NEDGROUP MEDICAL AID SCHEME

Scriptpharm RISK MANAGEMENT

CHRONIC MEDICINE BENEFIT APPLICATION FORM

WHO SHOULD COMPLETE THIS APPLICATION?

- The patient should complete Part 1 of this form. Should the treating doctor complete Part 1 on behalf of the patient, the patient must sign the DECLARATION BY PATIENT at the bottom of page 2.
- Where required (see table below), the relevant medical practitioner should complete Part 2 and arrange for additional requirements. For specific conditions only certain specialists can apply – please check the Clinical Entry Criteria annexures at the end of this document to ensure the relevant medical practitioner completes Part 2.

HOW SHOULD THIS APPLICATION BE COMPLETED AND RETURNED?

- Preferably complete and sign this application electronically (you can find more information about signing PDF documents electronically here) and email to Scriptpharm.
- If you are unable to sign electronically, please print, sign, scan and email the application form, together with the electronically completed PDF document, to Scriptpharm.
- Only in exceptional circumstances print and complete the entire form (excluding the Clinical Entry Criteria annexures on pages 7-8) by hand, in black ink, and email a scanned copy, or fax it to Scriptpharm. Note that this may result in input errors, and slow down your application.
- **Email:** nedgroup@scriptpharm.co.za | **Fax:** 086 679 1579

IDENTIFY YOUR SITUATION	DO THE FOLLOWING
This is a **first-time registration** with the NMAS Chronic Medicine Management (CMM) programme.	• Check whether the condition for which you want to register is covered on your Plan – see tables on pages 4-5. • Complete Part 1. • Get your doctor to complete Part 2 and to submit the required documentation.

I am already registered on the CMM programme and want to apply for -

- a **dosage or strength adjustment** to my current medicine for a registered condition.	• The pharmacy or your treating doctor can simply call Scriptpharm on 011 100 7557 to implement the change.
- a **change in medicine** for a registered condition.	• Please submit the updated prescription to Nedgroup@scriptpharm.co.za
- a **further chronic condition** that is **NOT hypertension or hyperlipidaemia**.	• Check whether the condition for which you want to register is covered on your Plan – see tables on pages 4-5. • Submit a copy of a valid prescription.
- medicine for **hypertension and/or hyperlipidaemia**.	• Complete Part 1. • Get your doctor to complete Part 2 and to submit the required documentation.

I am a **new member** and want to register a condition that was approved by my **previous medical scheme**.	• Check whether the condition for which you want to register is covered on your Plan – see tables on pages 4-5. • Complete Part 1. • Submit with a letter of motivation from the prescriber, letter of authorisation from your previous medical scheme, and a copy of a valid prescription. • A report from your doctor stating the name of the condition, medication and duration of treatment is also required.

WHAT IF I NEED HELP WITH, OR HAVE QUESTIONS ABOUT, THIS APPLICATION OR MY CHRONIC MEDICINE?

You can email Scriptpharm at nedgroup@scriptpharm.co.za, or call 011 100 7557.

PLEASE NOTE:

- **Applications will only be processed if the appropriate sections have been completed and once all relevant documents have been submitted. Clinical Entry Criteria (see annexures on page 9-10) must be met before medication for the listed chronic conditions will be authorised.**
- **Approved chronic medication which has not been claimed for in the last 6 consecutive months will be terminated and the member will have to re-apply for the benefit, with all the relevant tests accompanying a new application form.**

PART 1: TO BE COMPLETED BY THE PATIENT (or member, if patient is a minor)

One application form must be completed per patient.

PRINCIPAL MEMBER'S DETAILS (only complete this section if the patient is a minor)

Membership number | NMAS Plan

Surname

Full first names

Title | Initials | Date of birth *(YYYY/MM/DD)*

Telephone numbers Home | Cell

Work | Fax

E-mail address (will be treated as private)

Postal address | Code

PATIENT'S DETAILS

Membership number | Dependant code | NMAS Plan

Surname

Full first names | Title

Date of birth *(YYYY/MM/DD)* | Gender ☐ Male ☐ Female

Telephone numbers Home | Cell

Work | Fax

Email address (will be treated as private)

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 above for the communication option selected.

