CHRONIC MEDICINE BENEFIT APPLICATION FORM – 2018

- Please complete the application in black ink
- One application form must be completed per patient
- Please attach a copy of the Dr's prescription to the application form (original not required)
- Applications will not be processed unless the appropriate sections are completed and relevant documents are attached. The completed and signed application form may be faxed to **086 679 1579,** emailed to nedgroup@scriptpharm.co.za or posted to Scriptpharm Risk Management, Postnet Suite No. 230 Private Bag x19 Garden View 2047
- Clinical entry criteria must be met before medication for Prescribed Minimum Benefit (PMB) or chronic conditions will be authorised. See Section H.
- **Please note that Chronic medication approved but not claimed for at least 6 consecutive months will be terminated and the member will have to re-apply for the benefit with all the relevant tests and a new application form.**
- **Contact the call centre on 011 100 7557 for further assistance**

SECTION A. PRINCIPAL MEMBER'S DETAILS

Membership Number | Scheme and Option

Surname

Title | Initials | Date of Birth (Y Y Y Y M M D D)

Telephone numbers Home ( ) | Work ( )

Cell | Fax ( )

Postal Address

Postal code

Email Address (will be treated as private)

SECTION B. PATIENT'S DETAILS

Surname | Title

Full first name | Dependant Code

Date of Birth (Y Y Y Y M M D D) | Gender (M/F)

Telephone numbers Home ( ) | Work ( )

Cell | Fax ( )

Email Address (will be treated as private)

Please ***circle*** the preferred method of communication (if patient is under the age of 16 years, communication will be sent to the main member)

Email Fax Post

Please ensure that relevant details have been provided for the communication option selected

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SECTION C. DECLARATION BY PATIENT *(or member if patient is a minor)*

I hereby authorise my doctor to furnish and/or disclose any relevant clinical information required to review my application. I understand that the application is subject to formulary guidelines as well as Scheme rules. I also understand that generic equivalents will be authorised where applicable and co-payments will apply if I choose not to accept the generic substitution.

I, as a member of the Scheme, understand and have agreed that all the personal and health information supplied by myself or on my behalf by my doctor, and in connection with my chronic application, may be used by Scriptpharm Risk Management team to assess my condition(s) and/or health status. In addition, my health status may be disclosed to my Medical Aid Scheme, Administrator and various other 3rd parties contracted to the Medical Aid Scheme, for purposes of analysis and/or registration on disease management and/or health programs supported and endorsed by the Scheme.

Patient signature (unless a minor) _____ Date Y Y Y Y M M D D

Patient name and surname _____

Membership number _____

SECTION D. CARDIOVASCULAR RISK (to be completed by doctor when applying for PMB benefits for hypertension, hyperlipidaemia, diabetes mellitus type 2 and cardiac failure)

Weight in kg _____ Patient height in metres _____ Body Mass Index _____

Does the patient smoke? Yes/No _____

Is microalbuminuria present or is the GFR less than 60ml/min? Yes/No _____

If there is target organ damage and/or cardiovascular disease, please tick the appropriate box

☐ Angina	☐ Myocardial Infarction	☐ Hypertensive Retinopathy
☐ Heart Failure	☐ Prior Stenting	☐ Left Ventricular Hypertrophy
☐ Prior CABG	☐ Cardiomyopathy	☐ Peripheral Arterial Disease
☐ Stroke	☐ Chronic Renal Disease	☐ Transient Ischaemic Attack

For cardiac failure, please provide either the NYHA classification: Class _____, or the stage of cardiac failure according to the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines: Stage _____

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SECTION E. APPLICATION FOR HYPERTENSION
Please complete in conjunction with Section D

A specialist must complete this section for patients below the age of 30 years diagnosed with hypertension

1. Current blood pressure _____/_____mmHg

2. When did the patient commence drug therapy for hypertension?

Y	Y	Y	Y	M	M	D	D

3. For all newly diagnosed patients and those diagnosed in the last 6 months, please supply the 2 initial blood pressure readings (before drug therapy), performed at least 2 weeks apart

Date _____ _____/_____ mmHg Date _____ _____/_____ mmHg

4. Please provide additional clinical information if there are compelling indications for use of drug classes that are not first or second line therapy, such as Angiotensin Receptor Blockers.

_____

_____

_____

_____

SECTION F. APPLICATION FOR HYPERLIPIDAEMIA
Please complete in conjunction with Section D

Please attach a copy of a recent full lipogram.

