PLATINUM HEALTH

# Chronic Illness Benefit Application Form

Private Bag X82081, Rustenburg, 0300 • Tel: 014 590 1700 • www.platinumhealth.co.za phscript@platinumhealth.co.za

## Obtaining chronic medication

Chronic medication is used to treat long-term and/or recurring conditions.

PlatComprehensive, PlatCap and PlatFreedom members who choose to obtain chronic medication from the Chronic Medication Department of Platinum Health, should follows these four easy steps to ensure timeous delivery of their medication:

**Step 1**
Register for chronic medication approval if you are a first-time chronic medication user by requesting your doctor to complete a Chronic Illness Benefit Application form. The forms are available from the Client Liaison Officers on site during scheduled visits, or it can be downloaded from the Platinum Health website www.platinumhealth.co.za A separate application form is required for each family member who requires chronic medication.

**Step 2**
Both the chronic illness forms (application and delivery), along with supporting documentation and a six-month prescription has to be forwarded to the Chronic Medication Department. Platinum Health staff on site at Platinum Health facilities can assist members with submitting application forms to the Chronic Medication Department.

**Step 3**
The completed application form and supporting documentation has to be submitted to the Chronic Medication Department via any of the following channels:

Tel no: 014 590 1700
E-mail: phscript@platinumhealth.co.za
Fax: 086 577 0274 or 014 590 1752

**Step 4**
The Chronic Medication Department contacts the patient to confirm the details and arrange delivery. A courier service is available for the delivery of chronic medication to members who qualify for delivery. Members can request chronic medication to be delivered to their home, the Platinum Health medical facility for collection, or any other location convenient to them. Generally, three months' supply is issued.

## Important to remember

Once registered, please place follow-up medication orders at least seven working days before the current batch runs out. Orders can be placed telephonically, by e-mail or fax, and full member and contact details must be included in all correspondence.

PlatFreedom members who choose to obtain chronic medication from their Pharmacy of Choice, should follow these steps:

**Step 1**
Register for chronic medication approval if you are a first-time chronic medication user by requesting your doctor to complete a Chronic Illness Benefit Application form. The forms are available from the Client Liaison Officers on site during schedule visits, or it can be downloaded from the Platinum Health website www.platinumhealth.co.za. A separate application form is required for each family member who requires chronic medication.

**Step 2**
The completed application form and supporting documentation has to be submitted to the Chronic Medication Department via any of the following channels:

Tel no: 014 590 1700
E-mail: phscript@platinumhealth.co.za
Fax: 086 577 0274 or 014 590 1752

Upon receiving the completed Chronic Illness Benefit Application form, authorisation will be loaded on the system and the Pharmacy of Choice will be able to supply the medication to the member and submit the claim for payment to the Scheme.

**Please note**
- Members have to arrange collection/delivery of medication with their Pharmacy of Choice.
- Members have to place follow-up prescriptions with their Pharmacy of Choice.

Please complete and e-mail to phscript@platinumhealth.co.za

1. Please complete the Chronic Illness Benefit Application form in PRINT with black ink and forward to Platinum Health.
2. Relevant test results must be attached.
3. Prescription must be attached.
4. Failure to provide all information will result in unnecessary delays.

## 1. Patient Information (Please complete in full)

Platinum Health membership number: | | | | | | | | | | | Patient dependant code: | |

Title: Prof | Dr | Mr | Mrs  Initials:  Surname:

Names in full (as per identity document):

Date of birth: C C Y Y M M D D  E-mail:

Tel no (Home):  Tel no (Work):  Cell no:

Sex: Male | Female  Language preference: English | Afrikaans

The outcome of this application must be communicated to me via: E-mail | SMS

Delivery details (To be completed by patient or guardian)

| Patient Details | |
|---|---|
| Title | |
| Surname | |
| Name | |
| Telephone Number | Work |
| | Home |
| | Cellphone |
| Physical address for delivery | |
| | |
| | |

## 2. Declaration

I, hereby apply for Platinum Health chronic illness benefit and agree that I will be bound by the Rules of the Scheme as amended from time to time.

