APPLICATION FOR CHRONIC MEDICATION AND DISEASE MANAGEMENT

This form should be completed upon registration on the MyCare Health Solutions (MyCare) Chronic Medication and Disease Management Programme and submitted to MyCare either via:

- E-mail: new@mycaresolutions.co.za
- Fax: 086 575 4725

A. The following diseases are covered by the MyCare Health Solutions Programmes:

Chronic Disease Condition	Minimum Clinical Entry Criteria
Addison's Disease	None if diagnosis made by specialist physician/ endocrinologist or paediatrician
Asthma	None
Bipolar Mood Disorder	None if diagnosis made by psychiatrist
Bronchiectasis	None if diagnosis made by specialist physician/ endocrinologist or paediatrician
Cardiac Failure	None
Cardiomyopathy	None
Chronic Obstructive Pulmonary Disease	None
Chronic Renal Disease	None if diagnosis made by specialist physician/ nephrologist or paediatrician
Coronary Artery Disease	None
Crohn's Disease	None if diagnosis made by specialist physician/ gastroenterologist or paediatrician
Diabetes Insipidus	None if diagnosis made by specialist physician/ endocrinologist or paediatrician
Diabetes Mellitus Type 1	None if diagnosis made by specialist physician/ endocrinologist or paediatrician
Diabetes Mellitus Type 2	Please complete the application form in full
Dysrhythmias	None
Endometriosis	None if diagnosis made by gynaecologist
Epilepsy	None
Glaucoma	None if diagnosis made by ophthalmologist
Haemophilia	None if diagnosis made by haematologist or specialist physician
HIV and AIDS	Please complete HIV application form
Hyperlipidaemia	Please complete the application form in full
Hypertension	Please complete the application form in full
Hypothyroidism	None
Menopause	None
Multiple sclerosis	None if the initial diagnosis was made by a neurologist
Paraplegia	None
Parkinson's Disease	None
Polycystic Ovary Syndrome	None if diagnosis made by gynaecologist
Rheumatoid Arthritis	None if diagnosis made by rheumatologist
Schizophrenia	None if diagnosis made by psychiatrist
Systemic Lupus Erythematosus	None if the diagnosis was made by a specialist physician or dermatologist
Ulcerative Colitis	None

***This page does not need to be submitted**

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B. Benefit limitations:

- Limitations to the benefits specified in this protocol are:
  - Valid membership as per scheme rules at the time of application
  - Valid prescription by a registered medical practitioner
  - Limitation as set by the scheme such as waiting periods and member suspensions
- All drug utilization will be limited to the MyCare Health Solutions Formulary or the formulary specified by the Scheme.
- The classes of drugs mentioned in the pharmacology sections shall be reimbursed to a maximum monetary limit determined by the MyCare/Scheme formulary reference price.
- Any exceptions to the formulary, will only be considered where a protocol or specific treatment is or has been ineffective, or causes or would cause harm to the beneficiary, and all motivations will be reviewed by the Scheme for approval or decline based on the clinical motivation.
- Adjudicated exceptions to the formulary may be approved by the Scheme and may be subjected to co-payments determined by the Scheme.
  - All scheme exclusions as set out in the registered scheme rules apply
  - Dispensing is subject to the designated service provider as set out in the scheme rules, and any non-voluntary out-of-DSP exceptions to the designated service provider must be approved by the scheme.
- The condition eligibility list of the Scheme as prepared by the Scheme and/or its Administrator for PMB CDL Conditions, PMB DTP Conditions and other conditions using the ICD-10 coding system and this list will be used for the consideration of drugs for acceptance in performing the Managed Health Care Services. All conditions not included in the condition eligibility list, will not be eligible for chronic medicine benefits in terms of the protocol.

C. Please kindly note the following when completing this form:

1. This form need only be completed for Diabetes Mellitus Type 2, Hyperlipidaemia and Hypertension.
2. Benefits and formularies may change from time to time, please feel free to contact us at any time in order to have these explained to you.
3. By the member signing this form:
   a. Permission is given for the healthcare provider to provide MyCare Health Solutions with the diagnosis and other relevant clinical information required to review the application for the Chronic Medicine and Disease Management Programme.
   b. Funding from the Chronic Medicine and Disease Management Programme.is subject to meeting minimum entry criteria requirements as determined by MyCare Health Solutions.
   c. The Chronic Medicine and Disease Management Programme provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by the Chronic Disease Benefit.
   d. By registering for the Chronic Medicine and Disease Management Programme, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.
   e. Funding for medicine from the Chronic Illness Benefit will only be effective from when MyCare Health Solutions receives an application form that is completed in full.
4. Payment for the completion of this form, on submission of a claim, will be approved by MyCare only on receipt of a complete application form.

