



Request for pre-exposure prophylaxis (PREP)

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

Who we are

TFG Medical Aid Scheme (referred to as 'the Scheme'), registration number 1578, 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). We take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administration delays, please ensure this application is completed in full.
3. Once complete, please email it to HIV_Diseasemanagement@tfgmedicalaidscheme.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.

Consent withdrawal for your Disease Management Benefits

Withdrawing consent for your general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that you will no longer have access to funding from the applicable disease management benefits. Claims which would usually be funded from the disease management benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your benefit plan. Should you wish to continue with the consent withdrawal process, then please email HIV_Diseasemanagement@tfgmedicalaidscheme.co.za.

1. Patient's details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
ID or passport number	<input type="text"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<input type="text"/>		
Email	<input type="text"/>		
Relationship to main member	<input type="text"/>		

Please ensure your contact details are always up to date as we rely on this information to keep you updated. You may update your details on www.tfgmedicalaidscheme.co.za

2. Clinical data (to be completed by doctor)

Expected treatment start date:

D	D	M	M	Y	Y	Y	Y
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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 <input type="checkbox"/> No <input type="checkbox"/>	<input style="width: 200px;" type="text"/>	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
Serum Creatinine/eGFR	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input style="width: 200px;" type="text"/>	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				

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

3. Medicine (to be completed by doctor)

Medicine name	Dosage	Duration	May the patient use generics		If no, reason
			Yes	No	

Please specify any other medicine that the patient uses regularly

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

Name

BHF practice number

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Telephone

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 Cellphone

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Email

I acknowledge that the approval of this treatment is subject to the HIV status of the patient and that I have received the patient's consent to disclose their HIV status and any other related information to TFG Medical Aid Scheme and Discovery Health (Pty) Ltd.

Signature of doctor Date

D	D	M	M	Y	Y	Y	Y
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Original hand signature required