Contact details
Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

HIV*Care* Programme application form

This application form is to join LA Health's HIVCare Programme and to apply for antiretroviral therapy (ART). Cover for antiretroviral therapy is available through the Chronic Illness Benefit on all Discovery Health Plans subject to the scheme rules. Discovery MedXpress is the designated service provider for all LA Key Care members registered on the HIVCare programme. If you get your approved monthly ARV's from Discovery MedXpress you will be covered in full. A copayment of 20% will apply if you use any other provider for your approved ARV's.

We will approve antiretroviral medicine once the terms and conditions are met and based on our list of medicines. Antiretroviral medicine not on the list will be paid for up to a monthly Chronic Drug Amount except on KeyCare Plans. There is some medicine that the Chronic Illness Benefit does not cover. The Scheme will pay for certain multivitamins and vaccines according to the medicine list up to a limit for the year.

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'we', 'us' and 'our', or as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07).

How to complete this application form

A note to the treating healthcare professional

Please remember to send the patient's most recent relevant blood results with this form.

Send the completed and signed form to us by:

- Fax: **011 539 3151**
- Email: **HIV_Diseasemanagement@discovery.co.za**
- Post: PO Box 536, Rivonia, 2128

Please call us on 0860 103 933, if you have any questions about your application.

What you must do

Please go through these steps:

Step 1: Fill in section 1 to 2 of the application form.

Step 2: Take the form to your doctor to complete section 3 to 7 if you need medicine.

1. Main member details (information about the member)

Title | Surname

First names (as per identity document)

Membership number

Date of birth (Y Y Y Y M M D D) | ID number

Telephone (H) | (W)

Other | Fax

Cellphone

Email address

Patient's name and surname

Membership number

2. Patient details

Title Initials Surname

First name(s) (as per identity document)

ID or passport number Date of birth Y Y Y Y M M D D

Relationship to main member Sex M F

Telephone (H) (W)

Cellphone Fax

Email address

May we communicate your confidential information to this email address Yes ☐ No ☐ or fax number Yes ☐ No ☐ or SMS Yes ☐ No ☐

Best time to call : Please note: our case managers work between 08:00 and 17:00 Monday to Friday excluding public holidays.

3. Clinical data and examination (to be completed by the doctor)

Note: Investigation results are essential for registration. Please provide copies of recent reports (for the last three months).

Date of last test Y Y Y Y M M D D

More pathology investigations will be useful for a full clinical picture. Please provide copies of the following reports:

- Full blood count
- Liver function test
- Urea and creatinine

Is the patient pregnant? Yes ☐ No ☐

If yes, expected date of delivery Y Y Y Y M M D D

Height (m) Weight (kg) BSA (for children)

4. Other clinical data required (to be completed by the doctor)

Date of diagnosis Y Y Y Y M M D D

1. Clinical staging (Centre for Disease Control or World Health Organization)

2. Clinical information to substantiate staging in point 1

3. Drug history

Medicine	Duration of treatment	Please insert reason or code (detailed below) for discontinuation of previous antiretroviral therapy

Reason or code for discontinuation: A Side effects B Cost C Resistance D Other

If **other**, please provide a brief explanation

Please specify any other medicine that the patient uses on a regular basis

Patient's name and surname

Membership number

5. Medicine required for HIV and AIDS (to be completed by the doctor)

The HIV*Care* Programme provides cover for disease-modifying therapy. Medicine used for symptomatic control is not covered.

Diagnosis	Date when condition was first diagnosed	Medicine name, strength and dosage	Number of repeats	How long has the patient used this medicine?		May the patient use a generic medicine?	
				Years	Months	Yes	No

6. Doctor's details (to be completed by the doctor)

Name

Telephone

Fax

Practice email

Practice number

Preferred means of communication Email ☐ Fax ☐

Doctor's signature

Date Y Y Y Y M M D D

Note to doctor: The doctor's fee for completion of this form will be reimbursed on code 0199 provided that the patient is a member of the Scheme at the time of application. Payment of the claim will be made from the member's benefit, subject to the member's Benefit Option and availability of funds. Please also note that the pharmacy will need a new script every six months.

7. Address for delivery of medicine

Contact person

Address

Code

Telephone (H)

(W)

Cellphone

Fax

8. How to order your HIV medicine through MedXpress

Your medicine will be delivered to your door, anywhere in South Africa, saving you the inconvenience of waiting in queues or leaving home to get your medicine. In addition, we will keep you up to date on any changes that may affect your cover for chronic medicine when you call to place your monthly medicine order. Our qualified service agents will advise you on the most costeffective choices and you will always be charged at the Discovery Health Rate for medicines or less – making sure you have no copayments on your medicine order. Members can be rest assured that their confidentiality will always be protected.

Ordering your medicine is simple and easy You can order your repeatable prescription medicine order by following these easy steps:

1. **Mark the prescription clearly:** Make sure you clearly write the words "MedXpress" and your Discovery Health membership number on the prescription.
2. **Send the prescription to us:** Email your prescription to **medxpress@discovery.co.za**, or fax it to us at **011 539 1020**. We will send you an SMS within two hours after we receive your prescription.
3. **Place your order over the phone:** When you receive our SMS, call MedXpress on **0860 99 88 77** to place your order.

For all schedule 6 and 7 medicines, and the second fill of schedule 5 medicines, the final order can only be processed once Discovery MedXpress receives the original prescription. You can send this to Discovery MedXpress by registered mail or hand it directly to us at the walk-in centres at our offices.

If you have any questions about MedXpress please phone us on **0860 99 88 77** or visit our website at **www.discovery.co.za.**

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