I warrant that the information in this application, whether it is in my own handwriting or not, is complete and correct. This also applies to information in other documents provided by the healthcare provider, healthcare facility, any of my dependants or myself.

Principal Member signature:

Patient signature:  (If the patient is a minor, parent, legal guardian or custodian must sign the form

Date: C C Y Y M M D D

Please complete and e-mail to phscript@platinumhealth.co.za

Platinum Health membership number: | | | | | | | | | | |

Patient name and surname:

## 3. Application for the treatment of hypertension (to be completed by the doctor)

Patient weight in kilogram: | | | Patient height in metres: | | |

When did this patient commence drug therapy for hypertension?: C C Y Y M M D D

For hypertension diagnosed in the last six months and all newly diagnosed patients please supply two initial blood pressure readings (before drug therapy commenced) done at least two weeks apart in order to determine the stage of hypertension.

/ mmHg Date: C C Y Y M M D D

/ mmHg Date: C C Y Y M M D D

Current BP reading (for all patients): / mmHg

Does the patient have target organ damage or any of the associated conditions as listed below? Tick the relevant conditions below.

- ☐ Left ventricular hypertrophy
- ☐ Myocardial infarction
- ☐ Hypertensive retinopathy
- ☐ Angina
- ☐ Chronic renal disease
- ☐ Prior CABG (Coronary artery bypass graft)
- ☐ Stroke TIA
- ☐ Peripheral arterial disease
- ☐ Heart failure

## 4. Application for the treatment of hyperlipidaemia (to be completed by the doctor)

Primary Hyperlipidaemia
Please attach the diagnostic lipogram and current TSH. The application cannot be reviewed if this is not submitted.

Patient weight in kilogram: | | | Patient height in metres: | | |

Current BP reading (for all patients): / mmHg

Does the patient smoke: Yes | No

Family history (Please complete the table below for primary and familial hyperlipidaemia)

| | Father | Mother | Brother | Sister |
|---|---|---|---|---|
| Event description | | | | |
| Age at time of event/death | | | | |

Familial hyperlipidaemia

Please attach the diagnosing lipogram. Please indicate any signs of familial hyperlipidaemia in these patients:

- ☐ Xanthelasma
- ☐ Cerebrotendinous xanthomastosis
- ☐ Arcus Cornealis

Secondary prevention

Please indicate the condition(s) your patient has:

- ☐ Type 2 diabetes
- ☐ Type 1 diabetes who has had the condition for more than 10 years
- ☐ Any of the vasculitides eg SLE where there is associated renal disease
- ☐ Nephrotic syndrome and chronic renal failur
- ☐ Stroke TIA
- ☐ Prior CABG
- ☐ Ischaemic heart disease
- ☐ Intermittent claudication

Please complete and e-mail to phscript@platinumhealth.co.za

Platinum Health membership number: | | | | | | | | | | |

Patient name and surname:

## 5. Application for the treatment of type 2 diabetes

1. Please attach a laboratory report that comfirms the diagnosis of Type 2 Diabetes.

2. The Chronic Illness Benefit will fund medication for Type 2 Diabetes if the criteria for the diagnosis of this condition are met based on the SEMDSA Guidelines.

3. The specific criteria are:
   - Fasting plasma glucose concentration > 7 mmol/l;
   - Casual plasma glucose concentration > 11.1 mmol/l; and
   - Two-hour post-glucose or > 11.1 mmol/l during an Oral Glucose Tolerance Test (OGTT).

4. Please note that based on cost and clinical guidelines, applications for glitazones, nateglinide, GLP-1 agonists, and DPP-4 antagonists require a motivation for use over conventional therapy from a specialist physician or endocrinologist.

