**Contact us**
Tel: 0800 BANKMED (0800 226 5633) • Private Bag X2, Rivonia 2128 • www.bankmed.co.za

# Medication Advisory Services (Chronic Medication Programme) Enrolment Form

Please note this application form should be completed by members on the Core Saver, Traditional, Comprehensive and Plus Plans.

**Who we are**

Bankmed (referred to as 'the Scheme'), registration number 1279, is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07) which takes care of the administration of your membership for the Scheme.

**How to complete this form**

**Please complete the appropriate sections as indicated:**

1. For enrolment onto the Chronic Medication Programme, please complete all sections of this application form, i.e. sections A to G.
2. Once completed please return the form by e-mail to **chronic@bankmed.co.za**.
3. Alternatively for Chronic Medication authorisations, contact **0800 BANKMED (0800 226 5633)**.

**Please note that this form excludes application for enrolment onto the Oncology (cancer), HIV/AIDS and Maternity (Baby-and-Me) programmes.**

## Section A: Member / patient details

**To be completed by the applicant**
**Member details:**

Plan type | Membership number

Title | Date of birth (D D M M Y Y Y Y)

ID or passport number

Surname

First name(s)

E-mail address

**Patient details:**

First name(s)

Surname

Dependant code | Date of birth (D D M M Y Y Y Y)

ID or passport number

Postal address

☐ PO Box ☐ Private Bag Box number

☐ Suite ☐ Postnet Suite Number

Suburb | Postal code

E-mail address

Telephone (H) | Telephone (W)

Cellphone

## Section B: Healthcare Professional's details and consent

Full name(s)

Surname

Practice number  Speciality

Physical address

Unit/Suite number  Complex name

Street number  Street name

Suburb

City  Postal code

E-mail address

Telephone (W)

Cellphone

I confirm that, to my knowledge, the clinical details described in this document are accurate and correct. I understand that the Performance Health treatment protocols are guidelines only and that the ultimate responsibility regarding treatment and general management of my patient's condition resides with me. The reimbursement of therapy and related costs by the Scheme will be in accordance with the guidelines as well as the benefits available to the above patient from time to time.

Healthcare Professional's signature  Date D D M M Y Y Y Y

## Section C: Clinical examination

**To be completed by the attending Healthcare Professional**

**Gender:** Male ☐ Female ☐

**Measurements:** waist circumference ☐☐☐ cm  weight ☐☐☐ kg  height ☐☐☐ cm

(Waist measurement to be omitted in the case of pregnancy)

Smoking: ☐ Yes ☐ No  Stopped: ☐ less than 12 months ago ☐ more than 12 months ago

Exercise: ☐ Never ☐ less than 1 hour/week ☐ 1-3 hours/week ☐ more than 3 hours/week

Allergies: ☐ penicillin ☐ asprin ☐ Sulphonamides

Other

## Section D: Clinical Information

**To be completed by the attending Healthcare Professional**

| Diagnosis (ICD-10 CODES) | Description | Date of diagnosis |
|---|---|---|
| Primary: | | |
| Other: | | |
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| Results | | Test date |
|---|---|---|
| **Blood glucose results*<br>Hba1C** | | |
| Reading 1 | % | D D M M Y Y Y Y |
| Reading 2 | % | D D M M Y Y Y Y |
| Reading 3 | % | D D M M Y Y Y Y |
| **Glucose Tolerance Test** | | |
| Reading 1 | % | D D M M Y Y Y Y |
| Reading 2 | % | D D M M Y Y Y Y |
| Reading 3 | % | D D M M Y Y Y Y |
| **Fasting Blood glucose**** | | |
| Reading 1 | mmol/l | D D M M Y Y Y Y |
| Reading 2 | mmol/l | D D M M Y Y Y Y |
| Reading 3 | mmol/l | D D M M Y Y Y Y |
| **Lipogram results*<br>Total cholesterol** | | |
| Reading 1 | mmol/l | D D M M Y Y Y Y |
| Reading 2 | mmol/l | D D M M Y Y Y Y |
| Reading 3 | mmol/l | D D M M Y Y Y Y |
| **Low-density lipoproteins (LDL)** | | |
| Reading 1 | mmol/l | D D M M Y Y Y Y |
| Reading 2 | mmol/l | D D M M Y Y Y Y |
| Reading 3 | mmol/l | D D M M Y Y Y Y |
| **High-density lipoproteins (HDL)** | | |
| Reading 1 | mmol/l | D D M M Y Y Y Y |
| Reading 2 | mmol/l | D D M M Y Y Y Y |
| Reading 3 | mmol/l | D D M M Y Y Y Y |
| **Triglycerides (Tg)** | | |
| Reading 1 | mmol/l | D D M M Y Y Y Y |
| Reading 2 | mmol/l | D D M M Y Y Y Y |
| Fasting Reading 3 | mmol/l | D D M M Y Y Y Y |
| **Respiratory results*** | | |
| **FEV1/FVC readings** | | |
| Reading 1 | % | D D M M Y Y Y Y |
| Reading 2 | % | D D M M Y Y Y Y |
| Reading 3 | % | D D M M Y Y Y Y |
| **FEV1% pre bronchodilator** | | |
| Reading 1 | % | D D M M Y Y Y Y |
| Reading 2 | % | D D M M Y Y Y Y |
| Reading 3 | % | D D M M Y Y Y Y |

