ONLY COMPLETE THIS FORM IF YOU ARE A FULLY REGISTERED MEMBER OF GEMS

MEDICINE MANAGEMENT
CHRONIC MEDICINE BENEFIT APPLICATION

Please FAX completed form to: 086 651 8009 **Or mail to:** PO Box 38632, Pinelands, 7430
Member telephone: 0860 004 367 **Provider telephone:** 0860 100 608

gems
Government Employees Medical Scheme

A. TO BE COMPLETED BY THE MEMBER (PLEASE PRINT USING BLOCK LETTERS)

Please book at least 30 minutes with your doctor in order for him/her to examine you and complete this form. The ideal person to do this is the registered doctor who regularly prescribes your medication. Please keep a copy of the completed form for your records. **Member/patient signature is essential to process this application.**

Should you be accepted onto the Chronic Medicine Management programme, you will be informed in writing. You will receive a medicine "Access Card", which lists the medicine to be paid from the Chronic Medicine Benefit.

PRINCIPAL MEMBER'S DETAILS

Member's Surname		Title		First Name	
Medical Scheme	GEMS			Membership Number	
Option/Plan					

PATIENT'S DETAILS (IF NOT THE SAME AS THE PRINCIPAL MEMBER)

Patient's Surname		Title		First Name	
ID Number		Date of Birth	D D M M Y Y Y Y	Beneficiary Code	
Telephone Numbers and Code (H)	( )			(W)	( )
	Fax ( )			Cell	
Postal Address				Code	
E-mail Address					

MEDIPOST – GEMS's CHRONIC MEDICINE DELIVERY SERVICE PROVIDER
Chronic medicine dispensed by Medipost will not attract the co-payment stipulated in the GEMS scheme rules.

I agree to use Medipost: yes no If **yes** selected – please complete Section E and attach a valid repeatable prescription to form.

- I/we understand that all personal and clinical information supplied to the GEMS Medicine Management Programme will be kept confidential. The GEMS Medicine Management Programme will use this information to, inter alia, determine access to the Chronic Medicine Benefit for reimbursement of ongoing essential medication, promote optimal treatment and act in accordance with the rules of the scheme and the provisions of the Medical Schemes Act, Act 131 of 1998 (as amended). Medical staff will review this information in order to make informed recommendations regarding the provision of these benefits. Your medical practitioner, however, retains the ultimate responsibility for his or her patient, irrespective of benefits so authorised.
- I/we therefore authorise any healthcare professional, hospital, clinic and/or medical facility in possession of, or may hereafter acquire, any medical information regarding myself, the applicant, and any dependant, whether such information relates to the past or future, to disclose such information to the GEMS Medicine Management Programme, the Scheme and/or its administrator. I agree that this authorisation and request shall remain in force after my/their deaths. I indemnify the Scheme and its trustees, agents and administrator against any claim, of whatsoever nature, which may be made against them as a result of or arising out of the disclosure of any test results or medical information.
- I/we confirm that the information contained in this Chronic Medicine Benefit Application Form is correct.

MEMBER'S SIGNATURE _____ PATIENT'S SIGNATURE _____ Date D D M M Y Y Y Y
(not required if patient is a minor)

B. TO BE COMPLETED BY THE ATTENDING DOCTOR (PLEASE PRINT USING BLOCK LETTERS)

DETAILS OF THE ATTENDING DOCTOR

Doctor's Surname	Miller	Initials	L N	Qualifying Degree	PSYCHIATRIST
Practice Number	0760722	HPCSA Reg. No.		MP0679887	
Postal Address	7 Liduina Crescent Glenhazel			Code	2191
E-mail Address	drl.n.millerpsychiatry@gmail.com				
Telephone Numbers and Code	(011) 4409702	Cell		Fax	( )

PLEASE ENSURE THAT YOUR PATIENT IS APPLYING FOR THE FIRST TIME AS THE COMPLETION OF ONLY ONE APPLICATION WILL BE PAID FOR.

CLINICAL EXAMINATION GENERAL INFORMATION (TO BE COMPLETED FOR ALL APPLICANTS)

Gender M F Weight kg Height cms Blood pressure (sitting, having rested for 5 minutes) / mmHg

Smoking yes no Physical activity little regular very active TIA/Stroke yes no

Please indicate if the patient has a history of the following: Ischaemic Heart Disease yes no Peripheral Vascular Disease yes no

First degree relative with premature heart disease (PREMATURE = MI IN FEMALES <65 YEARS; MALES <55 YEARS) yes no

If the patient has diabetes, please provide the most recent HbA1c results.

