



APPLICATION FORM MEDICINE RISK MANAGEMENT PROGRAMME

Important to note:

- Please book time with your doctor in order for him/her to examine you and complete this form. The ideal person to do this is the GP who regularly prescribes your medication. Please keep a copy of the completed form for your records.
- Members may obtain their approved chronic medication from **Clicks Pharmacies or Clicks Direct Medicines.**
- Member/patient signature on this form is essential to process this application.
- You will be informed in writing, should you be accepted onto the Medicine Risk Management Programme. You will receive a chronic authorisation letter which will list the diagnosis you are registered for as well as the medication that will be paid from the chronic benefit subject to the rules of your benefit option.

How to complete this form:

- Complete the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be physically signed and cannot be signed digitally. The patient must sign and date any changes.
- Complete and sign sections 1 and 4.
- Take the application form to your doctor to complete section 2 and other relevant sections, sign and attach any test results, clinical reports or other information that we need to review the request. These requirements are shown in section 6.
- Send the completed application form and all supporting documents by email to chronic@bpmas.co.za.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

1. MEMBER AND PATIENT INFORMATION

TO BE COMPLETED BY APPLICANT

MAIN MEMBER DETAILS

Membership number	<input type="text"/>		
Surname	<input type="text"/>		
Title	<input type="text"/>	Initials	<input type="text"/>
Email address	<input type="text"/>		

PATIENT DETAILS

Name and surname	<input type="text"/>		
Title	<input type="text"/>	ID number	<input type="text"/>
Beneficiary code	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text"/>	Postal code	<input type="text"/>
Email address	<input type="text"/>		
Contact numbers	<input type="text"/>	Home	Cell phone <input type="text"/>
	<input type="text"/>	Work	
Membership number	<input type="text"/>	Doctor's practice number	<input type="text"/>

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY APPLICANT (CONTINUED)

Member consent

I understand that BP Medical Aid Society and its Administrators will maintain the confidentiality of my personal information and comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing my personal information for the purposes of registration on the Medicine Risk Management Programme.

I understand that:

- Funding from the chronic benefit is subject to meeting benefit entry criteria requirements as determined by the Society.
- The chronic benefit provides cover for disease-modifying therapy only, which means that not all medication for a listed condition will automatically be covered by the chronic benefit.
- By registering for the chronic benefit, 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.
- Funding for medication from the chronic benefit will only be effective once the Society receives an application form that is completed in full. Please refer to the table in Section 6 to see what additional information is required to be submitted for the condition(s) for which you are applying.
- Payment to the healthcare professional for the completion of this form, on submission of a claim, is subject to Society rules and where the member is a valid and active member at the service date of the claim.
- I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions.
- To ensure that we pay your claims from the correct benefit, any claims from your healthcare providers must include the relevant ICD-10 diagnosis code(s). Please ask your doctor to also include the relevant ICD-10 diagnosis code(s) on the referral form for any pathology and/or radiology tests. This will enable the pathologists and radiologists to also include the relevant ICD-10 diagnosis code(s) on the claims they submit, thus further ensuring that we pay your claims from the correct benefit.

Consent for processing my personal information

- 1.I hereby acknowledge that any prescribed medical treatment shall be the sole responsibility of my medical practitioner. I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.
- 2.I hereby give my consent to the Society and its Administrators to obtain my, or any of my dependants', special personal information (including general, personal, medical or clinical), whether it relates to the past or future (e.g. health and biometric) from my healthcare providers (e.g. pharmacist, pathologist, radiologist, treating doctor and/or specialist) to assess my medical risk, enrol me on the programme and to use such information to my benefit and to undertake managed care interventions related to my chronic condition(s).
- 3.I understand that this information will be used for the purposes of applying for and assessing my funding request for chronic benefits.
- 4.I give permission for my healthcare provider to provide the Society and its Administrators with my diagnosis and other relevant clinical information required to review and process my application.
- 5.I consent to the Society and its Administrators disclosing, from time to time, information supplied to them (including general, personal, medical or clinical) to my healthcare provider, to administer the chronic benefits.
- 6.Whilst the Society and its Administrators undertake to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Society and my healthcare provider (where necessary) shall also gain access to the same information. I shall therefore not hold the Society and its Administrators liable for any claims by me or my dependants arising from any unauthorised disclosure of my special personal information to other parties.
- 7.I understand and agree that special personal information relevant to my current state of health may be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

I hereby certify that the information provided in this application is true and correct.