| Results | | Test date |
|---|---|---|
| **FEV1% post bronchodilator** | | |
| Reading 1 | % | D D M M Y Y Y Y |
| Reading 2 | % | D D M M Y Y Y Y |
| Reading 3 | % | D D M M Y Y Y Y |
| **Peak flow** | | |
| Reading 1 | % | D D M M Y Y Y Y |
| Reading 2 | % | D D M M Y Y Y Y |
| Reading 3 | % | D D M M Y Y Y Y |
| **Cardiac results*<br>Blood pressure** | | |
| Reading 1 | mmHg | D D M M Y Y Y Y |
| Reading 2 | mmHg | D D M M Y Y Y Y |
| Reading 3 | mmHg | D D M M Y Y Y Y |

*Please indicate whether any of these results were recorded “on treatment” (i.e. not baseline values)
**Please indicate whether these are fasting or random glucose levels

**Additional information relevant to your patient’s condition(s):**

## Section E: Chronic medication application

**To be completed by the attending Healthcare Professional**

Please note that in order to comply with clinical funding protocols, the receipt of certain clinical information is mandated prior to the authorisation of chronic medication. This includes, but is not limited to, the following:

Clinical entry criteria for prescribed minimum benefits (PMB)

| Condition | Clinical Entry Criteria (please include the ICD10 code) |
|---|---|
| Addison’s Disease | Diagnosis to be confirmed by an endocrinologist, paediatrician or specialist physician |
| Asthma | 1. Diagnostic lung function test (pre- & post-bronchodilator) for children ≥7 years old and for all adults<br>2. For children <7 years of age, a confirmation of diagnosis from a paediatrician, pulmonologist or specialist physician is required |
| Bipolar Mood Disorder | Diagnosis to be confirmed by a psychiatrist and clinical subtype (type I or type II) to be specified |
| Bronchiectasis | Diagnosis to be confirmed by a pulmonologist or specialist physician |
| Cardiac Failure | New York Heart Association (NYHA) stage and left ventricular ejection fraction (LVEF) required |
| Cardiomyopathy | Subtype and left ventricular ejection fraction (LVEF) required |
| Chronic Obstructive Pulmonary Disease (COPD) | 1. Diagnostic Lung Function Test reflecting both pre- and post-bronchodilator FEV1 and FEV1/FVC |
| Chronic Renal Failure | 1. Diagnostic creatinine clearance or estimated Glomerular Filtration Rate (eGFR)<br>2. Hb results and iron studies required when applying for erythropoietin or intravenous iron |
| Coronary Artery Disease | Report with diagnostic findings required – e.g., ECG (exercise/stress), echocardiography, angiography, or details of cardiac event (ACS/MI/PCI/CABG, including date) |
| Crohn`s Disease | Diagnosis to be confirmed by a gastroenterologist, surgeon or specialist physician |
| Diabetes Insipidus | Diagnosis to be confirmed by an endocrinologist, paediatrician or specialist physician |

