## Request for pre-exposure prophylaxis (PREP)



Contact details

Tel: 0861 638 633 • PO Box 652509, Benmore 2010 • www.netcaremedicalscheme.co.za

This application form is to register for pre-exposure prophylaxis and to apply for antiretroviral prophylaxis medicine. Cover for antiretroviral prophylaxis medicine is available subject to the Scheme Rules and the terms and conditions of the benefit. This form is valid for 2024.

## Who we are

Netcare Medical Scheme, registration number 1584, 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), which takes care of the administration of your membership for Netcare 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. Once complete, please email it to hiv@netcaremedicalscheme.co.za.

## 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	Initials	
First name(s)		
Surname		
Membership number	ID or passport number	
Telephone (H)	Telephone (W)	
Cellphone		
Email		
Relationship to main me	mber	
2. Main member det	tails (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		
Patient's signature	Date Date Date Date Date Date Date Date	

If patient is a minor, main member must sign

Please ensure your contact details are always up to date as we rely on this information to send you important information. You may update your details on <a href="https://www.netcaremedicalscheme.co.za">www.netcaremedicalscheme.co.za</a>.

3. Clinical data (to I	be compl	eted	by do	ctor	·)																		
Expected treatment star	rt date	D	D M	M	Y	Y																	
Expected duration of tre	atment																						
Clinical reason for reque	esting PRE	P:																					
Patient's name																							
Patient's surname																							
Membership number																							
						]																	
Special investigation res	sults (pleas	e prov	vide cop	oies (	of the re	ports):																	
		Test o	done?		If yes,	specify							1	Test date									
Baseline HIV test*		Yes	No															D N	M	Л	Y		Y
Serum Creatinine/eGFR Yes No																		D N	M	Л	Y		Y
*We require a negative	ELISA resi	ult fron	n a test	com	pleted v	vithin o	ne mo	nth of t	he	date o	of su	bmis	sior	ı, be	fore	we	will	арр	rove	tre	atme	ent.	
4. Medicine (to be d	complete	d by	docto	r)																			
Medicine name	Dosa	age			Duration					y the				lf n	o, r	eas	on						
				_					use generics Yes No														
				_									<u> </u>										
													<u></u>										
													<u> </u>										
Please specify any other	r medicine	that t	he pati	ent u	ıses reg	ularly																	
5. Doctor's details	(to be co	mple	ted by	the	docto	r)																	
Name																							
BHF practice number											Tele	epho	ne										
Fax										Phor	ne N	umb	er	T	T		Ī	T	T			T	
Email																							
I acknowledge that the a																			atier	nt's	cons	ent	to
disclose their HIV status  Consent withdrawal for	-						are Me	edical S	che	eme a	nd E	ISCO	ver	/ He	alth	(Pt	/) Lt	id.					
Withdrawing consent for	-			_			inform	nation t	o b	e acce	esse	d or	sha	red	with	rele	evar	nt thi	rd pa	artie	es. m	near	ns that
you will no longer have a disease management be membership. Should yo	access to fenefits will,	unding once	g from t conser	the a	pplicabl withdraw	e disea /n, be f	se ma unded	nagem from o	ent the	benet r avail	fits. lable	Clair ben	ns v efits	vhicl s acc	h wo	ould ling	usu to th	ially ne ru	be fu	und of ye	ed fr	om	the
Signature of doctor															Da	ate	) [	) (C	Л	1	Y		Y

Netcare Medical Scheme is a registered medical scheme and regulated by the Council for Medical Schemes (CMS). The CMS contact details are as follows:
Email: complaints@medicalschemes.co.za | Customer Care Centre: 0861 123 267 | Website: www.medicalschemes.co.za | Physical address: Block A, Eco Glades 2 Office Park, 420 Witch – Hazel Avenue, Eco Park, Centurion, 0157

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