

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?

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.

1. / mmHg Date:

2. / mmHg Date:

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.

- | | | |
|---|--|--|
| <input type="checkbox"/> Left ventricular hypertrophy | <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Hypertensive retinopathy |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Chronic renal disease | <input type="checkbox"/> Prior CABG (Coronary artery bypass graft) |
| <input type="checkbox"/> Stroke TIA | <input type="checkbox"/> Peripheral arterial disease | <input type="checkbox"/> 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:

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Xanthelasma | <input type="checkbox"/> Cerebrotendinous xanthomastosis | <input type="checkbox"/> Arcus Cornealis |
|--------------------------------------|--|--|

Secondary prevention

Please indicate the condition(s) your patient has:

- | | | |
|---|---|---|
| <input type="checkbox"/> Type 2 diabetes | <input type="checkbox"/> Type 1 diabetes who has had the condition for more than 10 years | <input type="checkbox"/> Any of the vasculitides eg SLE where there is associated renal disease |
| <input type="checkbox"/> Nephrotic syndrome and chronic renal failure | <input type="checkbox"/> Stroke TIA | <input type="checkbox"/> Prior CABG |
| <input type="checkbox"/> Ischaemic heart disease | <input type="checkbox"/> Intermittent claudication | |

Please complete and email to phscript@platinumhealth.co.za

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5 APPLICATION FOR THE TREATMENT OF TYPE 2 DIABETES

1. Please attach a laboratory report that confirms 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 FIRST DIAGNOSIS	MEDICATION NAME, STRENGTH AND DOSAGE	HOW LONG HAS THE PATIENT USED THIS MEDICATION?		MAY A GENERIC BE USED?	
				YEARS	MONTHS	YES	NO

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:

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BHF practice number:

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Date:

C	C	Y	Y	M	M	D	D
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Speciality:

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Tel no (Practice):

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Doctor's signature:

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PRESCRIBED MINIMUM BENEFITS (PMBs)

ADDISON'S DISEASE: Application form must be completed by a paediatrician or endocrinologist.	CROHN'S DISEASE: Please attach proof of diagnosis completed by a gastroenterologist.	PARKINSON'S DISEASE: Only applications from a neurologist for non-formulary items will be considered.
ASTHMA: The South African Treatment Guidelines for Asthma, as published in the SAMJ are applied to all applications.	DIABETES INSIPIDUS: Please attach proof of diagnosis completed by an endocrinologist.	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.
BIPOLAR MOOD: Disorder Application form must be completed by a psychiatrist.	DIABETES TYPE 1: None	SCHIZOPHRENIA: Application must be completed by a psychiatrist.
BRONCHIECTASIS: Application form must be completed by a paediatrician or pulmonologist.	DIABETES TYPE 2: Refer to Section 5.	SYSTEMIC LUPUS ERYTHEMATOSUS: Application must be completed by a rheumatologist, nephrologist or physician.
CARDIAC FAILURE: None	DYSRHYTHMIAS: None	ULCERATIVE COLITIS: Please attach proof of diagnosis completed by a gastroenterologist.
CARDIOMYOPATHY: None	EPILEPSY: None	
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): Please attach a lung function test (LFT) report which includes the FEV1/FVC and FEV1 post bronchodilator use.	GLAUCOMA: None	
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.	HAEMOPHILIA: Please attach a laboratory report reflecting factor 8 or 9 levels.	
CORONARY ARTERY DISEASE: Please provide details of previous cardiovascular event(s) in patient, if applicable.	HIV/AIDS (ANTIRETROVIRAL THERAPY): Documented proof that patient qualified for ART treatment in accordance with National Antiretroviral Treatment guidelines.	
	HYPERLIPIDAEMIA: Section 4 must be completed by the doctor.	
	HYPERTENSION: Section 3 must be completed by the doctor.	
	HYPOTHYROIDISM: Please attach the initial or diagnostic laboratory report that confirms the diagnosis of hypothyroidism, including TSH, T4 and T3 levels.	
	MULTIPLE SCLEROSIS (MS): Please attach proof of diagnosis completed by a neurologist.	