Member/patient signature

Date

DD/MM/YYYY

Membership number

Doctor's practice number

2. MEDICAL PRACTITIONER'S INFORMATION AND CLINICAL EXAMINATION

TO BE COMPLETED BY ATTENDING MEDICAL PRACTITIONER

DOCTOR'S DETAILS

Surname	<input type="text"/>	Initials	<input type="text"/>
Speciality	<input type="text"/>		
Practice number	<input type="text"/>		
Contact numbers	<input type="text"/> Work	Cell phone	<input type="text"/>
Postal address	<input type="text"/>		
	<input type="text"/>	Postal code	<input type="text"/>
Email address	<input type="text"/>		

ASSOCIATED SPECIALIST DETAILS

Surname	<input type="text"/>	Initials	<input type="text"/>
Speciality	<input type="text"/>		
Practice number	<input type="text"/>		

CLINICAL EXAMINATION

Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other	Weight	<input type="text"/> kg	Height	<input type="text"/> cm
Blood pressure (on treatment)	<input type="text"/>	/	<input type="text"/> mmHg	Blood pressure (off treatment)	<input type="text"/>	/	<input type="text"/> mmHg
Smoking	<input type="checkbox"/> Never	<input type="checkbox"/> Ex-smoker	<input type="checkbox"/> <10 per day	<input type="checkbox"/> >10 per day			
Exercise	<input type="checkbox"/> Never	<input type="checkbox"/> <1 hour per week	<input type="checkbox"/> 1-3 hours per week	<input type="checkbox"/> >3 hours per week			
Allergies	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Sulphonamides				
Other	<input type="text"/>						

Please indicate if the patient has a history of the following:

Ischaemic heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Peripheral vascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TIA/Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If the patient has diabetes, please provide the most recent HbA1c results and pre-treatment glucose results for first-time registration:

Please note: Prescribed Minimum Benefit rules, chronic disease lists and medication formularies applicable to your benefit option will apply. As per the requirements of the Government Risk Equalisation Fund (REF), in order to register patients on the Medicine Risk Management Programme, documentation from a relevant specialist and/or test results verifying the diagnosis, is required for, but is not limited to, the following:

- Chronic obstructive airways disease: Documentation of lung function tests (most recent)
- Chronic renal failure: Documentation of creatinine clearance or Glomerular Filtration Rate (GFR) estimate (most recent)
- Haemophilia: Factors VIII and IX blood levels
- Hyperlipidaemia: Pre-treatment lipogram
- Diabetes type 1 or 2 and/or second- or third-line drugs: HbA1c and motivation

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3. MEDICATION PRESCRIBED

Please indicate below where you agree to a generic substitution and provide your preferred medication name. Chronic medication is subject to formularies and generic reference pricing.

ICD-10 code(s) and diagnosis	Medication name and date started (DD/MM/YYYY)	Strength (e.g. 50mg)	Directions (e.g. 2tds)	Special motivation/ investigations	Specialist's details (Practice number and name)	Treatment on previous medical scheme(s) for diagnosis* Yes/No?

* If you answer 'yes', please indicate the medical scheme name and supply proof of previous chronic registration.

4. MEDICATION STOPPED

ICD-10 code(s)	Diagnosis	Name (trade name or generic equivalent)	Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date medication stopped (DD/MM/YYYY)

5. PATIENTS WITH HYPERLIPIDAEMIA

ONLY COMPLETE THIS SECTION FOR PATIENTS WITH HYPERLIPIDAEMIA

Motivation for a lipid-modifying agent for the treatment of hyperlipidaemia

In line with the requirements of the Government Risk Equalisation Fund (REF), the application can only be assessed on receipt of the completed form and copies of the relevant lipograms.

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5. PATIENTS WITH HYPERLIPIDAEMIA (CONTINUED)

The reimbursement of lipid-modifying therapy for primary prevention is reserved for patients with a greater than 20% risk of an acute clinical coronary event in the next 10 years. This funding decision is in accordance with local and international guidelines for the management of hyperlipidaemia.

