Pick n Pay

Medical scheme

APPLICATION FORM
MEDICINE RISK MANAGEMENT PROGRAMME

IMPORTANT TO NOTE:

- Please book time with your doctor to examine you and complete this form. The ideal person to do this is the general practitioner (GP) who regularly prescribes your medication. Please keep a copy of the completed form for your records.
- Members may obtain their approved chronic medication from one of the pharmacies on the Scheme's pharmacy network.
- Member/patient signature on this form is essential to process this application.
- You will be informed in writing, should you be accepted onto the Medicine Risk Management Programme. You will receive a chronic authorisation letter which will list the diagnosis you are registered for as well as the medication that will be paid from the chronic benefit subject to the rules of your benefit option.

HOW TO COMPLETE THIS FORM:

- Complete the form in black ink and print clearly, or complete the form digitally.
- Please sign and date any changes.
- Complete and sign sections 1.
- Take the application form to your attending doctor to complete from section 2 onwards, sign and attach any test results, clinical reports or other information that we need to review the request. These requirements are shown in section 4.
- Send the completed application form and all supporting documents by email to chronic@pnpms.co.za.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

1. MEMBER AND PATIENT INFORMATION

TO BE COMPLETED BY THE APPLICANT

MAIN MEMBER DETAILS

Membership number

Benefit option ☐ Primary Option ☐ Plus Option

Title | Initials | ID number

Full name and surname

Email address

PATIENT DETAILS

Dependant code

Title | Initials | ID number

Full name and surname

Contact numbers | Home | Work

Cell phone

Postal address

Postal code

Email address

Membership number | **Doctor's practice number**

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY THE APPLICANT (CONTINUED)

PATIENT CONSENT

I understand that Pick n Pay Medical Scheme and Momentum Health Solutions, the Administrator, will maintain the confidentiality of my personal information and comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing my personal information for the purposes of registration on the Medicine Risk Management Programme.

I understand that:

- Funding from the chronic benefit is subject to meeting benefit entry criteria requirements as determined by the Scheme.
- The chronic benefit provides cover for disease-modifying therapy only, which means that not all medication for a listed condition will automatically be covered by the chronic benefit.
- By registering for the chronic benefit, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.
- Funding for medication from the chronic benefit will only be effective once the Scheme receives an application form that is completed in full. Please refer to the table in Section 4 to see what additional information is required to be submitted for the condition(s) for which you are applying.
- Payment to the healthcare professional for the completion of this form, on submission of a claim, is subject to Scheme rules and where the member is a valid and active member at the service date of the claim.
- I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.
- To ensure that we pay your claims from the correct benefit, any claims from your healthcare providers must include the relevant ICD-10 diagnosis code(s). Please ask your doctor to also include the relevant ICD-10 diagnosis code(s) on the referral form for any pathology and/or radiology tests. This will enable the pathologists and radiologists to also include the relevant ICD-10 diagnosis code(s) on the claims they submit, thus further ensuring that we pay your claims from the correct benefit.

CONSENT FOR PROCESSING MY PERSONAL INFORMATION

1. I hereby acknowledge that Pick n Pay Medical Scheme has appointed Momentum Health Solutions (Pty) Ltd as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner. I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.
2. I hereby give my consent to the Scheme, Momentum Health Solutions and its employees to obtain my, or any of my dependants', special personal information (including general, personal, medical or clinical), whether it relates to the past or future (e.g. health and biometric) from any of my healthcare providers (e.g. pharmacist, pathologist, radiologist, treating doctor and/or specialist) to assess my medical risk, enrol me on the programme and to use such information to my benefit and to undertake managed care interventions related to my chronic condition(s).
3. I understand that this information will be used for the purposes of applying for and assessing my funding request for chronic benefits.
4. I give permission for my healthcare provider to provide the Scheme and the administrator with my diagnosis and other relevant clinical information required to review and process my application.
5. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical) to my healthcare provider, to administer the chronic benefits.
6. Whilst Momentum Health Solutions undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Scheme and my healthcare provider (where necessary) shall also gain access to the same information. I shall therefore not hold Momentum Health Solutions and its employees or the Scheme and its trustees, liable for any claims by me or my dependants arising from any unauthorised disclosure of my special personal information to other parties.
7. I understand and agree that special personal information relevant to my current state of health may be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

I hereby certify that the information provided in this application is true and correct.