1. Please list the signs of Familial Hyperlipidaemia, if present _____

_____

2. Is there a family history of premature arteriosclerotic disease? Yes/ No _____
If the answer is YES, please provide the following details:

	Father	Mother	Sibling
Description of event			
Age at time of first event			

3. When did your patient commence drug therapy for hyperlipidaemia?

Y	Y	Y	Y	M	M	D	D

4. In terms of the European Guidelines adopted by the South African Heart Association, patients falling in the following categories are not required to be risk scored.
Please provide supporting clinical evidence or pathology results to confirm the health status of the patient.

1. Established atherosclerosis:
    a. Coronary Heart Disease
    b. Cerebrovascular atherosclerotic disease
    c. Peripheral vascular disease
2. Diabetes Type 2
3. Diabetes Type 1 with microalbuminuria or proteinuria

_____

_____

_____

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NEDGROUP MEDICAL AID SCHEME

5. For patients with ***primary hyperlipidaemia***, please assess your patient's risk using the following table. Kindly indicate the score by marking the appropriate percentage risk

Estimate of 10-year risk for ***MEN***

Age (years)	Points
20-34	-9
35-39	-4
40-44	0
45-49	3
50-54	6
55-59	8
60-64	10
65-69	11
70-74	12
75-79	13

Estimate of 10-year risk for ***WOMEN***

Age (years)	Points
20-34	-7
35-39	-3
40-44	0
45-49	3
50-54	6
55-59	8
60-64	10
65-69	12
70-74	14
75-79	16

Total Cholesterol (mmol/ L)	Points Age (years) 20-39	40-49	50-59	60-69	70-79
<4	0	0	0	0	0
4.1-5	4	3	2	1	0
5.1-6.2	7	5	3	1	0
6.21-7.2	9	6	4	2	1
≥7.2	11	8	5	3	1

	Points Age (years) 20-39	40-49	50-59	60-69	70-79
Non-smoker	0	0	0	0	0
Smoker	8	5	3	1	1

Total Cholesterol (mmol/ L)	Points Age (years) 20-39	40-49	50-59	60-69	70-79
<4	0	0	0	0	0
4.1-5	4	3	2	1	1
5.1-6.2	8	6	4	2	1
6.21-7.2	11	8	5	3	2
≥7.2	13	10	7	4	2

	Points Age (years) 20-39	40-49	50-59	60-69	70-79
Non-smoker	0	0	0	0	0
Smoker	9	7	4	2	1

Estimate of 10-year risk for ***MEN***

HDL (mmol/L)	Points
≥1.6	-1
1.30-1.59	0
1.00-1.29	1
<1	2

Estimate of 10-year risk for ***WOMEN***

HDL (mmol/L)	Points
≥1.6	-1
1.30-1.59	0
1.00-1.29	1
<1	2

Systolic BP (mmHg)	Points If untreated	If treated
<120	0	0
120-129	0	1
130-139	1	2
140-159	1	2
≥160	2	3

Systolic BP (mmHg)	Points If untreated	If treated
<120	0	0
120-129	1	3
130-139	2	4
140-159	3	5
≥160	4	6

Estimate of 10-year risk for ***MEN***

Total Points	10-year risk %
<0	<1
0	1
1	1
2	1
3	1
4	1
5	2
6	2
7	3
8	4
9	5
10	6
11	8
12	10
13	12
14	16
15	20
16	25
≥ 17	≥ 30

10-year risk _____%

Estimate of 10-year risk for ***WOMEN***

Total Points	10-year risk %
<9	<1
9	1
10	1
11	1
12	1
13	2
14	2
15	3
16	4
17	5
18	6
19	8
20	11
21	14
22	17
23	22
24	27
≥ 25	≥ 30

10-year risk _____%

Framingham scoring system for calculating the 10-year risk of major coronary events in adults without diabetes.

HDL denotes high-density lipoprotein cholesterol & BP blood pressure. All age ranges are given in years.
Reprinted from National Institutes of Health, National Heart, Lung and Blood Institute. Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation and Treatment of High blood cholesterol in Adults (Adult Treatment Panel III). Executive Summary. NIH Publication No. 01-3670; May 2001.

6. Based on the information supplied in Section F:
   - For patients **below** the age of **60** years: Does your patient have a 20% or greater risk of a coronary event in the next ten years? (Please circle Yes/No) **Yes** **No**
   - For patients **above** the age of **60**: Does your patient have a 30% or greater risk of a coronary event in the next ten years? (Please circle Yes/No) **Yes** **No**

We acknowledge that there are limitations to the Framingham Risk Assessment Score Chart. In order to assist with a funding decision, please motivate if you feel that your patient is negatively impacted by these limitations.