Registered starting doses of lipid-modifying drugs and incremental dosage increases will be considered. Higher dosages will be considered on motivation. Kindly consider a less costly alternative, e.g. generic atorvastatin.

Requested drug and dose

Funding of ezetimibe is limited to those very high-risk patients not reaching an LDLC of ≤ 3.0 mmol/l despite at least two months' compliance with maximum dose standard therapy e.g. rosuvastatin titrated to 40mg daily.

Requests for the funding of ezetimibe must be accompanied by a motivation.

Risk factors (please indicate by ticking the appropriate box):

	Yes	No	Comment
Smoker			
Diabetes type 1 with microalbuminuria or proteinuria (please supply supporting laboratory report)			
Ischaemic heart disease (e.g. angina, myocardial infarction [MI])			
Solid organ transplant (please supply relevant clinical information)			
Peripheral vascular disease (e.g. aortic aneurism)			
Stroke/transient ischaemic attacks (TIA)			
Chronic renal disease (please supply supporting laboratory report reflecting creatinine clearance)			
Renal artery stenosis			

History of fasting lipogram laboratory results (please indicate if the following results are pre-treatment or on treatment):

	Diagnosing lipogram (attach copy)	Lipogram on treatment (attach copy)
Date (DD/MM/YYYY)		
Lipid-modifying drug and dosage (please indicate mg/day in each column)		
Total cholesterol		
S-HDL		
S-LDL		
Total triglyceride		
TSH (where LDLC ≥ 4 mmol/l)		

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5. PATIENTS WITH HYPERLIPIDAEMIA (CONTINUED)

Familial hyperlipidaemia (FH)

Diagnosed by an endocrinologist Yes No

Doctor's name

Practice number

Signs of FH (e.g. tendon xanthomata)

Family history of premature atherosclerotic event in first-degree relative Yes No

Relative (e.g. father/sister)

Description (e.g. MI/stroke)

Age at time of event/death

Any other relevant clinical information about this patient that supports the diagnosis of hyperlipidaemia:

6. CHRONIC REGISTRATION CLINICAL CRITERIA

Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL)	Benefit entry criteria requirements
Addison's disease	Diagnosis by a specialist physician, paediatrician, endocrinologist or by a State doctor
Asthma (adult)	Diagnosis confirmed by a GP or specialist
Asthma (child <7 years)	Diagnosis made or confirmed by specialist paediatrician
Bipolar mood disorder	A psychiatrist prescription. Benzodiazepines excluded on chronic benefit
Bronchiectasis	Diagnosis confirmed by a specialist (entry criteria for pre-existing conditions will apply e.g. COPD)
Cardiac failure	Diagnosis confirmed by a specialist physician
Cardiac dysrhythmia	Diagnosis confirmed by a specialist physician
Cardiomyopathy	Diagnosis confirmed by a specialist physician
Chronic obstructive pulmonary disease (COPD)	Diagnosis confirmed by a GP or specialist. Copy of lung function test performed to American Thoracic Society (or similar) criteria demonstrating FEV1/FVC post-bronchodilator values <70% and FEV1 post-bronchodilator <80% of predicted as per risk equalisation fund criteria
Chronic renal disease	Diagnosis confirmed by a nephrologist or specialist physician. Copy of lab results required: serum creatinine clearance value or a glomerular filtration rate estimate of eGFR $\leq 60\text{ml}/\text{min}/1.73\text{m}^2$
Coronary artery disease	Diagnosis confirmed by a specialist physician or cardiologist
Crohn's disease	Diagnosis by a specialist physician, paediatrician, surgeon, gastroenterologist or by a provider employed by a State hospital. Endoscopy report with histology results (colonic disease). Small bowel disease: imaging studies. Lab results: FBC; ESR and CRP; stool culture
Diabetes insipidus	Diagnosis by a specialist physician, paediatrician, neurologist, neurosurgeon or endocrinologist with the relevant ICD-10 code(s)
Diabetes mellitus type 1	Specialist initiation and confirmatory lab results: <ul style="list-style-type: none"> • HbA1c >6.5% • x2 random glucose >11mmol/l • x2 fasting blood >7mmol/l • x1 blood glucose >15mmol/l • GTT (fasting glucose >7mmol/l and/or two hours post-prandial glucose load >11.1mmol/l)
Diabetes mellitus type 2	Diagnosis confirmed by a GP or specialist physician and confirmatory lab results as above