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 relation with my chronic application, may be used by the Scriptpharm Risk Management team to assess my condition(s) and/or health status. In addition, my health status may be disclosed to the Scheme, Administrator and various other 3rd parties contracted to the Scheme, for purposes of analysis and/or registration on disease management and/or health programs supported and endorsed by the Scheme.

I understand that approved medicines must be obtained from a **Nedgroup Network Pharmacy** and that if I obtain PMB medication from any other pharmacy, I will incur a 25% co-payment, whereas for non-PMB chronic medication, even if authorised, I will be fully liable. I further understand that if I am on the **Hospital Network Plan**, Pharmacy Direct (courier pharmacy) has been appointed as the sole Designated Service Provider for chronic medication supply and that if I obtain approved PMB medication from any other pharmacy – even if it is part of the Nedgroup Network – I will incur a 25% co-payment, while for non-PMB chronic medication, I will be fully liable.

Patient name and surname

Patient signature
(unless a minor/ elderly patient who cannot manage their own health)

Membership number

Date

PART 2: TO BE COMPLETED BY MEDICAL PRACTITIONER (MP)

A: MEDICAL PRACTITIONER'S DETAILS

Title | Initials | Surname

BHF Practice Number (not MP Number)

Speciality

Telephone number | Fax

Email address

Signature of Medical Practitioner | Date

B: CHRONIC CONDITION(S) FOR WHICH APPLICATION IS MADE

PMB CONDITIONS – covered on all Plans

Tick relevant condition(s) below. Unless specified otherwise, **refer to Annexure I for specific requirements** and **complete C** for all conditions in this table.

- ☐ Addison's disease
- ☐ Asthma
- ☐ Bipolar mood disorder
- ☐ Bronchiectasis
- ☐ Cardiac failure (Also complete D.)
- ☐ Cardiomyopathy
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Chronic renal disease
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Diabetes insipidus
- ☐ Diabetes mellitus type 1
- ☐ Diabetes mellitus type 2 (Also complete D.)
- ☐ Dysrhythmias
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Haemophilia
- ☐ Hyperlipidaemia (high cholesterol - also complete D and F.)
- ☐ Hypertension (high blood pressure - also complete D and E.)
- ☐ Hypothyroidism
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Rheumatoid arthritis
- ☐ Schizophrenia
- ☐ Systemic lupus erythematosus
- ☐ Ulcerative colitis

ADDITIONAL SCHEME-APPROVED CHRONIC CONDITIONS ON CERTAIN PLANS

Tick relevant condition(s) below. Unless specified otherwise, **refer to Annexure II for specific requirements** and **complete C** for all conditions in this table.

Only available on **Platinum, Comprehensive, Traditional** and **Savings** Plans

- ☐ Acne (cystic nodular)
- ☐ Allergic rhinitis
- ☐ Anxiety
- ☐ Attention deficit disorder (ADHD or ADD)
- ☐ Behcet's Disease
- ☐ Depression/Mood disorders
- ☐ Eczema (Just complete C.)
- ☐ GORD
- ☐ Gout (Just complete C.)
- ☐ Hypofunction of the pituitary gland
- ☐ Insomnia (sleep disorders)
- ☐ Migraine prophylactics (Just complete C.)
- ☐ Obsessive Compulsive Disorder
- ☐ Paget's Disease
- ☐ Psoriasis
- ☐ Sjogren's Disease

Only available on **Platinum, Comprehensive** and **Traditional** Plans

- ☐ Alzheimer's disease
- ☐ Chronic sinusitis
- ☐ Chronic urological infections (cystitis & UTI)
- ☐ Osteoarthritis
- ☐ Osteoporosis

C: MEDICATION PROPOSED FOR DIAGNOSED CONDITION

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

In terms of the Medical Schemes Act 131 of 1998, 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 the judgement of the medical practitioner.

D. CARDIOVASCULAR RISK

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
☐ Cardiac 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 _____.

E. HYPERTENSION

Current blood pressure / mmHg

When did the patient commence drug therapy for hypertension? *(YYYY/MM/DD)*

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 *(YYYY/MM/DD)* / mmHg

Date *(YYYY/MM/DD)* / mmHg

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.

F. HYPERLIPIDAEMIA

Please list signs of Familial Hyperlipidaemia, if present:

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			

When did your patient commence drug therapy for hyperlipidaemia? *(YYYY/MM/DD)*

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. However, 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

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 at the bottom.