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D. Patient Details:

Patient's name								
Membership number								
Beneficiary number								
ID number								
Date of birth	Y	Y	Y	Y	M	M	D	D
Cell phone number								
E-mail address								

Should there be no e-mail address, communication will only be via cell phone, but full treatment details will be communicated to the treating provider.

Signature of patient (in case of a minor <18 years, to be signed by main member):

Date:

E. Doctor's details:

Name and surname				
BHF practice number				
Specialist				
Telephone number				
Fax number				
E-mail address				
Outcome of my application to be sent to me via: (Tick option)	**E-mail**		**Fax**	

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F. Metabolic Syndrome

If a patient is diagnosed with either Hypertension, Hyperlipidaemia or Diabetes Mellitus Type 2, we require the following test results:

- BP
- Fasting Lipogram
- Fasting Glucose
- HbA1C

On all patients

1. Hypertension

Please note patients that require more than three classes of medication, the application form should be completed by a specialist physician.

a. Was this diagnosis of hypertension made more than 6 (six) months ago, and patient has been on treatment of at least that amount of time?	**Yes**	**No**	
b. If this is a new diagnosis (within the last 6 months)	**Is this patient younger than 30 years?**	**Yes**	**No**
	Please note that if the beneficiary is younger than 30 years, the application should be made by a cardiologist, paediatrician, nephrologist or endocrinologist.		
c. Blood pressure readings and date on which it was taken			
d. Has the patient have any of these conditions?	**Chronic Renal Disease**		
	Hypertensive Retinopathy		
	Prior Cardiac Surgery (i.e. CABG)		
	Peripheral Artery Disease		
	Congestive Cardiac Failure / CCF / CMO		
	Micro albuminuria / Elevated Creatinine		
	Stroke		
	Transchemic Ischaemic Attack		
	Angina Pectoris		
	Myocardial Infarction		
	Pre-eclampsia		

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2. Hyperlipidaemia

We require a full Lipogram not older than 30 days and before treatment has started on newly diagnosed patients.

Lipid levels:

Please select one of the following:	
Blood Test	**Result**
Total Cholesterol	**mmol/L**
LDL Cholesterol	**mmol/L**
HDL Cholesterol Male	
HDL Cholesterol Female	
Triglycerides	

Framingham Risk Score:

Male		Female	
On HPT medication		YES	NO
Male		Female	
-3 to 3		-2 to 5	
4 to 12		6 to 15	
13 to 17		16 to 20	
>18		>21	

Please select the following:

3. Diabetes Type 2

Is this a newly diagnosed patient, not on therapy yet? Yes / No

Kindly note that only pathology results will be accepted i.e. no finger pricks.

Test	Result
Fasting plasma glucose concentration	**mmol/L**
Random plasma glucose	**mmol/L**
Two hour post glucose tolerance test	**mmol/L**
HbA1C	**%**

Is patient on medication already? If yes please specify below			YES	NO
Drugs	**Start date**	**End date**	**Duration (Months)**	**Reason for discontinuation**

G. Medicine required (To be completed by doctor)

Formulary medicine will be funded up to the MyCare Health Solutions rate for medication. There will be no co-payment for medicine selected from the formulary.

For non-formulary medicine the member will be liable for a 40% co-payment for the specific medication.

ICD 10	Diagnosis description	Date when condition was first diagnosed	Medicine name, strength and dosage	How long has this patients used this medication	
				Years	Months

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H. Notes to doctors

1. In line with legislative requirements please ensure that 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 funding for multiple chronic conditions were applied for, then it would be appropriate to list all the relevant ICD-10 codes.
2. We will approve funding for generic medicine, where available, unless you have indicated otherwise.
3. Please submit all the requested supporting documents with this application to prevent delays in the review process.
4. You may call **0800 555 433** for **changes** to your patient's medicine for an **approved** condition. An application form only needs to be completed when applying for a **new chronic condition**.
5. If you have a complex clinical issue that you need to discuss with a doctor or pharmacist, please call **0800 555 433** or e-mail **info@mycaresolutions.co.za**.

Doctor's signature

Date

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