| | |
|---|---|
| Diabetes Mellitus Type 1 & 2 | Fasting blood glucose, and either the 2hr–OGTT, HbA1c (DCCT) or random blood glucose result are required (laboratory report); motivation including presenting symptoms required if only one test result provided |
| Dysrhythmias | Diagnosis to be confirmed by a cardiologist or specialist physician |
| Epilepsy | Diagnosis to be confirmed by a neurologist, specialist physician or paediatrician; alternatively, the seizure history or abnormal EEG report to be provided |
| Glaucoma | Diagnosis to be confirmed by an ophthalmologist |
| Haemophilia (A & B) | 1. Diagnosis to be confirmed by a specialist physician or haematologist<br>2. Pathology report indicating factor VIII or IX levels |
| Hyperlipidaemia | 1. Diagnostic Lipogram required – Must include Total Cholesterol, LDL, HDL and Triglyceride values<br>2. Blood pressure reading at time of diagnosis<br>3. Smoking status<br>4. Familial hyperlipidaemia requires an endocrinologist diagnosis<br>5. If applicable, please provide family history of premature cardiovascular event (detail required) |
| Hypertension | Two diagnostic blood pressure readings without any antihypertensive medication are required (the second reading to be 3 or more months after lifestyle modifications have been implemented) for newly diagnosed patients, unless diagnostic BP is ≥160/100 or significant CV risk factors present (please provide details thereof if applicable) |
| Hypothyroidism | Diagnostic thyroid function test results: TSH and FT4; thyroid antibody tests in case of sub-clinical results |
| Multiple Sclerosis | 1. Diagnostic confirmation from a neurologist or specialist physician<br>2. The following information must be submitted:<br>a. MRI reports<br>b. Relapsing-remitting history (clinical presentation and dates)<br>c. Extended Disability Status Score (EDSS)<br>d. Relapses requiring cortisone therapy<br>e. Current Functional Systems Scale score (Pyramidal System) |
| Parkinson's Disease | Diagnosis confirmation from a neurologist or specialist physician, otherwise the diagnostic motor signs and symptoms to be provided |
| Rheumatoid arthritis | 1. Diagnosis confirmation from a rheumatologist, paediatrician or specialist physician<br>2. Alternatively, supporting pathology report (CRP/ESR and Rheumatoid Factor) to be provided and clinical history confirming diagnosis, as well as treatment history |
| Schizophrenia | Diagnosis confirmation from a psychiatrist |
| Systemic Lupus Erythematosus | Diagnosis confirmation from a specialist physician or rheumatologist |
| Ulcerative Colitis | Diagnosis to be confirmed by a gastroenterologist, specialist physician or surgeon |

Clinical entry criteria for additional chronic conditions (plus, comprehensive & traditional plans)

| **Condition** | **Clinical Entry Criteria (please include the ICD10 code)** |
|---|---|
| Acne | Diagnosis to be confirmed by a dermatologist |
| Allergic Rhinitis | Diagnosis to be confirmed by an ENT, paediatrician or specialist physician unless there is associated asthma |
| Ankylosing Spondylitis | Diagnosis to be confirmed by a rheumatologist or specialist physician |
| Anxiety Disorder (chronic) | No specific criteria required apart from ICD10 code |
| Arrythmia/Dysrhythmia (non-PMB) | Diagnosis to be confirmed by a cardiologist or specialist physician |
| Atopic Dermatitis (Eczema) | Diagnosis to be confirmed by a dermatologist or paediatrician |
| Benign Prostatic Hyperplasia | No specific criteria except for ICD10-code for alpha blockers. For 5-α-reductase inhibitors, the prostate size in grams or millilitres is required |
| Cystic Fibrosis | Diagnosis to be confirmed by a pulmonologist, paediatrician or specialist physician |
| Gastro-oesophageal reflux disorder (GORD) | No specific information required apart from ICD-10 code for standard dose PPI up to 3 months, or for ongoing low dose PPI; FOLLOW UP scope report or gastroenterologist motivation required for standard dose PPI beyond 3 months and in all cases of double dose PPI |
| Gout | No specific criteria apart from ICD10 code |
| Hyperkinesis (Attention Deficit Hyperactivity Disorder) | Diagnosis to be confirmed by a paediatrician, neurologist or psychiatrist unless the prescriber is certified with a special qualification in ADHD (certification required) |
| Hypoparathyroidism | Laboratory results required |
| Hyperthyroidism | Diagnostic thyroid function results are required (TSH and T4) |
| Major depression | No specific criteria required apart from ICD10 code for antidepressants. A letter of motivation is required for any non-antidepressants (e.g., mood stabilisers and antipsychotics) |
| Menopause | Accepted from any prescriber for patients between the ages of 40 and 69 without cardiovascular comorbidities. Laboratory reports are required for confirmation of premature menopause |
| Motor Neuron Disease | Diagnosis to be confirmed by a neurologist or specialist physician |