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6. CHRONIC REGISTRATION CLINICAL CRITERIA (CONTINUED)

Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL)	Benefit entry criteria requirements
Epilepsy	New diagnosis confirmed by a specialist physician, neurologist, paediatrician or neurosurgeon
Glaucoma	Diagnosis confirmed by an ophthalmologist
Haemophilia	Diagnosis confirmed by a specialist physician. Copy of lab results of factor VIII or factor IX levels <5%
Hyperlipidaemia	Diagnosis confirmed by a GP or specialist physician. Copy of lipogram results and documentation related to the risk assessment (Framingham Risk Score). Details of patient history: established vascular disease and details of any procedure performed e.g. angioplasty, stent etc. Details of family history from prescribing doctor (to include details of cardiovascular events in member's first-degree relatives, including age of onset)
Hypertension	Diagnosis by a GP or specialist physician
Hypothyroidism	Diagnosis confirmed by a GP or specialist with relevant pathology
Multiple sclerosis	Diagnosis to be confirmed by a specialist physician, neurologist or neurosurgeon. Motivation and tick sheet to be filled in by a neurologist
Parkinson's disease	Diagnosis confirmed by a neurologist with relevant ICD-10 code(s)
Rheumatoid arthritis	Diagnosis confirmed by GP and a tick sheet to be completed, or diagnosis confirmed by a specialist physician, paediatrician or rheumatologist. We also require the following clinical information: Serum rheumatoid factor (RF), anti-CCP, ESR or C-reactive protein (CRP) and relevant X-rays
Schizophrenia	Diagnosis confirmed by a psychiatrist or paediatric psychiatrist
Systemic lupus erythematosus	Diagnosis by a specialist physician, paediatrician or rheumatologist
Ulcerative colitis	Diagnosis by a specialist physician, surgeon or gastroenterologist. Colonoscopy report with histology results. Lab results: FBC, ESR and CRP; stool culture

Additional chronic conditions	Further information/tests required
Acne	Prescription from a dermatologist. Authorised for maximum six months at a time. Soaps and cleansers will not be allocated from the chronic benefit
Allergic rhinitis	Either nasal corticosteroids (preferred) or oral antihistamine
Allergic conjunctivitis	ENT or ophthalmologist prescription
Alzheimer's disease	Psychiatrist/neurologist prescription and MMSE
Anaemia	Prescription with full blood count and iron studies not older than one month
Ankylosing spondylitis	Specialist prescription
Anorexia	Psychiatrist prescription/motivation
Anxiety disorder	Initiation by a GP or psychiatrist. Psychiatrist prescription for second-line treatment. Limited to 12 months approval
Aplastic anaemia	Specialist or GP prescription, full blood count and iron studies not older than one month
Attention deficit hyperactivity disorder	Diagnosis confirmed by a paediatrician, psychiatrist or neurologist or a prescription from a GP together with a report from a psychologist
Benign prostatic hypertrophy	Urologist prescription. GP prescription with PSA results
Cardiac arrhythmia	Cardiologist/physician's prescription
Cerebral palsy	Specialist prescription
Chronic leg ulcers	Specialist prescription
Collagen disease	Specialist prescription/motivation
Cushing's disease	Specialist prescription
Cystic fibrosis	Specialist prescription
Depression	Initiation by a GP or psychiatrist. Psychiatrist prescription for second-line treatment. Limited to 12 months approval
Dermatitis	A dermatologist prescription required for immunosuppressants. Benefits allocated for six months at a time
Dermatomyositis	Specialist prescription
Diverticulitis	Gastroenterologist prescription and investigation results
Dystonias	Neurologist prescription

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6. CHRONIC REGISTRATION CLINICAL CRITERIA (CONTINUED)