## 6. Current medication required (to be completed by the doctor)

Note to member and doctor: Generic substitution will be applied. Platinum Health will apply MMAP. Platinum Health has adopted a reference pricing programme, where the patient notwithstanding elects to take a higher priced product prescribed. The patient is liable for the difference in the calculated gross prices for the respective products.

| ICD-10 | Description of diagnosis | Date of diagnosis | Medication name, strength and dosage | HOW LONG HAS THE PATIENT USED THIS MEDICATION? | | MAY A GENERIC BE USED? | |
|---|---|---|---|---|---|---|---|
| | | | | Years | Months | Yes | No |
| | | | | | | | |
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## 7. Doctor's details and signature (to be completed by the doctor)

**Note to doctor:** The doctor's fee for completion of this form will be reimbursed on code 0199, on submission of a separate claim. Subject to scheme rules and availability of funds. In line with legislative requirements, please ensure that when using code 0199, you submit the ICD-10 diagnosis code(s). As per industry standards, the appropriate ICD-10 code(s) to use for this purpose would be those reflective of the actual chronic condition(s) for which the form was completed. If multiple chronic conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes. You may call 014 590 1700 (option 4) for changes to your patient's medication for an approved condition. An application form only needs to be completed when applying for a new chronic condition.

Name: BHF practice number:

Date of birth: C C D Y Y M M D Speciality:

Tel no (Practice): Doctor's signature:

Please complete and e-mail to phscript@platinumhealth.co.za

Platinum Health membership number: | | | | | | | | | | |

Patient name and surname:

## Prescribed Minimum Benefits (PMBs) – Applicable to PlatComprehensive, PlatCap and PlatFreedom

1. Addison's Disease: Application form must be completed by a paediatrician or endocrinologist.
2. Asthma: The South African Treatment Guidelines for Asthma, as published in the SAMJ are applied to all applications.
3. Bipolar Mood: Disorder Application form must be completed by a psychiatrist.
4. Bronchiectasis: Application form must be completed by a paediatrician or pulmonologist.
5. Cardiac Failure: None
6. Cardiomyopathy: None
7. Chronic Obstructive Pulmonary Disease (COPD): Please attach a lung function test (LFT) report which includes the FEV1/FVC AND FEV1 post bronchodilator use.
8. Chronic Renal Disease: 1. Please attach proof of diagnosis completed by a nephrologist. 2. Please attach a diagnosing laboratory report reflecting creatinine clearance. 3. Please attach a report reflecting haemoglobin or haematocrit levels when applying for erythropoietin, indicating if the results are on or off drug therapy.
9. Coronary Artery Disease: Please provide details of previous cardiovascular event(s) in patient, if applicable.
10. Chronic Disease: Please attach proof of diagnosis completed by a gastroenterologist.
11. Diabetes Insipidus: Please attach proof of diagnosis completed by an endocrinologist.
12. Diabetes Type 1: None
13. Diabetes Type 2L Refer to Section 5
14. Dysrhythmias: None
15. Epilepsy: None
16. Glaucoma: None
17. Haemophilia: Please attach a laboratory report factor 8 or 9 levels.
18. HIV/AIDS (Antiretroviral Therapy): Documented proof that patient qualified for ART treatment in accordance with National Antiretroviral Treatment guidelines.
19. Hyperlipidaemia: Section 4 must be completed by the doctor.
20. Hypertension: Section 3 must be completed by the doctor.
21. Hypothyroidism: Please attach the initial or diagnostic laboratory report that the diagnosis of hypothyroidism including TSH, T4 and T3 levels.
22. Multiple Sclerosis (MS): Please attach proof of diagnosis completed by a neurologist.
23. Parkinson's Disease: Only applications from a neurologist for non-formulary items will be considered.
24. Rheumatoid Arthritis: 1. Please attach proof of diagnosis completed by a rheumatologist. 2. Applications for anti-inflammatories as monotherapy (on its own) must be motivated for by a rheumatologist. 3. Applications for COXIB's must be accompanied by a motivation for its use over conventional anti-inflammatories. 4. Only applications from a rheumatologist for non-formulary items will be considered.
25. Schizophrenia: Application must be completed by a psychiatrist.
26. Systemic Lupus Erythematosus: Application must be completed by a rheumatologist, nephrologist or physician.
27. Ulcerative Colitis: Please attach proof of diagnosis completed by a gastroenterologist.