C. TO BE COMPLETED BY THE ATTENDING DOCTOR (PLEASE PRINT USING BLOCK LETTERS)

DIAGNOSIS AND MEDICINES FOR WHICH AUTHORISATION IS REQUESTED

Please note: Prescribed Minimum Benefit rules, chronic disease lists and medicine formularies applicable to the specific medical scheme/option will apply. As per the requirements of the Risk Equalisation Fund (REF), in order to register patients on the chronic medicine programme, documentation from a relevant specialist and/or test results verifying the diagnosis, is required for the following diagnoses:

Diagnosis	Requirement
Hyperlipidaemia	Documentation of lipogram results and risk criteria. Please complete Section D.
Chronic Renal Disease	Documentation of creatinine clearance or Glomerular Filtration Rate (GFR) estimate. (Most recent)
COPD	Documentation of lung function test. (Most recent)

Diagnosis & ICD-10 code	Medicine trade name	Strength e.g. 10 mg	Directions e.g. 1 TDS	Special investigations/ motivations	Specialist's details (name & practice no.)	Treatment on previous medical scheme for diagnosis	
						Yes*	No
						Yes*	No
						Yes*	No
						Yes*	No
						Yes*	No
						Yes*	No

*If yes indicated: Medical Scheme name _____ Date D D M M Y Y Y Y

DRUG ALLERGIES

Please specify _____

_____

Acknowledgement by doctor

Having conducted a personal examination and/or procured the tests and/or other diagnostic investigations referred to, I certify that the particulars are, to the best of my knowledge and belief, true and accurate. I acknowledge that the GEMS Medicine Management Programme will rely on such particulars when making any recommendations regarding the payment of ongoing/chronic medication.

This refers specifically to patient:

Surname _____

First name _____

DOCTOR'S SIGNATURE _____ Date D D M M Y Y Y Y

ONLY COMPLETE THIS FORM FOR PATIENTS WITH HYPERLIPIDAEMIA

D. TO BE COMPLETED BY THE ATTENDING DOCTOR (PLEASE PRINT USING BLOCK LETTERS)

MOTIVATION FOR A LIPID MODIFYING AGENT FOR THE TREATMENT OF HYPERLIPIDAEMIA

In line with the requirements of the 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 that 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 simvastatin.

PATIENT'S DETAILS

Patient's Surname | Title | First Name

Medical Scheme | Membership Number

Date of Birth D D M M Y Y Y Y | Gender M F

Height ____ cms Weight ____ kg Calculated BMI ____ Latest BP ____ / ____ mmHg (sitting, having rested for 5 minutes)

Requested drug and dose

Ezetimibe is only considered for funding where very high risk patients have not reached an LDLC of ≤ 3.0mmol/l despite at least 2 months' compliance with standard therapy e.g. simvastatin/atorvastatin titrated to 80/40mg respectively. Requests for the funding of Ezetimibe must be accompanied by a motivation.

Risk factors *(please indicate by ticking the appropriate box)*

	Yes	No	Comment
Smoker			
Diabetes Mellitus			
Ischaemic Heart Disease (e.g. angina, myocardial infarct [MI])			
Peripheral Vascular Disease (e.g. aortic aneurism)			
Stroke/Transient Ischaemic Attacks (TIA)			
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)	Lipogram on treatment (attach copy)
Date			
Lipid modifying drug & dosage		mg/day	mg/day
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 xantomata)

Family history of premature atherosclerotic event in 1st degree relative yes no

Relative (e.g. father/sister)

Description (e.g. MI/stroke)

Age at time of event/death

DOCTOR'S SIGNATURE _____ Date D D M M Y Y Y Y

ONLY COMPLETE THIS FORM IF GEMS CHRONIC DSP (MEDIPOST) SHOULD SUPPLY CHRONIC MEDICATION ONCE AUTHORISED

E. TO BE COMPLETED BY THE MEMBER (PLEASE PRINT USING BLOCK LETTERS)

PATIENT DETAILS:

Patient Surname: | Patient First name:

Medical Scheme: | Membership No.: | Beneficiary Code:

DELIVERY DETAILS

Delivery method (tick one option only):

- ☐ **Post Office** (I/designated signatory will collect the medication at the counter at my convenience on the advised date)
- ☐ **To-Door** (I/designated signatory will be available to receive the medication)
- ☐ **Collect** (I/designated person will fetch the medication from Medipost Pharmacy)

If **"Post Office"** or **"To-Door"** is preferred, please complete the following:

Delivery Address – Complete the appropriate section:

Name of post office: | Postal code:

Delivery Address:

Postal code:

Alternate person to sign for the medication on your behalf:

Name:

Relationship:

An SMS advising of the monthly delivery must be sent to:

Cellular number:

MEDICATION CONSIGNMENT DETAILS

MPL is a reference pricing system that uses a benchmark (reference) price for generically similar products. The fundamental principle of any reference pricing system is that it does not restrict a member's choice of medicines, but instead limits the amount that will be paid.

MPL reference prices are set in such a way as to ensure availability of medicines without co-payments being necessary. In other words, you will be able to afford the medicine you need without paying from your own pocket, but you may have to select a generic over a brand name product. However, should you prefer the more expensive product GEMS will only pay up to the MPL reference price. You will then have to pay the difference (co-payment) to Medipost.

Generic Equivalent Substitution (tick one option only):

- ☐ Yes, I agree that all items be substituted for generic equivalents, where possible
- ☐ No, I do not want to take generic equivalents for all items
- ☐ Yes and No, I want generic equivalents for all items besides:

_____

_____

_____

If generic equivalents are not acceptable, the outstanding monies can be paid for in any of the following ways. A consultant will supply you with the details pertaining to each payment method. Please indicate the method of choice.

- ☐ Credit card transaction
- ☐ Debit order transaction
- ☐ Direct bank deposit

Please remember to send a valid repeatable prescription together with this application to 0866 518 009.

FOR ANY ASSISTANCE IN COMPLETING THIS PAGE KINDLY CONTACT GEMS CHRONIC DSP ON 0860 00 4367.