APPLICATION FORM

Medicine Risk Management

INSTRUCTIONS

1. Complete this application form to register for chronic benefits for the first time or to register an additional chronic condition .
2. Complete one application form for each patient requiring chronic benefits.
3. Attach copies of any reports to support diagnosis of chronic condition, where applicable.
4. Please fax completed forms and results to +265 1 771 976or e-mail to:
   preauth@medhealth.mw

TO BE COMPLETED BY APPLICANT

Member details

Payer Name

Option

Membership number

Full Name

Title

Initials

Patient details

Name and surname

Title

ID number or date of birth

Address

Email address

Telephone (H) (W)

(Cell)

I authorise my medical practitioner to furnish and/or disclose to the Medicine Risk Management Department any fact relating to this application as well as any additional information that may be required from time to time.

If your application to the Medhealth International Disease Management Programme is declined, the relevant medication can be regarded as acute medication, subject to Medhealth Scheme Rules and availability of funds.

Member's signature _____

Date

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TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Doctor's Details

Full Name

Initials

Practice number

Specialty

Telephone

Fax

Cellphone

Email address

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TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (Continued)

Clinical examination

Gender ☐ M ☐ F Weight ☐☐☐ kg Height ☐☐☐ cm Blood pressure ☐☐☐/☐☐☐

Smoking: ☐ Never ☐ Ex-Smoker ☐ <10 per day ☐ >10 per day

Exercise: ☐ Never ☐ <1 hour per week ☐ 1-3 hours per week ☐ >3 hours per week

Allergies: ☐ Penicillin ☐ Aspirin ☐ Sulphonamides

Other ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

The receipt of certain clinical information is mandated prior to the authorisation of chronic medicines. These include:

» Asthma:	Lung Function Tests/Peak Flow Measurements x3
» Chronic Obstructive Pulmonary Disorder	Lung Function Tests
» Chronic Renal Failure:	Creatinine Clearance/Glomerular Filtration Rate
» Haemophilia:	Factors VIII and IX blood levels
» Hyperlipidaemia:	Lipogram.
» Diabetes:	HBA1C /Fasting Glucose

In addition, Medicine Risk Management requires certain special investigations to expedite the chronic authorization process. This includes, but is not limited to, the following:

» Long-acting insulin analogues, glitazones:	HBA1C
» Bisphosphonates and other agents for osteoporosis:	Bone Mineral Density and motivation
» Angiotensin Receptor Blockers (ARBs):	And Motivation

* In primary prevention patients requesting lipid-modifying therapy (e.g. statins), reimbursement is reserved for patients with a greater than 20% risk of an acute clinical coronary event within the next 10 years, as calculated by the Framingham Risk Calculation in accordance with locally and internationally accepted treatment guidelines. Please note that generic simvastatin is the preferred statin in these instances.

Generic medication or therapeutic alternatives can significantly reduce prescription costs. Should a generic equivalent be available, this will be authorised in place of your prescribed medication unless your doctor has specified otherwise.

MEDICATION PRESCRIBED (Please use block letters)

ICD-10 Code(s)	Detailed diagnosis and date of 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				

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APPLICATION FOR HYPERLIPIDAEMIA

Please attach Lipogram - To include total cholesterol, S-HDL, S-LDL, Total Triglyceride.

The reimbursement of lipid modifying therapy for primary prevention is reserved for patients with a greater than 20% risk of an acute clinical coronary e vent in the last 10 years. This funding decision is in accordance with international guidelines.

Please risk rate your patient as per the table and indicate your patient's score by circling the appropriate % risk below

RISK FACTORS		
Age (Years)	SCORE WOMEN	SCORE MEN
30-34	-9	-1
35-39	-4	0
40-44	0	1
45-49	3	2
50-54	6	3
55-59	7	4
60-64	8	5
65-69	8	6
70-74	8	7
TC (mmol/L)		
<4.2	-2	-3
4.2–5.2	0	0
5.3–6.2	1	1
6.3–7.2	1	2
>7.2	3	3
HDL-C (mmol/L)		
<0.91	5	2
0.91–1.16	2	1
1.17–1.29	1	0
1.3–1.55	0	0
>1.55	-3	-2
BP (mmHg)		
<120/ 80	-3	0
120-129/ 80-84	0	0
130-139/ 85-89	0	1
140-159/ 90-99	2	2
>160/100	3	3
Smoker	2	2
Diabetic	2	2

SCORE	% RISK FACTORS		
	SCORE WOMEN	SCORE MEN	
-2	1	0	
-1	2	2	
0	2	3	
1	2	3	
2	3	4	
3	3	5	
4	4	7	
5	4	8	
6	5	10	
7	6	13	
8	7	16	
9	8	20	Drug therapy indicated
10	10	25	
11	11	31	
12	13	37	
13	15	45	
14	18	>53	
15	20	>53	
16	24	>53	
17	>27	>53	

ADD UP RISK SCORES

These risk factors should also be considered

- Obesity
- Family History
- Definite diagnosis of F.H.

Source: SAMJ February 2000, Vol. 90, No 2

Based on the information supplied, does your patient have a 20% or greater chance of a coronary event in the next ten years? YES NO

We will not refund medication in patients with less than 20% risk of a coronary event in the next ten years. This is a funding decision to ensure the long-term sustainability of this benefit and does not in any way question your clinical decision.

Patients name

Membership number

APPLICATION FOR ANGIOTENSIN-II-BLOCKERS (ARB)

Please fax the relevant pathology results to confirm the diagnosis of microalbuminuria

Which ACE inhibitor(s) did the patient use? Please specify the period of use as well as the strength and dosage.

Is the patient intolerant to ACE inhibitors? YES NO

If the patient is intolerant to ACE inhibitors, which side effects did the patient experience? Please specify and describe the severity of the side effects.

APPLICATION FOR ANGIOTENSIN-II-BLOCKERS (ARB) (CONTINUED)

Specify which anti-hypertensive medicines, except ACE-inhibitors or angiotensin-II-blockers, were used previously and indicate the reason why the medicine was discontinued. Please specify the medicine, duration of use, strength and dosage.

_____

_____

_____

Does the patient have any of the following diseases?

Microalbuminuria (confirmed by three different microalbuminurea: creatinin ratio reports) Left	YES	NO
ventricular hypertrophy	YES	NO
Chronic renal disease	YES	NO
A previous myocardial infarction	YES	NO
Coronary artery stenosis Heart failure	YES	NO
Please specify the angiotensin-II-blocker for which you are applying	YES	NO

_____ ICD-10 Code

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

I hereby certify that information provided is true and correct.

_____ _____

Member's signature Prescribing doctor's signature Date

Membership no. Doctor's practice no.

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