OTHER CHRONIC DISEASES

ACNE: Only applications from a dermatologist for isotretinoin will be considered.	DEPRESSION: 1. Application for firstline therapy will be accepted from GP's for six months only. 2. Psychiatrist motivation required for further cover.	PANCREATIC DISEASE: Please attach proof of diagnosis by an endocrinologist.
ALLERGY MANAGEMENT (CONJUNCTIVITIS AND KERATOCONJUNCTIVITIS, VASOMOTOR AND ALLERGIC RHINITIS, ATONIC DERMITITIS AND URTICARIA): None	DYSRHYTHMIA (NON PMB): None	PLEGIA: HEMI, PARA, QUAD: None
ALZHEIMER'S DISEASE: Please attach proof of diagnosis by a psychiatrist or neurologist.	ENDOCARDITIS: None	PARATHYROID DISORDERS: Please attach proof of diagnosis by an endocrinologist or physician.
ANAEMIA (CHRONIC): 1. Attach proof of specific anaemia. 2. Request for iv treatment to be accompanied by relevant blood results.	GASTRO-OESOPHAGEAL REFLUX DISEASE AND DIAPHRAGMATIC HERNIA: Applications must be accompanied by latest gastroscopy report.	PEPTIC ULCER: Application must be accompanied by latest gastroscopy report.
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 anti-inflammatories. 3. Only applications from a rheumatologist for non-formulary items will be considered.	GOUT (CHRONIC): None. Colchicine will not be considered for chronic treatment.	PERIPHERAL VASCULAR DISEASE: None
ANXIETY DISORDER (CHRONIC): 1. Application for firstline therapy will be accepted from GP's for six months only. 2. Psychiatrist motivation required for further cover.	IRRITABLE BOWEL SYNDROME / DIVERTICULITIS: None	PITUITARY GLAND DISORDERS: Please attach proof of diagnosis by an endocrinologist.
ATTENTION DEFICIT DISORDER (ADD): 1. Full psychometric evaluation required. 2. Diagnosis by psychiatrist.	MENIERE'S DISEASE: None	POLYCYSTIC OVARIAN SYNDROME: Please attach proof of diagnosis by appropriate specialist.
BENIGN PROSTATIC HYPERTROPHY: None	MENOPAUSE: Application for hormone replacement therapy will only be considered up to the age of 60 years. Exceptions must be motivated by a gynaecologist.	POST TRAUMATIC STRESS DISORDER: Application for firstline therapy will be accepted from GP's for six months only. Psychiatrist motivation required for further cover.
CEREBRAL PALSY: Please attach proof of diagnosis by a neurologist.	MIGRAINE: Only firstline therapy will be considered from GP's, otherwise application from neurologist.	PROLACTINOMA: Please attach proof of diagnosis by an endocrinologist or physician.
CEREBROVASCULAR ACCIDENT (STROKE): None	MOTOR NEURON DISEASE: None	PSORIASIS: None
CHRONIC BRONCHITIS: None	MUSCULAR DYSTROPHY AND OTHER INHERITED MYOPATHIES: None	PULMONARY INTERSTITIAL FIBROSIS: None
CHRONIC LIVER DISEASE: Please attach proof of diagnosis by a gastroenterologist. Immune modulators will only be considered by a specialist.	NARCOLEPSY: Please attach proof of diagnosis by a neurologist.	RESTLESS LEGS SYNDROME: None
CLOTTING DISORDERS: None	NEUROPATHY: None	SCHIZOAFFECTIVE DISORDERS: Please attach proof of diagnosis by a psychiatrist.
CYSTIC FIBROSIS: Please attach proof of diagnosis by a pulmonologist (or paediatrician if the patient is a child).	OBESITY: Non-surgical weight management.	SCLERODERMA: Please attach proof of diagnosis by appropriate specialist.
DEEP VEIN THROMBOSIS: None	OBSESSIVE COMPULSIVE DISORDER: Application for firstline therapy will be accepted from GP's for six months only. Psychiatrist motivation required for further cover.	TOURETTE'S SYNDROME: Please attach proof of diagnosis by a neurologist.
	OSTEOARTHRITIS: X-ray report.	TRIGEMINAL NEURALGIA: Please attach proof of diagnosis by a neurologist.
	OSTEOPOROSIS: Application must be accompanied by a DEXA bone mineral density (BMD) scan report.	TUBERCULOSIS: Please attach proof that patient qualifies for treatment according to national guidelines.
	PAGET'S DISEASE: Please attach proof of diagnosis by a specialist physician or paediatrician (in case of a child).	URINARY INCONTINENCE: Application for non-formulary items will only be considered from a urologist.
		VALVULAR HEART DISEASE: Please attach proof of diagnosis by a cardiologist/physician.
		VASCULAR DEMENTIA: Please attach proof of diagnosis by a neurologist.

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