

HIV RISK MANAGEMENT APPLICATION FORM

Pre Exposure Prophylaxis (PrEP)

A. Important Information: *(This form must be completed by members of NMC and PSEMAS.)*

- HIV benefits for PrEP cover medications (TDF/FTC) – HIV (ELISA), HBV and Creatinine only.
- Supplements and vitamins are not covered under PrEP benefits.
- **PrEP treatment benefits are not covered under Topaz and Topaz Plus.**
- The member is expected to maintain their health. It is their responsibility to adhere to the recommended schedules for blood tests (HIV and creatinine), i.e., three months after treatment initiation and thereafter at six-month intervals for HIV ELIZA, and Creatinine at 12-month intervals..
- **PMTCT benefits ONLY cover Nevirapine and Zidovudine (AZT) under Topaz and Topaz Plus.**
- Counselling is critical. Thus, our counsellors will contact the member after the completion of the registration process.
- If renal function becomes impaired, the treatment regimen should be reassessed and discontinued if the risks outweigh the benefits.
- Submit all relevant and correct information documents on time to avoid delays. Please complete all sections.*
- Signing the forms indicates that you agree with the terms and conditions of the HIV clinical management programme.
- Email the completed forms, relevant baseline blood results and the prescription to mhsp@methealth.com.na.

*This form is subjected to renewal after 12 months.

B. Patient's Personal and Clinical Details*

Surname

First Names

Gender M F Date of Birth: Marital Status: Single Married Divorced Child

Cell Phone Number Email Address

City/Town Preferred Language

C. Medical Aid Details*

Medical Aid Fund: *(Please tick the correct Fund)* NMC PSEMAS Option:

Medical Aid Number: Membership Code:

D. Clinical Information

1. Reasons for PrEP Treatment *(Please tick the appropriate box)* Discordance Conceive Other Risk

Other risk, please specify

Specify ICD

2. Sexual Partner on ART? Yes No Unknown Please Provide Partner's Current VL Yes No Unknown

3. Member Well Informed and Basic Counselling Provided Yes No 4. Weight kg Height cm

5. Baseline Blood Tests Requested: HIV Creatinine HBV *Any other blood tests are not covered under PrEP benefits.

6. Other Clinical/Chronic Conditions CKD Diabetic Hypertension Hyperlipidemia

Mental illness

HepB (HBsAg)

7. Recommended Regimen TDF300mg/FTC200mg/3TC 300mg

***Vitamins and supplements are not covered under PrEP benefits.**

I confirm that the information provided in this application form is correct, and the patient comprehends all the information regarding the treatment.

Doctor's Full Names _____

Practice Number _____

Doctor's Signature: _____

Date

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Member Signature: _____

Date

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