PROVIDENCE
Healthcare Risk Managers

CHRONIC MEDICATION BENEFIT APPLICATION FORM

A. IMPORTANT INFORMATION

1. One application must be completed per beneficiary applying for chronic medication.
2. Allow **5 working** days for the processing of your application.
3. The original prescription must be given to the provider who dispenses your medication.
4. It is essential that you submit all required information correctly and timeously as incomplete forms will not be processed.
5. Approval of chronic medication is subject to the rules of the Scheme and PROVIDENCE Chronic Protocols
6. Some medication may be subject to the PROVIDENCE Chronic Value (PCV) which is a reference price for specific drug classes
7. You may contact the Pharmacy Benefit Management (PBM) Team at (**041) 395 4482** or email **pbm@providence.co.za**
8. Send completed forms via fax **086 680 8855**, mail **PO Box 1672, Port Elizabeth, 6000** or e-mail **pbm@providence.co.za**

B. MEMBER DETAILS

Scheme and Plan

Membership Number | Suffix (if available)

Surname | First Names

Title | Date of Birth (Y Y Y Y M M D D) | ID Number

Telephone number (Home) | (Work)

Fax number (Confidential) | Cellular

Email address (Confidential)

Postal Address

Code

C. PATIENT DETAILS (Beneficiary who requires Chronic Medication)

Surname | First Names

Title | Date of Birth (Y Y Y Y M M D D) | ID Number

Telephone number (Home) | (Work)

Fax number (Confidential) | Cellular

Email address (Confidential)

D. PATIENT DECLARATION

By signing below, I hereby give permission for, acknowledge and/or agree to the following:

- my (or my minor dependant's) doctor may provide clinical information regarding my/minor's condition to the PBM Team;
- the successful approval of the Chronic Medication Benefit shall be subject to certain clinical criteria and formularies;
- it may be a pre-condition to the approval of the Chronic Medication Benefit that I register and comply with the requirements of a Disease Management Programme and that non-compliance may lead to the withdrawal of this benefit;
- my (or my minor dependant's) doctor retains the responsibility for my (or my minor dependant's) condition, based on the understanding that the I (or my minor dependant) also has a responsibility towards my (or my minor dependant's) own health concerns, irrespective of the outcome of this application;
- the medication prescribed by my (or my minor dependant's) doctor may be substituted with an alternative medication provided it is of better or equal quality and efficacy to the medication prescribed and that the doctor has approved the substitution in the case of therapeutic equivalents; and
- any information concerning this application will remain confidential at all times.

Patient Signature (or member if patient is a minor) _____ Date (Y Y Y Y M M D D)

E. PATIENT HEALTH INFORMATION (to be completed by attending doctor)

Weight (kg) | Height (m) | Hip/Waist ratio | Smoker? (Y N) | Ave per day

Exercise: Frequency (X per week) | Intensity (Please tick) | Low | Medium | High

Current blood pressure (mmHg) | Fasting Blood Glucose (If available) (mmol/L)

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Patient name and membership number	

F. CLINICAL CRITERIA

The following information is required when applying for a new chronic condition

Certain conditions which do not appear on the form below may be considered for approval on the Chronic Benefit, although not all long-term conditions, which a doctor may define as chronic, will fulfil the criteria for approval.