The PMB benefit will *not* provide cover in patients with less than a 20% (<60 years) or 30%(>60 years) risk of a coronary artery event within the next ten years. This is based on the local and international treatment guidelines and is in line with the Medical Scheme Council Clinical Algorithm. This is a funding decision, to ensure the long term sustainability of this benefit and does not in any way question your clinical decision.

SECTION G: APPLICATION FOR OSTEOPOROSIS (to be completed by Medical Practitioner. Please attach a BMD report)

Osteoporotic fracture: (Please circle Yes or No) **Yes** **No**	If yes, please supply date of most recent fracture:	Y	Y	Y	Y	M	M	D	D
Please indicate fracture location/s:									

SCRIPTPHARM RISK MANAGEMENT

NEDGROUP MEDICAL AID SCHEME

MEDICAL PRACTITIONER TO COMPLETE

MEDICAL PRACTITIONER'S DETAILS

Title | Initials

Surname

BHF Practice Number (***Not MP Number***)

Speciality

Telephone Number ( ) | Fax Number ( )

Email address

PATIENT'S DETAILS

Title | Initials | Surname

Membership Number | Dependant Code

MEDICATION AND CONDITION DETAILS
Please ensure that all fields are completed to avoid delays in processing

Please note that in terms of the Medical Schemes Act, Scriptpharm Risk Management will apply a formulary (available on www.scriptpharm.co.za). This is a funding decision to ensure the long-term sustainability of this benefit and does not question your clinical judgement.

Diagnosis	ICD10 code	Medication	Strength	Dosage/ Quantity per month	How long has your patient been on this medication?		Repeats
					Years	Months	

Please ensure that all requested documentation is supplied.

Signature of medical practitioner _____ **Date** Y Y Y Y M M D D

SCRIPTPHARM RISK MANAGEMENT

NEDGROUP MEDICAL AID SCHEME

SECTION H. PRESCRIBED MINIMUM BENEFITS: CLINICAL ENTRY CRITERIA

1. Please note that your application will not be processed if the requested information is not supplied
2. Some conditions may require completion of the form by a relevant specialist
3. Each time you register for **a new chronic disease**, the information in the following table is required.

Once registered for a chronic condition, you may be required to submit further documentation if your medication is changed.

	SUBMISSION REQUIREMENTS
a. Application for a change in medicine where you are currently registered for the same condition.	Section A, B and C and a copy of a valid prescription.
b. Application for medication for a second condition where you have already registered for a first.	Complete application form including clinical criteria and copy of valid prescription.
c. If the condition applied for was approved by your previous medical scheme, a report from your doctor stating the name of the condition, medication and duration of treatment is required.	Section A, B and C, a letter of motivation from the prescriber and a copy of a valid prescription.

PMB CONDITION	***CLINICAL ENTRY CRITERIA***
Addison's Disease	1. Serum cortisol levels a. ACTH stimulation test to distinguish primary from secondary adrenal insufficiency. The PMB is only applicable to primary Addison's disease b. A specialist physician, paediatrician or endocrinologist must make the diagnosis.
Asthma	1. The South African Treatment Guidelines for asthma will be used to assess all applications 2. Applications for leukotriene inhibitors (e.g. Montelukast) must be supported by a pre- and post lung function test to substantiate the additional benefit and must be from a Pulmonologist.
Bipolar Mood Disorder	A psychiatrist prescription and written diagnosis are required.
Bronchiectasis	Please attach a report based on the findings of a radiological examination (Chest X-ray or CT scan)
Cardiac Failure	1. Please indicate the level of functional incapacity according to the New York Heart Association's classification and/or 2. The stage of cardiac failure according to the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines (February 2002) Please record level/stage in Section D
Cardiomyopathy	The diagnosis must be confirmed by a specialist physician or cardiologist
Chronic Obstructive Pulmonary Disease (COPD)	Please attach a lung function test. The REF (risk equalisation fund) criteria are in line with the GOLD classification
Chronic Renal Disease	1. A specialist physician must complete the application 2. Indicate the creatinine clearance 3. When applying for erythropoetin, a report indicating haemoglobin, T_{sat} and ferritin levels must be provided. Please also state whether the patient is currently on or off drug therapy 4. A report indicating T_{sat} and ferritin must be provided when applying for iron supplementation
Coronary Artery Disease	Please attach a copy of the stress or exercise ECG report confirming the diagnosis of coronary artery disease
Crohn's Disease	The application form must be completed by a gastroenterologist or specialist physician. If the condition is managed by a general practitioner, a gastroenterologist must confirm the diagnosis