Additional chronic conditions	Further information/tests required
Eczema (allergic dermatitis)	A dermatologist prescription required for immunosuppressants. Benefits allocated for six months at a time
Endometriosis	Gynaecologist prescription. Diagnosis confirmed by laparoscopy report (histology)
Enuresis	Urologist prescription and motivation
Gastro-oesophageal reflux disease	Gastroscopy results required
Gout	Diagnosis confirmed by a GP or specialist
Glomerular disease	Nephrologist prescription/motivation and relevant pathology
Huntington's disease	Neurologist motivation
Hyperthyroidism	GP or specialist prescription with relevant pathology
Hyperaldosteronism	Specialist motivation with relevant pathology
Hypoparathyroidism	Specialist prescription with relevant pathology
Hypopituitarism	Specialist prescription/motivation with relevant pathology
Intestinal malabsorption syndrome	Gastroenterologist prescription and investigation results
Ischaemic heart disease (angina)	Cardiologist/physician's prescription or proof of IHD
Macular degeneration	Ophthalmologist prescription and diagnostic OCT results
Major depression	Psychiatrist prescription. Benefits allocated for 12 months at a time. Benzodiazepines and sleeping tablets excluded on the chronic benefit
Ménière's disease (vertigo)	GP or specialist prescription with motivation
Menopause	Hormone profile for patients <50 years unless prescribed by a gynaecologist or hysterectomy done
Migraine prophylaxis	GP or specialist prescription
Motor neuron disease	Specialist prescription
Muscular dystrophy	Specialist prescription
Myasthenia gravis	Specialist prescription
Narcolepsy	Specialist prescription
Neuropathy	GP or specialist prescription
Obsessive compulsive disorder	Psychiatrist prescription
Onychomycoses	GP or specialist prescription
Organ transplant	Specialist prescription/motivation
Osteo-arthritis	GP or specialist prescription
Osteoporosis	Dexa scan results required indicating osteoporosis and fracture history if applicable
Paget's disease	Dexa scan results required, fracture and medication history if applicable
Pancarditis	Cardiologist prescription
Panic disorder	Psychiatrist prescription. Benefits allocated for 12 months at a time. Benzodiazepines and sleeping tablets excluded on the chronic benefit
Paraplegia	Letter of motivation detailing clinical history from prescriber
Pemphigus	Dermatologist prescription
Peripheral vascular disease	GP or specialist prescription
Pituitary adenomas	Specialist prescription and relevant pathology
Pituitary disease	Specialist prescription and relevant pathology
Polyarteritis nodosa	Specialist prescription
Polycystic ovarian disease	Gynaecologist motivation with scans/relevant pathology
Post-traumatic stress syndrome	Psychiatrist prescription
Psoriasis	GP or dermatologist initiation. A dermatologist prescription will be required for immunosuppressants

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6. CHRONIC REGISTRATION CLINICAL CRITERIA (CONTINUED)

Additional chronic conditions	Further information/tests required
Psoriatic arthritis	Specialist prescription
Pulmonary hypertension	Cardiologist/physician prescription and diagnostic test results
Pulmonary interstitial fibrosis	Pulmonologist prescription and relevant diagnostic test results
Quadriplegia	Letter of motivation detailing clinical history from prescriber
Rosacea	Dermatologist prescription
Sarcoidosis	Specialist motivation
Scleroderma	Specialist prescription
Sjogren's disease	Specialist motivation and relevant pathology confirming the diagnosis
Spasticity disorders (including cerebral palsy)	Motivation
Stroke (CVA/TIA)	Specialist prescription
Systemic sclerosis	Specialist prescription
Tic disorder	Psychiatrist/specialist prescription
Thromboangiitis obliterans	Specialist prescription
Thrombocytopaenic purpura	Specialist prescription
Thromboembolic disorder	GP or specialist prescription
Tourette's syndrome	Psychiatrist motivation
Trigeminal neuralgia	Specialist prescription
Tuberculosis	GP or specialist prescription and diagnostic test results
Urinary incontinence	GP or specialist prescription
Urinary tract infections (chronic)	GP or specialist prescription
Valvular heart disease	Specialist prescription

Acknowledgement by examining doctor

Having conducted a personal examination and/or procured the tests and/or other diagnostic investigations referred to, I certify that the particulars are, to the best of my knowledge and belief, true and accurate. I acknowledge that the Scheme and its Administrators will rely on such particulars when making any recommendations regarding the payment of ongoing/chronic medication to BP Medical Aid Society.

Prescribing doctor's signature

Date

DD/MM/YYYY

Membership number

Doctor's practice number

12/2025

Medicine Risk Management Programme

Tel:0800 001 607 Email: chronic@bpmas.co.za Website: www.bpmas.co.za