* Chronic conditions which may only be available on certain plans

Condition	Requirements
Addison's Disease	1. Serum Cortisol Test 2. ACTH Stimulation Test 3. Initial Specialist Application
ADHD *	1. Initial Specialist Application 2. Motivation if > 12 years 3. Initial Specialist Application
Alzheimer's Disease*	1. Folstein's Mini Mental Examination State (MMSE) result. 2. Initial Specialist Application
Ankylosing Spondylitis*	1. Initial Specialist Application
Asthma	1. Lung function test (8 yrs and older)
Benign Prostatic Hypertrophy*	1. Motivation for 2nd line agents (E.g. Avodart®, Flomax® and Xatral®)
Bipolar Mood Disorder	1. Specialist to complete Section J
Bronchiectasis	1. Attach relevant radiology report 2. Initial Specialist Application
Cardiac failure	1. Please classify according to NYHA or ACC-AHA Classification
Cardiomyopathy	1. Details of diagnosing specialist to be supplied
Chronic Obstructive Pulmonary Disease	1. Lung function test including FEV1/FVC and FEV1 post bronchodilator
Chronic Renal Disease	1. Serum Creatinine Clearance 2. Initial Specialist(Nephrologist) Application
Coronary Artery Disease	1. Stress ECG confirming diagnosis 2. Attach history of previous cardiovascualr disease event(s)
Crohn's Disease	1. Details of diagnosing specialist to be supplied
Cystic Fibrosis	1. Details of diagnosing specialist to be supplied
Depression	1. Prescriber to complete Section J
Diabetes Insipidus	1. Water deprivation test results 2. Initial Specialist Application
Diabetes Mellitus	1. Attach initial diagnostic report
Dysrhythmias	1. Prescriber to clearly indicate ICD-10 code
Epilepsy	1. EEG report confirming diagnosis 2. Attach detailed seizure history
Generalised Anxiety Disorder*	1. Specialist motivation required for treatment exceeding a 6 month period
Glaucoma	1. Supply initial diagnostic intra-ocular pressure
GORD*	1. Diagnostic Gastroscopy or Barium Meal Swallow report
Haemophilia	1. Haemophilia A (Factor VIII as % of Normal) 1. Haemophilia B (Factor IX as % of Normal)
Hyperlipidaemia	1. Prescriber to complete Section G and I
Hypertension	1. Prescriber to complete Section G and H 2. Initial Specialist Application if younger than 30 years
Hyperthyroidism	1. Attach report showing T3, T4 and TSH levels
Hypothyroidism	1. Attach initial diagnostic report
Menopause*	1. Motivation required for early-onset menopause (< 40yrs) and the prescription of Livifem ®
Multipile Sclerosis	1. Extended disability status Score (EDSS) 2. Comprehensive disease history 2. Initial Specialist Application
Osteoporosis*	1. DEXA bone mineral density (BMD) scan and report on any additional risk factors
Parkinson's Disease	1. Initial Specialist Application
Rheumatoid Arthritis (RA)	1. Initial diagnostic test results confirming RA may be required where a "stepped therapy" approach has not been implemented. 2. Initial Specialist Application and motivation for Enbrel® and Revellex®
Schizophrenia	1. Psychiatrist to complete Section J
Systemic Lupus Erythematosus	1. Initial Specialist Application
Ulcerative Colitis	1. Details of diagnosing specialist to be supplied

Patient name and membership number

G. CARDIOVASCULAR (to be completed by doctor when applying for hypertension, hyperlipidaemia or diabetes mellitus)

Is the patient (if female) post-menopausal? Y N

Is Microalbuminuria present? Y N

Is GFR less than 60ml/min? Y N

Please indicate which of the following co-morbities/risk factors apply to this patient?

Peripheral arterial disease		Nephropathy		Retinopathy		Heart Failure	
Left ventricular hypertrophy		Chronic renal disease		Cardiomyopathy		Prior stroke/TIA	
Prior myocardial infarction		Prior Coronary Artery Bypass Graft (CABG)		Prior Stent		Angina	

If Heart failure is present, please indicate classification below:

NYHA/ACC-AHA Classification A B/I(Mild) C/II(Mild)-III(Moderate) D/IV(Severe)

Ref: De Marco T, Delgado RM III, Agocha A. et al. J Cardiac Fail. 2004;10

H. HYPERTENSION (to be completed by attending doctor when applying for hypertension)

Please supply two blood pressure readings, performed at least two weeks apart before intiating drug therapy, for newly diagnosed patient

1) Y Y Y Y M M D D mmHg 2) Y Y Y Y M M D D mmHg

I. HYPERLIPIDAEMIA (to be completed by attending doctor when applying for hyperlipidaemia)

Please attach a copy of the initial diagnosing lipogram (primary hyperlipidaemia)

Is there a family history of early-onset arteriosclerotic disease? Y N

If yes, please provide details below:

Does the patient suffer from familial hyperlipidaemia? Y N

If yes, please indicate the signs below?

Family history of disorder/ heart attack at early age | High LDL levels (Treatment resistant) | Tendon Xanthoma

Other

Please risk your patient as per the Framingham coronary prediction algorithm %

J. PSYCHIATRIC CONDITIONS (to be completed by doctor when applying for psychiatric disorders)

Please indicate DSM IV Diagnosis

Please indicate number of relapses

K. ADDITIONAL NOTES

Patient name and membership number

L. MEDICAL PRACTITIONER DETAILS

Surname Initials

Practice number Speciality

Telephone number Cellular

Fax number (Confidential)

Email address (Confidential)

M. CONDITION AND MEDICATION DETAILS (to be completed by attending doctor)

ICD-10 Code	Medication prescribed (Name, strength & dosage)	Date Medication initiated & prescriber details	Repeats

Signature of Medical Practitioner ______________________ Date Y Y Y Y M M D D

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