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

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

Smoking	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

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

Total Cholesterol	Points				
	Age (years)				
(mmol/ L)	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

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

Patient's 10-year Risk %

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

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

Smoking	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

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

Total Cholesterol	Points				
	Age (years)				
(mmol/ L)	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

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

Patient's 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.

Based on the information supplied above:

- **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? ☐ 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? ☐ 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.

CLINICAL ENTRY CRITERIA

THE FOLLOWING ANNEXURES ARE FOR INFORMATIONAL PURPOSES ONLY AND DO NOT NEED TO BE RETURNED WITH PRINTED AND SCANNED APPLICATIONS.

ANNEXURE I: PRESCRIBED MINIMUM BENEFITS (PMB) CONDITIONS COVERED ON ALL PLANS	
Addison's Disease	Serum cortisol levels • ACTH stimulation test to distinguish primary from secondary adrenal insufficiency. The PMB is only applicable to primary Addison's disease. • A specialist physician, paediatrician or endocrinologist must make the diagnosis.
Asthma	• The South African Treatment Guidelines for asthma will be used to assess all applications. • 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	• Please indicate the level of functional incapacity according to the New York Heart Association's classification and/or • Please record the level/stage of cardiac failure according to the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines (February 2002) 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	• A specialist physician must complete the application. • Indicate the creatinine clearance. • When applying for erythropoietin, a report indicating haemoglobin, Tsat and ferritin levels must be provided. Please also state whether the patient is currently on or off drug therapy. • A report indicating Tsat 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.
Diabetes Insipidus	• An endocrinologist, specialist physician, paediatrician, neurologist or neurosurgeon must complete the application form. • The results of a water deprivation test are required.
Diabetes Mellitus Type I	The application form must be completed by a medical practitioner.
Diabetes Mellitus Type II	Blood results are required.
Dysrhythmias	The medical practitioner must indicate the ICD 10 code from a cardiologist or specialist physician.
Epilepsy	• Please attach a detailed seizure history. • Please attach an EEG report confirming the diagnosis of epilepsy.
Glaucoma (open and closed angle)	The application form must be completed by an ophthalmologist. For newly diagnosed patients, please provide the intra-ocular pressure at diagnosis.
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.
Hypertension	For patients below the age of 30 years a specialist must complete section E.
Hypothyroidism	Please attach the diagnostic report that confirms the initial diagnosis of hypothyroidism.
Multiple Sclerosis	• A specialist physician or neurologist must complete the application form and indicate the specific type of multiple sclerosis. • Please provide the following information when applying for chronic medicine benefits for Interferon: 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	• Copies of the relevant blood test reports and supportive clinical history confirming the diagnosis of rheumatoid arthritis are required. • Applications for COXIBs must be supported by a motivation indicating the risk factors considered for their use over conventional anti-inflammatories. • Applications for anti-inflammatories as monotherapy MUST be motivated by a rheumatologist.
Schizophrenia	A psychiatrist prescription and written diagnosis are 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.

ANNEXURE B: ADDITIONAL (NON-PMB) CHRONIC CONDITIONS COVERED ON SPECIFIC PLANS	
Acne (cystic nodular only)	For Isotretinoin therapy, the patient's weight, date of commencement with treatment and duration of therapy is required.
Allergic Rhinitis	Under the Savings Plan, Allergic Rhinitis will only be covered in children under the age of 12 years, or in patients on concurrent asthma therapy.
Alzheimer's Disease	Please submit the results of a mini-mental state examination (MMSE).
Anxiety	Only considered 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.
Chronic Urological Infections	Chronic urological infections, which includes cystitis and urinary tract infection, will be considered. No clinical entry criteria. (Subject to formulary.)
Chronic Sinusitis	No clinical entry criteria. (Subject to formulary.)
Eczema	No clinical entry criteria. (Subject to formulary.)
Hypopituitarism	A specialist or endocrinologist must complete the application form. Basal / stimulation test results are required.
Major Depression	First-line therapy from a GP will be funded 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)	A 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	• Applications must include a DEXA bone mineral density scan (BMD) report. • A short report on additional risk factors must be included (e.g., previous fractures, family history, long-term oral corticosteroid use). • An endocrinologist motivation is required for females under the age of 30, males, 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.