Medicine Management

Chronic Medicine Benefit application

gems
Government Employees Medical Scheme

Please fax completed form to: 0861 00 4367 **or post to:** GEMS, Private Bag X782, Cape Town, 8000 **or email to:** chronicdsp@gems.gov.za
Member and provider telephone: 0860 00 4367

Only complete this form if you are a fully registered member of GEMS

Section 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 medicine. 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 GEMS 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. Please pay special attention to the drug indicators on your "Access Card".

Main member details

Surname | Title | Full first name

Member no | Medical scheme option

Patient's details (if not the same as main member)

Surname | Title | Full first name

ID no | Date of birth D D M M Y Y Y Y | Dependant code

Tel no (H) ( ) | (W) ( )

Fax no ( ) | Cell phone no

Postal address

Code

Email

- 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 medicine, 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. However, your medical practitioner 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.

Patient's signature _____ Gaurdians signature _____ Date D D M M Y Y Y Y

(If patient is not a minor)

Section B: To be completed by the attending doctor (please print using block letters)

Details of the attending doctor

Surname | Initials | Qualifying degree

Practice no | HPCSA Reg no

Postal address

Code

Email

Tel no (H) ( ) | Fax no ( ) | Cell phone no

Please ensure that your patient is applying for the first time as the completion of only one application per dependant will be paid for, where applicable.

Clinical examination general information (to be completed for all applicants)

Gender M F | Weight kg | Height cm | BMI | 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. _____

Section C: To be completed by the attending doctor (please print using block letters)

Diagnosis and medicines for which authorisation is requested

Please note: PMB 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 GEMS Medicine Management 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 and ICD-10 code	Medicine trade name	Strength e.g. 10 mg	Directions e.g. 1 TDS	Special investigations/ motivations	Specialist's details (name and 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 or chronic medicine.

This refers specifically to patient:

Surname

First full name

Doctor's signature _____ Date D D M M Y Y Y Y

Only complete this form for patients with Hyperlipidaemia

Section D: To be completed by the attending doctor

(please print using block letters and complete all the fields especially ICD10, risk factors and special investigations to avoid any delay in processing your request for outstanding information)

Motivation for a lipid modifying agent for the treatment of Hyperlipidaemia

In line with the requirements of the 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 simvastatin.

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 and 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 no ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

Section E: To be completed by the member (please print using block letters)

Patient's details

Surname | Full first name

Medical scheme

Membership no | Dependant code

Delivery details

Delivery method (tick one option only):

- ☐ **Courier Pharmacy** (I/designated signatory will be available to receive the medicine)
- ☐ **Network Pharmacy** (I/designated person will fetch the medicine)
- ☐ **State Facility**

If **"Courier Pharmacy"** is preferred, please complete the following:

Delivery address

Code

Alternate person to sign for the medicine on your behalf:

Full name and surname

Relationship

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

Cell phone no

Medicine consignment details

MPL is a Scheme Rule which uses 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 Courier or Network Pharmacy. MPL applies to the Ruby, Emerald and Onyx options, where applicable, as per Scheme Rules.

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 repeat prescription together with this application to 0861 00 4367 or chronicdsp@gems.gov.za.

For any assistance in completing this page kindly contact GEMS Chronic Medicine Management on 0860 00 4367.