## Other Chronic Conditions – Applicable to PlatComprehensive

1. Acne: Only applications from a dermatologist for isotretinoin will be considered.
2. Allergy Management (Conjunctivitis and Keratoconjuctivitis, Vasomotor and Allergic Rhinitis, Atonic Dermatitis and Urticaria): None
3. Alzheimer's Disease: Please attach proof of diagnosis by a psychiatrist or neurologist.
4. Anaemia (Chronic): 1. Attach proof of specific anaemia. 2. Request for IV treatment to be accompanied by relevant blood results.
5. Ankylosing Spondylitis: 1. Please attach proof of diagnosis by a rheumatologist. 2. Application for COXIBS must be accompanied by a motivation for its use over conventional 3. Only applications from a rheumatologist for non-formulary items will be considered.
6. Anxiety Disorder (Chronic): 1. Application for first line therapy will be accepted from GP's for six months only. 2. Psychiatrist motivation required for further cover.
7. Attention Deficit Disorder (ADD): 1. Full psychometric evaluation required. 2. Diagnosis by psychiatrist.
8. Benign Prostatic Hypertrophy: None.
9. Cerebral Palsy: Please attach proof of diagnosis by a neurologist.
10. Cerebrovascular Accident (Stroke): None
11. Chronic Bronchitis: None
12. Chronic Liver Disease: Please attach proof of diagnosis by a gastroenterologist. Immune modulators will only be considered by a specialist.
13. Clotting Disorders: None
14. Cystic Fibrosis: Please attach proof of diagnosis by a pulmonologist (or paediatrician if the patient is a child).
15. Deep Vein Thrombosis: None
16. Depression: 1. Application for first line therapy will be accepted from GPs for six months only. 2. Psychiatrist motivation required for further cover.

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Platinum Health membership number:

Patient name and surname:

## Other Chronic Conditions – Applicable to PlatComprehensive

17. Dysrhythmia (Non-PMB): None
18. Endocarditis: None
19. Gastro-Oesophageal Reflux Disease (GORD): Applications must be accompanied by latest gastroscopy report.
20. Gout (Chronic): None. Colchicine will not be considered for chronic treatment.
21. Irritable Bowel Syndrome / Diverticulitis: None
22. Meniere's Disease: None
23. Menopause: Application for hormone replacement therapy will only be considered up to the age of 60 years. Exceptions must be motivated by a gynaecologist.
24. Migraine: Only first line therapy will be considered from GPs, otherwise application from neurologist.
25. Motor Neuron Disease: None
26. Muscular Dystrophy and Other Inherited Myopathies: None
27. Narcolepsy: Please attach proof of diagnosis by a neurologist.
28. Neuropathy: None
29. Obesity: Non-surgical weight management.
30. Obsessive Compulsive Disorder: Application for first line therapy will be accepted from GPs for six months only. Psychiatrist motivation required for further cover.
31. Osteoarthritis: X-ray report.
32. Osteoporosis: Application must be accompanied by a DEXA bone mineral density (BMD) scan report.
33. Paget's Disease: Please attach proof of diagnosis by a specialist physician or Paediatrician (in case of a child).
34. Pancreatic Disease: Please attach proof of diagnosis by an endocrinologist.
35. Plegia: HEMI, PARA, QUAD: None
36. Parathyroid Disorders: Please attach proof of diagnosis by an endocrinologist or physician.
37. Peptic Ulcer: Application must be accompanied by latest gastroscopy report.
38. Peripheral Vascular Disease: None
39. Pituitary Gland Disorders: Please attach proof of diagnosis by an endocrinologist.
40. Polycystic Ovarian Syndrome: Please attach proof of diagnosis by appropriate specialist.
41. Post Traumatic Stress Disorder: Application for first line therapy will be accepted from GPs for six months only. Psychiatrist motivation required for further cover.
42. Prolactinoma: Please attach proof of diagnosis by an endocrinologist or physician.
43. Psoriasis: None
44. Pulmonary Interstitial Fibrosis: None
45. Restless Legs Syndrome: None
46. Schizoaffective Disorders: Please attach proof of diagnosis by a psychiatrist.
47. Scleroderma: Please attach proof of diagnosis by appropriate specialist.
48. Tourette's Syndrome: Please attach proof of diagnosis by a neurologist.
49. Trigeminal Neuralgia: Please attach proof of diagnosis by a neurologist.
50. Tuberculosis: Please attach proof that patient for treatment according to national guidelines.
51. Urinary Incontinence: Application for non-formulary items will only be considered from an urologist.
52. Valvular Heart Disease: Please attach proof of diagnosis by a cardiologist/physician.
53. Vascular Dementia: Please attach proof of diagnosis by a neurologist.