| | |
|---|---|
| Myasthenia Gravis | Diagnosis to be confirmed by a neurologist or specialist physician |
| Osteoarthritis | No specific criteria apart from ICD10 code |
| Osteoporosis | DEXA scan to be supplied; in the case of fractures, an X-ray report is also required |
| Paget's Disease | Diagnosis to be confirmed by a neurologist or specialist physician |
| Peptic Ulcer | No specific information required apart from ICD-10 code for standard dose PPI up to 3 months, or for ongoing low dose PPI; FOLLOW UP scope report or gastroenterologist motivation required for standard dose PPI beyond 3 months and in all cases of double dose PPI |
| Psoriasis | Diagnosis to be confirmed by a dermatologist |
| Schizo-affective Disorder | Diagnosis to be confirmed by a psychiatrist |
| Spinal cord injuries (paraplegia/quadriplegia) | Diagnosis to be confirmed by a neurologist, neurosurgeon or specialist physician. All relevant reports (including scans) to be submitted. |
| Stroke | Date of event required |
| Transient Ischaemic Attack | Date of event required |
| Urinary incontinence | No specific criteria apart from ICD10 code |

Clinical entry criteria for additional chronic conditions (plus and comprehensive only)

| **Condition** | **Clinical Entry Criteria (please include the ICD10 code)** |
|---|---|
| Alzheimer's Disease | 1. Diagnosis to be confirmed by a neurologist or psychiatrist<br>2. Baseline Folstein MMSE score is required<br>3. CT scan report to be supplied (if available)<br>4. Laboratory test results confirming the exclusion of other causes of dementia to be supplied (e.g., vitamin B12) |
| Meniere's Disease | Diagnosis to be confirmed by an ENT or neurologist |

Clinical entry criteria for additional chronic conditions (all plans)

| **Condition** | **Clinical Entry Criteria (please include the ICD10 code) Nephrotic** |
|---|---|
| Nephrotic Syndrome | Diagnosis to be confirmed by a nephrologist. All supporting diagnostic investigations (including urine analysis and histology if applicable) to be submitted |
| Pulmonary Embolism | Date of event required as well as clinical risk factors for recurrence |

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|---|---|
| Insulin for Diabetes type 2: | HbA1c and motivation |
| DPP-4 inhibitors and GLP-1 analogues: | HbA1c and motivation |
| Glitazones and SGLT2 inhibitors: | HbA1c and motivation |

* In primary prevention patients requesting lipid-modifying therapy (e.g. statins), reimbursement is reserved for patients with a significant risk of an acute clinical coronary event within the next 10 years, as calculated by the Framingham Risk Calculation and in accordance with locally and internationally accepted treatment guidelines. Please note that generic simvastatin is the preferred statin in these instances.

** At least two pre-treatment readings required, separated by 3-6 months, unless BP is severely increased. Lifestyle modification is strongly advised as a first line treatment and in addition to medication.

*** Both the pre-treatment TSH and T4 levels are required; in the case of sub-clinical hypothyroidism, a supporting motivation and/or laboratory report indicating anti-thyroid antibody levels is required

## Medication prescribed

Please use block letters. Kindly indicate below where you agree to a generic substitution and provide your preferred medication name.

| ICD-10 code(s) | Diagnosis | Name (trade name or generic equivalent) | Generic substitution | | Strength (e.g. 50mg) | Directions (e.g. 2tds) | Date medication started | Type and date of investigation/report |
|---|---|---|---|---|---|---|---|---|
| | | | Yes | No | | | | |
| | | | Y | N | | | | |
| | | | Y | N | | | | |
| | | | Y | N | | | | |
| | | | Y | N | | | | |
| | | | Y | N | | | | |
| | | | Y | N | | | | |
| | | | Y | N | | | | |
| | | | Y | N | | | | |

