# PATHFINDER: CHRONIC MEDICATION APPLICATION FORM

**RETURN FORM TO: CHRONIC MEDICATION PRIVATE BAG X128 CENTURION 0046. FAX (012) 673 5524 CONFIRM 0861 147 741**

## *1. How to complete this form:*

- Pathfinder Medical Schemed adheres to the ABCDE Medicine formulary.
- This form should only be completed for items where supportive diagnostic test results are required. (Please see under point 9).
- Telephonic authorisations can be done where authorisation is required, but no supportive diagnostic information is needed.
- Telephonic authorisation can be done for above items by asking your doctor to call the Provider Chronic Authorisation line at 0861 147 741.
- Please retain the original prescription and present it to the dispenser of your choice once the application has been processed.

## *Section A – To be completed by the member*

### *1. Patient particulars (user of medication)*

| Surname | | Membership no | | |
|---|---|---|---|---|
| First name | | | Dependant no | |
| Change of address | | Scheme option | | |
| | | Tel (home) code | | |
| | | Tel (work) code | | |

### *2. Principal member particulars*

| Surname | | | Title | | Initials | |
|---|---|---|---|---|---|---|
| Tel (w) | | No | Cell phone no. | | | |
| Tel (h) | | No | Fax code / no. | | | |

### *3. Please communicate completion of processing via sms to:*

| Patient cell phone no | |
|---|---|

### *4. Dispenser information:*

*Please mark only ONE option:*

☐ **OPTION 1:** My real-time, on-line pharmacy or courier pharmacy (please submit prescription yourself )

☐ **OPTION 2:** Fax pre-certification document to my dispensing doctor (provide details)

| Dispensing doctor | | | Dr Practice no | |
|---|---|---|---|---|
| Contact person | | Tel (Code) | | |
| Fax (Code) | | | e-mail address | |

### *5. Patient declaration*

- I understand and accept that personal clinical information will be made available to my medical scheme and their authorised agents in order to make informed recommendations regarding my chronic medication needs and that my medical practitioner has to state the diagnosis on the application form. I understand that the information will remain confidential at all times. I declare that the supplied information is correct.
- I understand that MMAP (Maximum Medical Aid Pricing) and MAC (Maximum Allowed Price) apply according to fund rules to acute and chronic medication and that the member will be responsible for the difference in price if the original prescribed item is preferred and dispensed.

| | | |
|---|---|---|
| Signature of patient<br>(If patient is older than 14 years) | Signature of principal member<br>(If patient is younger than 14 yrs old | Date |

## Section B – To be completed by the doctor

### 6. Important information

- Please complete one form per patient only for the items as required under point 8.
- Telephonic authorisations can be done for other items by calling Provider Chronic Authorisation line at 0861 147 741.
- Generic substitution and MAC (Maximum allowed cost) is applicable.
- Clinical protocols applies

### 7. Patient particulars

| | | | | | |
|---|---|---|---|---|---|
| Surname | | Membership number | | | |
| Initials | | Title | | Dependant no | |

### 8. Treatment to be considered for chronic authorisation

| ICD10 Diagnosis code | Medicine and strength | Daily dosage | Monthly quantity | Number of repeats | Period on medication? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Clinical motivation for all diagnoses:** Supply interpretation of all special investigations and attach relevant document where applicable. Approval of chronic medication depends on interpretation of attached clinical and diagnostic test results.

### 9. Requirements and medical information (only applicable for certain options)

| Weight kg | Height | Smoking: | YES | NO |
|---|---|---|---|---|

| State drug allergies of patient: | Details of previous surgical history: |
|---|---|
| | |

| | |
|---|---|
| **Hypercholesterolaemia:** | Simvastatin 20mg is available on chronic benefits on the automated list without co-payment. Alternative statins may be subject to a co-payment. For increased dosages, please motivate for special indications. Attach a base line lipogram. |
| **Gastro-intestinal:** | PPI's available for short-term *ad hoc* use (quantity limited to 1 months) on acute benefits. Only apply if long-term use is indicated. Please submit the latest available gastroscopy report (base line where applicable) when applying for long-term use of PPI's.<br>Previous eradication therapy for *H.pylori:* YES NO |
| **Musculo-skeletal:** | Hormone replacement therapy (oestrogen only preparations) is considered as first line therapy for osteoporosis in post hysterectomy patients. Should it be contra-indicated, please supply detailed information and submit proof of osteoporosis (DEXA scan or history of fragility fractures) |
| **Skin conditions and chronic infections appendages:** | A dated, post card size, colour photograph of affected areas should accompany applications for isotretinoin. Treatment history as well as the grade of acne should be supplied. Please supply weight in kg. kg |

### 10. Particulars of medical practitioner

| | | | |
|---|---|---|---|
| Name of practitioner | | | |
| Address | | | |
| HPCSA number | | Tel (code) | |
| Practice number | | Fax ( code) | |
| Date | | Qualification | |
| **Signature** | | e-mail address | |