Request for pre-exposure prophylaxis (PREP)

LA Health
Powered by Discovery

Contact us
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). We take care of the administration of your membership for the Scheme.

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

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

Additionally, if you are on the LA KeyPlus option Please log on to the LA Health website **(www.lahealth.co.za)** to confirm a Designated Service Provider pharmacy near you or contact MedXpress.

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

1. Patient details

Title | Surname

First name/s

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

Membership number

Telephone (H) | (W)

Cellphone | Fax

Email address

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 this information keep you updated. 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)

Title | Surname

First name/s

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

Membership number

Telephone (H) | (W)

Cellphone | Fax

Email address

Main member's signature: Original hand signature required

Date (Y Y Y Y M M D D)

Patient's name and surname

Membership number

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 < one month old before we will approve treatment.

Patient's name and surname

Membership number

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 (to be completed by the doctor)

Name

Practice number

Telephone

Cellphone

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 LA Health Medical Scheme and Discovery Health (Pty) Ltd.

Signature of doctor Original hand signature required

Date Y Y Y Y M M D D