# VITREORETINAL DISORDERS APPLICATION FORM

Please attach the relevant Optical Coherence Tomography (OCT) results indicating retinal thickness (initial/most recent).

## 1. TREATMENT PROTOCOL

| 1ST LINE TREATMENT | 2ND LINE TREATMENT | 3RD LINE TREATMENT |
|---|---|---|
| ▪ Avastin/Vitreal S<br>▪ 3 Injections per treatment cycle | ▪ Lucentis/Eylea<br>▪ Only considered if first line treatment was tried and failed<br>▪ Lucentis – will fund 3 injections per treatment cycle<br>▪ Eylea – will fund injections for initial treatment cycle (3 months), thereafter will be funded every second month | ▪ Ozurdex<br>▪ Only considered if first and second line treatments have failed<br>▪ 1 Injection every 6 months |

*Please note:*
- *No treatment will be considered on a continuous basis.*
- *Procedure for in doctor's rooms. Applicable tariff codes include:*
  - *0190/0191/0192*
  - *3003/3004*
  - *3009*
  - *3014*
  - *3028*

## 2. PARTICULARS OF PRINCIPAL MEMBER

Surname

First name

Membership number

Date of birth D D M M Y Y Y Y

## 3. PARTICULARS OF THE PATIENT

Surname

First name

Date of birth D D M M Y Y Y Y  Gender M F  Dependant code

## 4. MEDICAL QUESTIONNAIRE

Please answer the following questions by indicating with an 'X' in the appropriate column:

**4.1. Treatment History**

| | | | |
|---|---|---|---|
| 4.1.1. Has the patient previously received treatment for any vitreoretinal disorders? | | Yes | No |
| 4.1.2. If, yes,<br>(a) please specify which medicine | | | |
| (b) for which eye(s) | | Left | Right | Both |
| 4.1.3. Please specify the previous treatment date(s). | D D M M Y Y Y Y<br>D D M M Y Y Y Y<br>D D M M Y Y Y Y | | |

Please answer the following questions by indicating with an 'X' in the appropriate column:

**4.2. New treatment request**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 4.2.1. Please provide the ICD-10 code | | | | | | | | | |
| 4.2.2. What medicine is required? | | | | | | | | | |
| 4.2.3. Please specify the affected eye(s) where the new treatment is needed. | | | | | | | | Left | Right / Both |
| 4.2.4. Please provide the relevant date(s). When will the requested treatment, as per this application form, be performed? | Treatment 1 | D | D | M | M | Y | Y | Y | Y |
| | Treatment 2 | D | D | M | M | Y | Y | Y | Y |
| | Treatment 3 | D | D | M | M | Y | Y | Y | Y |
| 4.2.5. Will the treatment be performed at the doctor's practice or in-hospital? | | | | | | | | Doctor's practice | In-hospital |

4.2.6. If your procedure is taking place in-hospital, please provide a motivation.

4.2.7. Please provide any additional tariff codes for consideration, with a quantity and motivation.

| | TARRIF CODE | QUANTITY | MOTIVATION |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

## 5. DECLARATION OF ATTENDING DOCTOR

I declare that to the best of my knowledge, all the information is true and accurate, based on the examinations and tests performed on this patient.

Initials | Surname

Full name

Discipline

Practice number

Practice Tel | Fax

E-mail

Doctor's signature

Date D D M M Y Y Y Y