

# Request for pre-exposure prophylaxis (PREP)

## Contact details

Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • [www.lahealth.co.za](http://www.lahealth.co.za)

## Who we are

LA Health Medical Scheme, registration number 1145, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). Discovery Health (Pty) Ltd administers the Scheme.

## How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Please make sure the form is completed in full and signed by a healthcare professional.
3. Once complete, please email it to [HIV\\_Diseasemanagement@discovery.co.za](mailto:HIV_Diseasemanagement@discovery.co.za) or fax to **011 539 3151** or post it to PO Box 536, Rivonia, 2128.
4. You can also contact our call centre on **0860 103 933** if you have any questions.

## You must use the services of the Scheme's Network Providers

If you are on a LA Comprehensive, LA Core, LA Active or LA Focus option, you must use the services of a Premier Plus HIV Network GP to manage your condition to avoid a 20% co-payment on consultations.

If you are on the LA KeyPlus option, you must make use of the services of a KeyCare Network GP or a Premier Plus HIV Network GP to avoid a 20% co-payment on consultations.

Please also log on to [www.lahealth.co.za](http://www.lahealth.co.za) to confirm a Designated Service Provider pharmacy near you, or contact MedXpress.

## 1. Patient details

Title	<input type="text"/>	Surname	<input type="text"/>
First name/s	<input type="text"/>		
Date of birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D	ID or passport number	<input type="text"/>
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
Email address	<input type="text"/>		

The outcome of this application must be sent to me by Email  Fax

**Please ensure your contact details are always up to date as we rely on that information to send you important information. You may update your details on [www.lahealth.co.za](http://www.lahealth.co.za)**

## 2. Main member details (Please ONLY complete this section if the patient is a minor)

Title	<input type="text"/>	Surname	<input type="text"/>
First name/s	<input type="text"/>		
Date of birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D	ID or passport number	<input type="text"/>
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
Email address	<input type="text"/>		

The outcome of this application must be sent to me by Email  Fax

Main member's signature

Date  Y  Y  Y  Y  M  M  D  D

Original hand signature required

Patient's details and surname

LHRPPP001

Membership number

### 3. Clinical data (to be completed by doctor)

Expected treatment start date

Expected duration of treatment

Clinical reason for requesting PREP


Special investigation results (please provide copies of the reports)

	Test done?	If yes, specify results	Test date
Baseline HIV test*	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>
Serum Creatinine/eGFR	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>

\*Require a negative ELISA result < 1 month old before we will approve treatment.

### 4. Medicine (to be completed by doctor)

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 generic medicine?		Reason if no
				Years	Months	Yes	No	
HIV								
Opportunistic infections								

We will approve funding for generic medicine where available, unless you have indicated otherwise

Please specify any other medicine that the patient uses regularly


**5. Doctor's details (doctor to complete)**

Name

Practice Number

Telephone

Cellphone

Email

I acknowledge that:

- 1. The approval of this treatment is subject to the HIV status of the patient, and
- 2. That I have received the patient's consent to disclose their HIV status and any other related information to LA Health Medical Scheme and Discovery Health (Pty) Ltd.

Signature of doctor

Original hand signature required

Date