Member/patient signature
(or signature of parent/ guardian if patient is under the age of 18)

Date
DD/MM/YYYY

Membership number

Doctor's practice number

2. MEDICAL PRACTITIONERS' INFORMATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS

Practice number

Initials | Speciality

Surname

Contact numbers | Work | Fax

Cell phone

Postal address

Postal code

Email address

ASSOCIATED SPECIALIST DETAILS

Practice number | Speciality

Full name and surname

Contact number

Email address

3. CLINICAL EXAMINATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Gender ☐ Male ☐ Female ☐ Other | Weight ____ kg | Height ____ cm

Blood pressure (on treatment) ____ / ____ mmHg | Blood pressure (off treatment) ____ / ____ mmHg

Smoking ☐ Never ☐ Ex-smoker ☐ <10 per day ☐ >10 per day

Exercise ☐ Never ☐ <1 hour per week ☐ 1-3 hours per week ☐ >3 hours per week

Allergies ☐ Penicillin ☐ Aspirin ☐ Sulphonamides

Other

Please indicate if the patient has a history of the following:

Ischaemic heart disease ☐ | Peripheral vascular disease ☐ | TIA/Stroke ☐

If the patient has diabetes, please provide the most recent HbA1c results and pre-treatment glucose results for first-time registration:

Please note: Prescribed Minimum Benefit rules, chronic disease lists and medication formularies applicable to your benefit option will apply. As per the requirements of the Government Risk Equalisation Fund (REF), in order to register patients on the Medicine Risk Management Programme, documentation from a relevant specialist and/or test results verifying the diagnosis, is required for, but is not limited to, the following:

- Chronic obstructive airways disease: Documentation of lung function tests (most recent)
- Chronic renal failure: Documentation of creatinine clearance or Glomerular Filtration Rate (GFR) estimate (most recent)
- Haemophilia: Factors VIII and IX blood levels
- Hyperlipidaemia: Pre-treatment lipogram
- Diabetes type 1 or 2 and/or second- or third-line drugs: HbA1c and motivation

Membership number | **Doctor's practice number**

3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

MEDICATION PRESCRIBED

Please indicate below where you agree to a generic substitution and provide your preferred medication name. Chronic medication is subject to formularies and generic reference pricing. **NOTE! If more space is required for the information in this table, please include an additional sheet with this application form.**

ICD-10 code(s)	Detailed diagnosis	Medication name and date started DD/MM/YYYY	Strength (e.g. 50mg)	Directions (e.g. 2tds)	Specialist's details (Practice number and name)	Treatment on previous medical scheme(s) for diagnosis* Yes/No?

***If you answer 'yes', please indicate the medical scheme name and supply proof of previous chronic registration.**

Additional information, special motivation and investigations:

Membership number **Doctor's practice number**

3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

MEDICATION STOPPED

ICD-10 code(s)	Diagnosis	Medication name (trade name or generic equivalent)	Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date medication stopped DD/MM/YYYY

PATIENTS WITH HYPERLIPIDAEMIA

ONLY COMPLETE THIS SECTION FOR PATIENTS WITH HYPERLIPIDAEMIA

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 atorvastatin.

