Request for pre-exposure prophylaxis (PREP)

LA Health
Powered by Discovery

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

Who we are

LA Health Medical Scheme (referred to as "the 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@lahealthms.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 to confirm a Designated Service Provider pharmacy near you, or contact MedXpress.

Consent for processing my personal information

I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application. I understand that this information will be used for the purposes of applying for and assessing my funding request for the PREP benefit. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider and to relevant third parties, to administer the PREP Benefit as well as undertake managed care interventions related to the benefit.

1. Patient details

Title | Initial(s)

Surname

First name(s)

Membership number

ID or passport number | Telephone (H)

Telephone (W) | Cellphone

Email address

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

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

Membership number

ID or passport number

Member's name

Member's surname

Email address

LHRPPP001

Please note that this form expires on 31/03/2025. Up to date forms are available on www.lahealth.co.za.

Patient's signature

Date D D M M Y Y Y Y

If patient is a minor,main member must sign

3. Clinical data (to be completed by doctor)

Expected treatment start date Y Y Y Y M M D D

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*	Yes No		Y Y Y Y M M D D
Serum Creatinine/eGFR	Yes No		Y Y Y Y M M D D

*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?		
				Years	Months	Yes	No	Reason if 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

LHRPPP001

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

Date Y Y Y Y M M D D

Original hand signature required