## Other Chronic Conditions – Applicable to PlatFreedom

1. Acne: Only applications from a dermatologist for isotretinoin will be considered.
2. Allergic Rhinitis: None
3. Alzheimer's Disease: Please attach proof of diagnosis by a psychiatrist or neurologist.
4. Ankylosing Spondylitis: 1. Please attach proof of diagnosis by a rheumatologist. 2. Application for COXIBS must be accompanied by a motivation for its use over conventional 3. Only applications from a rheumatologist for non-formulary items will be considered.
5. Attention Deficit Hyperactivity Disorder (ADHD): Application form must be completed by a psychiatrist, neurologist or paediatrician.
6. Becket's Disease: Application form must be completed by a rheumatologist or specialist physician.
7. Cystic Fibrosis: Please attach proof of diagnosis by a pulmonologist (or paediatrician if the patient is a child).
8. Depression: 1. Application for first line therapy will be accepted from GPs for six months only. 2. Psychiatrist motivation required for further cover.
9. Dermatomyositis: Application form must be completed by a dermatologist, rheumatologist or specialist physician.
10. Eczema: None
11. Gastro-Oesophageal Reflux Disease (GORD): Applications must be accompanied by latest gastroscopy report.
12. Generalised Anxiety Distorder: 1. Application for first line therapy will be accepted from GP's for six months only. 2. Psychiatrist motivation required for further cover. Application form must be completed by a psychiatrist for patients <18 years of age.

Platinum Health membership number: | | | | | | | | | | |

Patient name and surname:

## Other Chronic Conditions – Applicable to PlatFreedom

13. Gout/Hyperuricaemia: None. Colchicine will not be considered for chronic treatment.
14. Migraine: Only first line therapy will be considered from GPs, otherwise application from neurologist.
15. Motor Neuron Disease: None
16. Myasthenia Gravis: None
17. Obsessive Compulsive Disorder: Application for first line therapy will be accepted from GPs for six months only. Psychiatrist motivation required for further cover.
18. Osteoarthritis: X-ray report.
19. Osteopenia: None
20. Osteoporosis: Application must be accompanied by a DEXA bone mineral density (BMD) scan report.
21. Paget's Disease: Please attach proof of diagnosis by a specialist physician or Paediatrician (in case of a child).
22. Panic Disorder: Application for first line therapy will be accepted from GP's for six (6) months only. Application from psychiatrists will be required for further cover. Application form must be completed by a psychiatrist for patients <18 years of age.
23. Polyarteritis Nodosa: Application form must be completed by a rheumatologist.
24. Post Traumatic Stress Disorder: Application for first line therapy will be accepted from GPs for six months only. Psychiatrist motivation required for further cover.
25. Prolactinoma: Please attach proof of diagnosis by an endocrinologist or physician.
26. Psoriasis: None
27. Pulmonary Interstitial Fibrosis: None
28. Sjogren's Syndrome: Application form must be completed by a rheumatologist, nephrologist or specialist physician.
29. Systemic Sclerosis: Application form must be completed by a rheumatologist or specialist physician.
30. Urinary Incontinence: Application for non-formulary items will only be considered from an urologist.
31. Urticaria: None
32. Venous Thrombotic Disorders: None
33. Wegener's Granulomatosis: Application form must be completed by a rheumatologist, nephrologist or specialist physician.

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