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 two 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

	✓	Comment
Smoker	☐	
Diabetes type 1 with microalbuminuria or proteinuria (please supply supporting laboratory report)	☐	
Ischaemic heart disease (e.g. angina, myocardial infarction [MI])	☐	
Solid organ transplant (please supply relevant clinical information)	☐	

Membership number _____ **Doctor's practice number** _____

3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

Risk factors (continued)

	✓	Comment
Peripheral vascular disease (e.g. aortic aneurism)	☐	
Chronic renal disease (please supply supporting laboratory report reflecting creatinine clearance)	☐	
Stroke/transient ischaemic attacks (TIA)	☐	
Chronic renal disease (please supply supporting laboratory report reflecting creatinine clearance)	☐	
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)
Date (DD/MM/YYYY)		
Lipid-modifying drug and dosage (please indicate mg/day in each column)		
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 xanthomata)

Family history of premature atherosclerotic event in first-degree relative ☐ Yes ☐ No

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

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3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

Familial hyperlipidaemia (FH) (continued)

Any other relevant clinical information about this patient that supports the diagnosis of hyperlipidaemia:

4. CHRONIC REGISTRATION CLINICAL CRITERIA

Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL)	Benefit entry criteria requirements
Addison's disease	Diagnosis by a specialist physician, paediatrician, endocrinologist or by a State doctor
Asthma (adult)	Diagnosis confirmed by a GP or specialist
Asthma (child <7 years)	Diagnosis made or confirmed by specialist paediatrician
Bipolar mood disorder	A psychiatrist prescription. Benzodiazepines excluded on chronic benefit
Bronchiectasis	Diagnosis confirmed by a specialist (entry criteria for pre-existing conditions will apply e.g. COPD)
Cardiac failure	Diagnosis confirmed by a specialist physician
Cardiac dysrhythmia	Diagnosis confirmed by a specialist physician
Cardiomyopathy	Diagnosis confirmed by a specialist physician
Chronic obstructive pulmonary disease (COPD)	Diagnosis confirmed by a GP or specialist. Copy of lung function test performed to American Thoracic Society (or similar) criteria demonstrating FEV1/FVC post-bronchodilator values <70% and FEV1 post-bronchodilator <80% of predicted as per Risk Equalisation Fund (REF) criteria
Chronic renal disease	Diagnosis confirmed by a nephrologist or specialist physician. Copy of lab results required: serum creatinine clearance value or a glomerular filtration rate estimate of eGFR ≤60ml/min/1.73m²
Coronary artery disease	Diagnosis confirmed by a specialist physician or cardiologist
Crohn's disease	Diagnosis by a specialist physician, paediatrician, surgeon, gastroenterologist or by a provider employed by a State hospital. Endoscopy report with histology results (colonic disease). Small bowel disease: imaging studies. Lab results: FBC; ESR and CRP; stool culture
Diabetes insipidus	Diagnosis by a specialist physician, paediatrician, neurologist, neurosurgeon or endocrinologist with the relevant ICD-10 code(s)
Diabetes mellitus type 1	Specialist initiation and confirmatory lab results: • HbA1c >6.5% • x2 random glucose >11mmol/l • x2 fasting blood >7mmol/l • x1 blood glucose >15mmol/l • GTT (fasting glucose >7mmol/l and/or two hours post-prandial glucose load >11.1mmol/l)
Diabetes mellitus type 2	Diagnosis confirmed by a GP or specialist physician and confirmatory lab results as above
Epilepsy	New diagnosis confirmed by a specialist physician, neurologist, paediatrician or neurosurgeon
Glaucoma	Diagnosis confirmed by an ophthalmologist
Haemophilia	Diagnosis confirmed by a specialist physician. Copy of lab results of factor VIII or factor IX levels <5%
Hyperlipidaemia	Diagnosis confirmed by a GP or specialist physician. Copy of lipogram results and documentation related to the risk assessment (Framingham Risk Score). Details of patient history: established vascular disease and details of any procedure performed e.g. angioplasty, stent etc. Details of family history from prescribing doctor (to include details of cardiovascular events in member's first-degree relatives, including age of onset)
Hypertension	Diagnosis by a GP or specialist physician
Hypothyroidism	Diagnosis confirmed by a GP or specialist with relevant pathology

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4. CHRONIC REGISTRATION CLINICAL CRITERIA (CONTINUED)

Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL)	Benefit entry criteria requirements
Multiple sclerosis	Diagnosis to be confirmed by a specialist physician, neurologist or neurosurgeon. Motivation and tick sheet to be filled in by a neurologist
Parkinson's disease	Diagnosis confirmed by a neurologist with relevant ICD-10 code(s)
Rheumatoid arthritis	Diagnosis confirmed by GP and a tick sheet to be completed, or diagnosis confirmed by a specialist physician, paediatrician or rheumatologist. We also require the following clinical information: Serum rheumatoid factor (RF), anti-CCP, ESR or C-reactive protein (CRP) and relevant X-rays
Schizophrenia	Diagnosis confirmed by a psychiatrist or paediatric psychiatrist
Systemic lupus erythematosus	Diagnosis by a specialist physician, paediatrician or rheumatologist
Ulcerative colitis	Diagnosis by a specialist physician, surgeon or gastroenterologist. Colonoscopy report with histology results. Lab results: FBC, ESR and CRP; stool culture

Additional chronic conditions PLUS OPTION ONLY	Further information/tests required
Allergic rhinitis (hay fever)	ENT, paediatrician or physician. Prescription from a GP will be considered if condition is severe or associated with asthma
Alzheimer's disease	Psychiatrist/neurologist prescription and MMSE
Auto-immune haemolytic anaemia	Prescription with full blood count and iron studies not older than one month
Benign prostatic hypertrophy	Urologist prescription. GP prescription with PSA results
Cardiac arrhythmia	Cardiologist/physician's prescription
Cerebral aneurysm	Specialist prescription and motivation
Conn's Syndrome	Specialist prescription and motivation
Cushing's disease	Specialist prescription
Cystic fibrosis	Specialist prescription
Deep vein thrombosis (DVT)	Doctor's prescription
Gastro-oesophageal reflux disease (GORD)	Gastroscopy results required
Gout	Diagnosis confirmed by a GP or specialist
Major depression	Psychiatrist prescription. Benefits allocated for 12 months at a time. Benzodiazepines and sleeping tablets excluded on the chronic benefit
Menopause	Hormone profile for patients <50 years unless prescribed by a gynaecologist or hysterectomy done
Myasthenia gravis	Specialist prescription
Osteo-arthritis	GP or specialist prescription
Osteoporosis	DEXA scan results required indicating osteoporosis and fracture history if applicable
Paraplegia	Letter of motivation detailing clinical history from prescriber
Pemphigus	Dermatologist prescription
Peripheral vascular disease	GP or specialist prescription
Psoriasis	GP or dermatologist initiation
Scleroderma	Specialist prescription
Stroke (CVA/TIA)	Specialist prescription
Tuberculosis	GP or specialist prescription and diagnostic test results
Waldenström's syndrome	Specialist prescription and motivation
Wilson's disease	Specialist prescription and motivation

Membership number _____ **Doctor's practice number** _____

4. CHRONIC REGISTRATION CLINICAL CRITERIA (CONTINUED)

Non-Chronic Disease List (CDL) conditions PRIMARY OPTION ONLY	Further information/tests required
Acne	Prescription
Allergic rhinitis (hay fever)	Prescription and motivation required if steroid nasal spray and antihistamine being requested where there is no associated asthma
Depression	Prescription Benzodiazepines and sleeping tablets excluded on the chronic benefit
Dysrhythmias (non-PMB)	Prescription
Migraine	Prescription Only the prophylaxis is covered
Gout	Prescription
Menopause	Prescription
Osteo-arthritis	Prescription

Acknowledgement by attending doctor

Having conducted a personal examination and/or procured the tests and/or other diagnostic investigations referred to in this application, I, the undersigned, hereby certify that the particulars are true and correct to the best of my knowledge and belief. I acknowledge that Momentum Health Solutions will rely on such particulars when making any recommendations to Pick n Pay Medical Scheme regarding the payment of ongoing/chronic medication.

Attending doctor's signature

Date

DD/MM/YYYY

Membership number

Doctor's practice number