Oncotype Dx test application form 2024

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): 0860 44 55 66, **www.discovery.co.za**, PO Box 784262, Sandton, 2146,
1 Discovery Place, Sandton, 2196.

Purpose of the form

This is an application form to participate in the Oncotype Dx testing for breast cancer. This is available to members on all Discovery Health Medical Scheme health plans and all schemes administered by Discovery Health. Participation is subject to clinical entry criteria provided by an external, independent panel of specialists. Please make sure you are using the most up-to-date form. Download the latest version of all forms from **www.discovery.co.za**, under Medical Aid > Find documents and certificates.

Criteria for Oncotype Dx:
Newly diagnosed breast cancer patients (not for recurrent or second cancers) where;

- The member has undergone final/definitive resection of their breast cancer tumour and
- The tumour is strongly oestrogen positive (ER positive) and
- The tumour is HER2/FISH negative
- Tumours greater than 0.5cm but smaller than 5cm
- Node negative (1 micro-metastasis <2 mm) or
- Node positive N1 (1-3 positive axillary nodes) for members age 50> or postmenopausal.

What you must do

- Fill in the form in black ink and print clearly or complete the form digitally. You can view the list of approved digital signature providers on **www.discovery.co.za**, under Medical Aid > Find documents and certificates > Application forms.
- The treating doctor needs to complete sections 2 and 3.
- Please include the original treatment plan and histology with this application form.
- You, the patient needs to complete sections 1 and 4 and must sign section 4.
- Please read and understand the terms and conditions for participation in the project (section 4) and give your consent to these terms and conditions.
- Send the completed and signed form, with a copy of the treatment plan and histology by email to **Oncotype_pilot@discovery.co.za**, or get help on **www.discovery.co.za** under Medical Aid > Get Help > Submit a document and follow the guided steps through our Virtual Agent.

1. Patient details

Title | Initials

Surname

First name(s)

Membership number

ID or passport number

Telephone (H) | Telephone (W)

Cellphone

Email

Relationship to main member

The outcome of this application will be communicated to you via email

2. Referring oncologist details

Title | Initials

First name(s)

Surname

BHF practice number | Contact number

Date completed D D M M Y Y Y Y

Signature

Please only sign if information is true, complete and correct.

3. Clinical Information

Is this the first diagnosis of breast cancer? Yes No

Has the patient undergone final or definitive resection of the tumour? Yes No

Tumour size | Staging T N M

ER status | PR status

Grade | Histology sub-type

Lymph node status | Ki-67 index | HER 2 / FISH / SIS status

Would you have proposed treatment for this patient? If so, please specify, for example chemotherapy:

If yes, please indicate: Code | Average cost per cycle | Number of cycles

4. Agreement to the terms and conditions of participation in the pilot project

I hereby agree to take part in the Oncotype Dx test and understand that the following terms and conditions apply:

1. The Oncotype Dx pilot is for testing in early stage breast cancer only.
2. Approval is subject to clinical entry criteria.
3. Discovery Health Medical Scheme and Discovery Health requires a copy of my original treatment plan and histology that confirms my diagnosis. The treating oncologist (cancer specialist) will provide an indication of the treatment that would have been given to me without using the Oncotype Dx test. The clinical information may be reviewed in a format that is totally anonymous by an external panel.
4. The cost of the Oncotype Dx test will be covered from the Oncology Benefit and will add up to the relevant benefit threshold where applicable.
5. A registry will be kept for the purpose of outcomes measurement.

Member's acceptance and permission

I give permission for my healthcare provider to provide Discovery Health Medical Scheme and the administrator with my diagnosis and other relevant clinical information required to review my application. I agree to my information being used to develop registries (this means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and make informed funding decisions).

I understand that:

4.1. PMB funding is subject to meeting benefit entry criteria as determined by Discovery Health Medical Scheme.
4.2. The PMB provide cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by PMB.
4.3. By registering for PMB, I agree that my condition may be subject to disease management interventions and periodic review, and that this may include access to my medical records.
4.4. Funding for PMB treatment will only be effective from when Discovery Health Medical Scheme receives an application form that is completed in full.
4.5. An application form needs to be completed when applying for a newly diagnosed PMB condition.
4.6. If we approve benefits to be paid as PMB, you need to let us know when your treating doctor changes your treatment plan so that we can update the authorisation. You can do this by e-mailing the new prescription to us, or by asking your doctor or pharmacist to do this for you.

4.7. To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include the ICD-10 code on the claims they submit and on the form that they complete when they refer you to the pathologists and/or radiologists for tests. This will enable the pathologists and radiologists to include the same codes on the claims they submit, ensuring that we pay your claims from the correct benefit.

Your name and surname

Signature

Date D D M M Y Y Y Y

Please only sign if information is true, complete and correct.