
Iron Deficiency Anaemia	Diagnostic and most recent laboratory report with FBC and Iron studies required
Major Depression	1. Diagnosis to be confirmed by a GP (adults only) or Psychiatrist 2. Only generic first line therapy (SSRIs or TCAs) will be reimbursed from the GP script 3. Psychiatrist / Paediatric Psychiatrist script required for patients younger than 18 years
Meniere`s Disease	Diagnosis to be confirmed by an ENT
Migraine Prophylaxis	Only preventative therapy will be reimbursed
Myasthenia Gravis	Diagnosis to be confirmed by a Neurologist
Osteoporosis	1. Diagnosis to be confirmed by a GP, Specialist Physician or Gynaecologist 2. DEXA Bone Mineral Densitometry (BMD) report (& X-ray report were applicable) required 3. Clinical history, including fractures, and risk factors required – please capture in Section 6
Peripheral Vascular Disease	1. Diagnosis to be confirmed by a GP, Specialist Physician or Vascular Surgeon 2. For a GP diagnosis a Doppler Ultrasound report is required 3. Ankle-Brachial Index or Rutherford stage required – please capture in Section 6

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RAND WATER
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Patient's Full Name

Patient's Surname

Membership Number

The section below must be completed by the relevant doctor:

4. APPLICATION FOR HYPERTENSION

1. ICD 10 Code ____________________
2. Height (cm) Waist circumference (cm) __________ Weight (kg)
3. Diagnostic BP (prior to drug therapy)
   i. Date ____________ / ____________ mmHg
   ii. Date ____________ / ____________ mmHg
4. When did the patient commence drug therapy for Hypertension?
5. Current blood pressure ____________ / ____________ mmHg
6. Please indicate below if there is target organ damage and / or cardiovascular disease:

- ☐ Angina
- ☐ Cardiac Failure
- ☐ CKD/ Microalbuminuria
- ☐ Hypertensive Retinopathy
- ☐ Left Ventricular Hypertrophy
- ☐ Myocardial Infarction
- ☐ Nephropathy / Microalbuminuria
- ☐ Peripheral Vascular Disease
- ☐ Prior CABG
- ☐ Prior Stent / Angioplasty / Angiogram
- ☐ Stroke / TIA

7. Is the patient currently smoking? Yes ☐ No ☐
8. Is there a family history of Arteriosclerotic disease? Yes ☐ No ☐

   If yes, please complete table under point 5 of Hyperlipidaemia (Section 5)

9. Please provide clinical information for use of drug classes that are not standard first or second line therapy (any drugs other than ACE-Is, CCBs and thiazides / thiazide-like diuretics) and please provide a motivation if a beta-blocker is prescribed for essential hypertension:

Patient's Full Name

Patient's Surname

Membership Number

The section below must be completed by the relevant doctor:

5. APPLICATION FOR HYPERLIPIDAEMIA

1. Please attach diagnosing lipogram as well as the most recent lipogram
2. ICD 10 Code ______________________________
3. Height (cm) Weight (kg)
4. Does the patient smoke?
5. Is there a family history of Arteriosclerotic disease?

If yes, please complete table below:

	Mother	Father	Sister	Brother
Event details				
Age at time of event				

6. When did the patient commence drug therapy for Hyperlipidaemia?
7. Current blood pressure ____________/ ____________mmHg (if not completed in Section 4)
8. Current fasting glucose ____________/ ____________mmol / L (Only for Primary Hyperlipidaemia)
9. TSH (Only for Primary Hyperlipidaemia)
10. Does the patient have Familial Hyperlipidaemia (FH)?

If yes, please list signs of FH in this patient:

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11. Please indicate whether application is for primary ☐ or secondary prevention ☐

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Patient's Full Name	
Patient's Surname	
Membership Number	

The section below must be completed by the relevant doctor:

6. ADDITIONAL CLINICAL INFORMATION
Please refer to Sections 2 and 3 for requirements relating to Clinical Entry Criteria.

Patient's Full Name

Patient's Surname

Membership Number

The sections below must be completed by the relevant doctor:

7. CURRENT MEDICINE DETAILS

Please refer to Sections 2 and 3 for information relating to Clinical Entry Criteria.

Diagnosis	ICD 10 Code	Date of Diagnosis	Medicine Name and Strength	Dosage/ Quantity per month	How long has the patient used this medicine		Repeats
					Years	Months	

8. DOCTOR DETAILS

Name

BHF Practice Number

Speciality ______________________

Telephone: Work

E-mail address: ______________________

Doctor's Signature ______________________ Date

1. Please ensure all relevant reports and / or tests are included with this application form.
2. For completion of this application form, use claim code 0199. Please remember to use the relevant ICD 10 code with the claim.
3. This form only needs to be completed when applying for a new chronic condition.
4. For any changes to the patient's medicine for approved conditions please call **0800 132 345.**