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PMB CONDITION	*CLINICAL ENTRY CRITERIA*
Diabetes Insipidus	1. An endocrinologist, specialist physician, paediatrician, neurologist or neurosurgeon must complete the application form 2. The results of a water deprivation test are required
Diabetes Mellitus Type I	Application form must be completed by a medical practitioner
Diabetes Mellitus Type II	Section D must be completed by a medical practitioner. Blood results required.
Dysrhythmias	The medical practitioner must indicate the ICD 10 code from a Cardiologist or Specialist Physician.
Epilepsy	1. Please attach a detailed seizure history 2. Please attach an EEG report confirming the diagnosis of epilepsy
Glaucoma (open and closed angle)	Please provide the intra-ocular pressure at diagnosis. This is only required for newly diagnosed patients
Haemophilia	Haemophilia A: Please provide the Factor VIII level as a % of normal Haemophilia B: Please provide the Factor IX level as a % of normal
Hyperlipidaemia	Please attach a copy of the diagnosing (for primary hyperlipidaemia) or current (for secondary hyperlipidaemia) lipogram. The medical practitioner must complete Sections D and F of the application form.
Hypertension	Section D and E of the application form must be completed by the medical practitioner
Hypothyroidism	Please attach the diagnostic report that confirms the initial diagnosis of hypothyroidism
Multiple Sclerosis	1. A specialist physician or neurologist must complete the application form and indicate the specific type of multiple sclerosis 2. Please provide the following information when applying for chronic medicine benefits for inteferon: a) Extended disability status score (EDSS) b) Relapsing-remitting history c) Number of relapses requiring IV cortisone treatment
Parkinson's Disease	Applications for non-formulary products will only be considered if prescribed by a neurologist, or if the application is supported by a neurologist's motivation
Rheumatoid Arthritis	1. Copies of the relevant blood test reports and supportive clinical history confirming the diagnosis of rheumatoid arthritis are required 2. Applications for COXIBs must be supported by a motivation indicating the risk factors considered for their use over conventional anti-inflammatories 3. Applications for anti-inflammatories as monotherapy **MUST** be motivated by a rheumatologist
Schizophrenia	A psychiatrist prescription and written diagnosis is required
Systemic Lupus Erythematosus (SLE)	A rheumatologist, specialist physician or paediatrician must complete the application form and indicate the diagnostic criteria used
Ulcerative Colitis	A gastroenterologist or specialist physician must complete the application form. If the condition is managed by a general practitioner, a gastroenterologist or specialist physician must confirm the diagnosis

SECTION I. NON-PRESCRIBED MINIMUM BENEFITS CHRONIC DISEASES	
CHRONIC CONDITION	***CLINICAL ENTRY CRITERIA REQUIREMENTS***
Acne (Cystic nodular only)	For isotretinoin therapy, the patient's weight, date of commencement with treatment and duration of therapy is required.
Allergic Rhinitis	Only covered in children under the age of 12 years, or in patients on concurrent asthma therapy.
Alzheimer's Type Dementia	Please submit the results of a mini-mental state examination (MMSE)
Anxiety	Only reviewed if member is approved for a PMB/Chronic psychiatric condition
Attention Deficit Disorder (ADHD or ADD)	A paediatrician, psychiatrist or neurologist must complete the application form. This condition will only be covered in patients under the age of 18 years.
Behcet's Disease	A Specialist must complete the application form.
Eczema	No clinical entry criteria. (Subject to formulary)
Hypopituitarism	A Specialist or Endocrinologist must complete the application form. Basal / Stimulation test results required.
Major Depression	First-line therapy will be funded from a GP for 6 months, pending review from a Psychiatrist. An initial Psychiatrist's prescription is required for all other anti-depressants and mood stabilisers.
Gastro-oesophageal Reflux Disease (GORD)	Gastroscopy report, including the Los Angeles Grading is required. Generic omeprazole, cimetidine or ranitidine will be funded. Please submit a detailed, clinically relevant motivation for other products.
Gout	No clinical entry criteria. (Subject to formulary)
Insomnia	Only reviewed if member is approved for a PMB/Chronic psychiatric condition
Migraine	Only prophylaxis will be covered
Obsessive Compulsive Disorder	A Psychiatrist must complete the application form.
Osteoarthritis	Applications for COXIBs must be supported by a motivation indicating the risk factors considered for their use over conventional anti-inflammatories
Osteoporosis	1. Applications must include a DEXA bone mineral density scan (BMD) report 2. A short report on additional risk factors must be included (e.g. previous fractures, family history, long term oral corticosteroid use). Please complete Section G 3. An endocrinologist motivation is required for males, females under the age of 30, and children.
Paget's Disease	A Specialist must complete the application form.
Psoriasis	A Dermatologist must complete the application form.
Sjogrens Disease	A Specialist must complete the application form.

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