Request for pre-exposure prophylaxis (PREP)

Contact details
Tel: 0860 116 116 • PO Box 652509, Benmore 2010 • www.yourremedi.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. Please log on to the Remedi website www.yourremedi.co.za to confirm a DSP pharmacy near you or make use of MedXpress.

This form is valid for 2024.

Who we are

Remedi is the medical scheme, registration number 1430, which is 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 Remedi.

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@yourremedi.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 names(s)

Surname

Membership number

ID or passport number

Telephone (H) | Telephone (W)

Cellphone

Email address

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.yourremedi.co.za

2. Main member details (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 D D M M Y Y Y Y

If patient is a minor,main member must sign

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 ☐	Serum Creatinine/eGFR Yes ☐ No ☐	Serum Creatinine/eGFR Yes ☐ No ☐
Serum Creatinine/eGFR	Yes ☐ No ☐	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.

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

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 Remedi Medical Aid Scheme and Discovery Health (Pty) Ltd.

Signature of doctor Date D D M M Y Y Y Y

Original hand signature required