BOTULINUM TOXIN UNITS ARE NOT INTERCHANGEABLE

Application for Dysport® Therapy Reimbursement

Dysport®
CLOSTRIDIUM BOTULINUM TYPE A TOXIN

Auth_ZA@acino.swiss Tel: 087 742 1892

1. Doctor Details

Doctor: _____ Practice No.: _____

Contact Person: _____ Tel. No.: _____

Fax: _____ Email: _____

Delivery Address:

Facility Address:

2. Patient Details:

Title: _____ First Name: _____ Surname: _____

ID No.: _____ Age: _____ D.O.B.: _____

Dependent Code: _____ Tel No.: _____

3. Main Member Details:

Title: _____ First Name: _____ Surname: _____

ID No.: _____ Medical Aid Name: _____

Medical Aid No.: _____ Medical Aid Option: _____

Email: _____ Cell No.: _____

I, _____ (full name and surname)
Hereby declare that my information above is correct.

I agree / do not agree (delete what is not applicable) that my doctor can disclose my health records and any other relevant information to the authorised representatives of the suitable supplier in order to assist me with the payment for the treatment by my medical aid. I realise that my medical scheme may require specific motivations or information to justify the treatment, and that the suitable supplier may be able to help with this. I also realise that the support does not mean that the medical aid will necessarily pay either in full or in part for the medicine or related treatment. I understand that this process may sometimes take a couple of months.

I understand that this assistance will take place with the full co-operation and support of my doctor. I also understand that I can always ask my doctor for further advice, including advice on alternative therapies.

I understand that my personal information will only be used for the purpose of addressing medical scheme matters. I understand that, when I so request, or when the matter is regarded as finalised by myself, the suitable supplier will destroy all personal information of me that they have. They will only keep a statistical record stating the category of issue I had, my diagnosis and how the matter was resolved. I understand that I can at any stage opt out of this agreement, and that, should I wish to do so, I will immediately inform my doctor in writing, who will inform the suitable supplier, in writing, and all support will immediately stop and all information destroyed.

I hereby appoint _____ practice number: _____ as my provider of choice for the delivery of my medication, and give them permission to access my medical records in order to assist with the reimbursement process.

By signing this, I confirm that I have not been forced to agree to the above. I understand what this consent means.

Name and Surname: _____

Signature: _____ Date: _____

S4 Dysport Each vial contains 500 U of *Clostridium botulinum* type A toxin-haemagglutinin complex.
Excipients: Human albumin solution, lactose monohydrate. Reg No.: 37/30.4/0683. HCR: Acino Pharma (Pty) Ltd.
Reg. No.:1994/008717/07. 106, 16th Road, Midrand,1686.
LP4639 22/03/2023
Exp 03/2025

acino

Details

Treatment Date: _____

Procedure Code: _____

_____

Nappi Code: _____

History

Date of Onset/Injury: _____

Diagnosis (Please tick where applicable): Dystonia: ☐

CVA: ☐ TBI: ☐ SCI: ☐ Progressive: ☐ Other (State): ☐ _____

ICD 10 Code: _____

Previous/Current Physiotherapy:

YES ☐ NO ☐

If yes, please state duration of therapy: _____

Previous Dysport® Therapy:

YES ☐ NO ☐

If yes, how many cycles of treatment: _____

Into which muscles: _____

Indication for Dysport®: _____

Muscles Targeted for Injections: _____ _____

_____ _____

Co-morbidities: (Please state current treatments of the patient)

Hypertension: ☐ Diabetes: ☐ Other: (Please explain) ☐ _____

Treatments: _____

_____

Current Treatment: _____

Other Medical History:

_____

_____

_____

_____

Checklist for Reimbursment:

☐ Treatment Date ☐ Procedure Code ☐ Nappi Code

☐ Practice Code ☐ Facility ☐ Prescription

☐ Motivation ☐ Treatment Goals ☐ Patient Consent