BMW Employees Medical Aid Society

Administered by Discovery Health

**Contact details**
Tel: 0860 002 107 • PO Box 652509, Benmore 2010 • www.bemas.co.za

# Request for pre-exposure prophylaxis (PREP) 2024

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

The BMW Employees Medical Aid Society (referred to as 'BEMAS'), registration number 1526, 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 BEMAS.

### 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@bemas.co.za**

### Consent for processing my personal information

I give the Society 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 Society 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 Claims which would usually be funded from the disease management benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your plan. Should you wish to continue with the consent withdrawal process, then please email **HIV_Diseasemanagement@bemas.co.za**.

## 1. Patient details

Title ____ Initials ____

Surname ____

First name(s) ____

Date of birth D D M M Y Y Y Y ID or passport number ____

Gender M ____ F ____ Membership number ____

Telephone (H) ____ Telephone (W) ____

Cellphone ____

E-mail ____

**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.bemas.co.za**

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

Surname ____

First name(s) ____

Date of birth D D M M Y Y Y Y ID or passport number ____

Membership number ____

Telephone (H) ____ Telephone (W) ____

BEMRPP001

Please note that this form expires on 31/03/2025. The latest version of the application form is available on www.bemas.co.za. Alternatively members can phone 0860 002 107 and health professionals can phone 0860 44 55 66.

Cellphone

E-mail

Main member's signature

Date D D M M Y Y Y Y

## 3. Clinical data (to be completed by doctor)

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

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

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

Patient's name and surname

Membership number

## 4. 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

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

Name

BHF Practice Number

Telephone

Cellphone

E-mail

**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 BMW Employees Medical Aid Society and Discovery Health (Pty) Ltd.**

Signature of doctor

Date D D M M Y Y Y Y