**Additional information/motivation**

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**PLEASE NOTE: All chronic medication is subject to the Scheme Reference Price. Should the patient be unable to use a preferred alternative, the prescribing Healthcare Professional would need to submit a detailed clinical motivation including outcomes/adverse reactions experienced in response to treatment using the preferred alternate agents.**

## Medication stopped (please use block letters)

| ICD-10 code(s) | Diagnosis | Name (trade name or generic equivalent) | Strength (e.g. 50mg) | Directions (e.g. 2tds) | Date medication stopped |
|---|---|---|---|---|---|
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## Section F: Prescribed Minimum Benefits

**To be completed by the attending Healthcare Professional**

If your patient has one or more of the following chronic conditions, he/she may qualify for additional services. Please indicate which condition(s) he/she has by placing an “X” next to the applicable condition.

| | | | | | |
|---|---|---|---|---|---|
| Addison’s Disease | | Crohn’s Disease | | Hypertension | |
| Asthma | | Diabetes Insipidus | | Hypothyroidism | |
| Bipolar Mood Disorder | | Diabetes Mellitus Type I | | Multiple sclerosis | |
| Bronchiectasis | | Diabetes Mellitus Type II | | Parkinson’s Disease | |
| Cardiac Failure | | Dysrhythmias | | Rheumatoid Arthritis | |
| Cardiomyopathy Disease | | Epilepsy | | Schizophrenia | |
| Chronic Obstructive Pulmonary Disorder | | Glaucoma | | Systemic Lupus Erythematosus | |
| Chronic Renal Disease | | Haemophilia | | Ulcerative colitis | |
| Coronary Artery Disease | | Hyperlipidaemia | | | |

## Section G: Patient consent

1. I hereby confirm that the information provided in this application is true and correct.
2. I acknowledge that the Bankmed Medical Scheme ("Bankmed") has appointed Performance Health (Pty) Ltd, a subsidiary of MediKredit Integrated Healthcare Solutions (Pty) Ltd to manage the Chronic Medication Programme and that any medical treatment prescribed, as well as the general management of my condition(s), will be the sole responsibility of my healthcare provider(s), in consultation with me. Performance Health and Bankmed (collectively, the "Bankmed Parties") will accordingly not be liable for any claims by me or my dependants arising from the implementation of the Programme, save insofar as provided in the Bankmed Rules.
3. I hereby give my consent to the Bankmed Parties and its staff to obtain my Special Personal Information (i.e. health and biometric), to assess my medical risk and to use such information to my benefit. I understand and agree that Special Personal Information relevant to my current state of health can be disclosed to third parties for the purpose of scientific, epidemiological and/ or financial analysis, without disclosure of my identity. I furthermore agree to the Programme's consultants sharing my Special Personal Information with any other healthcare provider involved in my care (including the Hospital Advisory Services professionals appointed by Bankmed).
4. I understand that no information regarding my case will be made available to my employer(s) or any other person not directly involved in my care.
5. I give my consent to the Bankmed Parties to electronically store, access, process and retain my healthcare information for the purposes set out in this document as may otherwise be required to administer the Programme.
6. Whilst the Bankmed Parties will use their best endeavours to uphold the confidentiality of all my Special Personal Information, the Bankmed Parties will not be liable for any claims by me or my dependants arising from any unauthorised disclosure of my Special Personal Information to a third party.
7. I understand that telephone calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the Medication Management Programme department.
8. I understand and acknowledge that "consent", for the purposes of this document, means my informed consent, in other words:
   - 8.1. I have read and understood the contents of this document.
   - 8.2. I understand and acknowledge the nature of the Special Personal Information that will be made available to and disclosed, used, processed and retained by service providers, as set out in this consent.
   - 8.3. I understand and acknowledge the purpose for which the Special Personal Information relating to me will be made available to, and disclosed, used, processed and retained by the Bankmed Parties and my healthcare provider(s), as set out in this consent.
   - 8.4. I have the legal capacity to give my informed consent, in other words, I am over the age of 18 years and am able to fully understand and make decisions about my healthcare.

Patient's signature

**(or signature of parent/guardian if patient is under age 18)**

Date D D M M Y Y Y Y