

Medicine Management

Chronic Medicine Benefit Application



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 or call 0800 00 4367 (toll-free) and providers can call 0860 436 777.

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 Chart (MAC), which lists the medicine to be paid from the Chronic Medicine Benefit. Please refer to the GEMS Disease Management Member Guide on www.gems.gov.za to obtain more information about the Medicine Access Card and the Chronic Medicine Benefit.

Main member details

Surname Title Full first name
Member no Medical scheme option

Patient details (if not the same as main member)

Surname Title Full first name
ID no Date of birth Dependant code
Tel no (H) () (W) ()
Fax no () Cellphone 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 _____ Guardian's signature _____ Date
(If patient is 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 () Cellphone 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) /
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 specialists and/or test results verifying the diagnosis, is required for the following diagnosis:

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 Option: _____ Date

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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:

[illegible]

Doctor's signature _____ Date

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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 generic substitution.

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 $\geq$ 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

Section E: To be completed by the member (please print using block letters)**Patient 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)
- ☐ **Retail 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:

Cellphone no

Medicine consignment details

Drug Reference Pricing (DRP) is a managed care protocol which uses a reference pricing system that uses a benchmark (reference) price for generically or therapeutically equivalent 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 by the Scheme.

DRP reference prices are set in such a way as to ensure the 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. However, should you prefer the high costing product GEMS will only pay up to the DRP. You will then have to pay the difference (co-payment) to the Courier or Retail Network Pharmacy. DRP applies to the Tanzanite One, Beryl, Ruby, Emerald, Emerald Value, and Onyx options, where applicable, as per Scheme Rules.

Drug Reference Pricing (DRP) includes two types of products:

- Generic medicines (medicine with the same active ingredient, strength, and dosage form) and
- Therapeutic equivalent medicine (medicine with a different active ingredient, strength and/or dosage form but have similar effects for the treatment of the same condition).

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 (fax) or chronicdsp@gems.gov.za.

For any assistance in completing this page kindly contact GEMS Chronic Medicine Management on 0800 00 4367.