Retail Medical Scheme

Administered by Discovery Health

Contact details
Tel: 0860 101 252 • PO Box 652509, Benmore 2010 • www.retailmedicalscheme.co.za

Request for pre-exposure prophylaxis (PREP)

Who we are

Retail Medical Scheme (the Scheme) registration number 1176, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (the administrator) is a separate company and an authorised financial services provider (registration number 1997/013480/07). Discovery Health (Pty) Ltd administers Retail Medical 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. Please return the completed form to us by email to **HIV_Diseasemanagement@discovery.co.za** **or fax to 011 539 3151**

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

To avoid a 20% co-payment on consultations, you must use the services of a Premier Plus HIV Network GP to manage your condition.

MediRite pharmacy is the Scheme's preferred service provider for medicines.

1. Patient details

Title | Surname

First name/s

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

Gender M F | Membership number

Telephone (H) | (W)

Cellphone

Personal email address (not your branch or work email)

Please ensure your contact details are always up to date as we rely on this to send important information to you. You may update your details on www.retailmedicalscheme.co.za or contact our call centre on 0860 101 252

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

Title | Surname

First name/s

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

Gender M F | Membership number

Telephone (H) | (W)

Cellphone

Personal email address

Patient's signature (if patient is a minor, main member must sign) | Date (Y Y Y Y M M D D)

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

5. Doctor's details (doctor to complete)

Name and surname

BHF practice Number

Telephone

Cellphone

Email

I acknowledge that:

1. The approval of this treatment is subject to the HIV status of the patient.
2. I have received the patient's consent to disclose their HIV status and any other related information to the Scheme and the Administrator.

Signature of doctor

Date Y Y Y Y M M D D

Please only sign if the information is true, complete and correct.