What you need to know about...

PharmaCare Orthotic Benefits:
Application for Financial Assistance
(Health Form #5400)

General Instructions

- Health care providers must apply for pre-approval for their patients for all benefits valued at $400 or more. **PharmaCare does not cover any item at or above that value unless pre-approval has been granted.**
- Pre-approval is valid for 6 months from the date noted on the approved form returned to the health care provider.
- Include a prescription authorizing the device. More complex cases may require a prescription from a specialist physician.
- The form is designed to capture the functional need for the device/service and should therefore include a description of the biomechanical problems that the bracing is expected to correct.
- Please forward all appropriate documentation with the form when it is sent for pre-approval.
- **Remember to sign the form before sending it.**

Send completed and signed forms to:

Health Insurance British Columbia, Practitioner & Patient Claims Support

Fax: **250 405-3590**

Mail: PharmaCare
PO Box 9655 Stn Prov Govt
Victoria BC V8W 9P2

Note: Writing outside the boxes on the application form may not be visible when faxed.

Resubmitted Applications

Sometimes an application has to be resubmitted to address questions from the Prosthetic and Orthotic Committee or to address the patient's changing health needs. In these cases, please:

1) Create a new page 2 (or copy your original) – this "new" page 2 should not have any information in the ***PharmaCare Use Only*** portion of the application. This "new" page 2 should include any changes that you are making to the ***Detailed Information*** section.
2) Mark "Resubmitted" in block letters above the ***Date of Application*** field at the top of this "new" page 2.
3) If necessary, you can add a cover letter to include any information that was missing or incomplete in your original application (from page 1, 2 or 3). The cover letter may also include any updates to the information that was included in the original application.
4) Fax the "new" page 2 of the application and/or cover letter to Health Insurance British Columbia (HIBC) using the fax number on the application form.

This process will assist in streamlining resubmitted applications and prevent multiple copies of numerous page(s) being faxed back and forth.

Field-by-Field Instructions for Page 1

The PharmaCare forms are in a "fill and print" PDF format. When the patient information on page 1 is completed, it will automatically update the subsequent pages.

Patient Information

Patient Name	Patient's name as shown on his or her CareCard.
Birth Date	Patient's full birth date (in **YYYY/MM/DD** format). **YYYY** = the year that the person was born; **MM** = the two digits for the month they were born (e.g., 01 = January); and **DD** = the two digits for the day they were born.
Personal Health (CareCard) Number	Patient's Personal Health Number from their CareCard.
Date of Application	Date you are completing the form (in **YYYY/MM/DD** format).
Lower Limb Measurement Attached	Please check here to indicate that a Lower Limb Measurement form is included with the *Application*.

Health Care Provider Information

Facility	Name of the orthotic facility requesting the funding approval.
Pharmacy Equivalency Code	Your facility's 10-digit pharmacy equivalency code (PEC) (e.g., BC00000A01).
Facility Fax Number	Your facility's current fax number to, where forms may be faxed back to once they have been reviewed.

Service Information

<table>
<tr><td rowspan="4">Request</td><td>Initial?</td><td>Check here if this is the first request to fit this patient for an orthosis for this limb or body part.</td></tr>
<tr><td>Replacement?</td><td>Check here if this request is for a replacement orthosis for this patient.</td></tr>
<tr><td>Repair?</td><td>Check here if this request is for a repair to an existing orthosis funded by PharmaCare, excluding work during the health care provider's warranty period.</td></tr>
<tr><td>Adjustment?</td><td>Check here if this request is for an adjustment to an existing orthosis funded by PharmaCare, excluding work during the health care provider's warranty period.</td></tr>
<tr><td>Planned Mgmt of Spasticity/Increased Tone</td><td colspan="2">Is this patient currently receiving, or on a wait list for, any planned procedure(s) for the management of spasticity or increased tone? If so, please indicate whether it is medical or surgical.

Note: In this area of the form, indicate whether any of the above plans may affect bracing in the very near future. You do not need to detail previous successful or unsuccessful attempts. An appointment with a specialist, an appointment for Botox or an upcoming surgery date may delay replacement of the current bracing to allow for changes.

Include the date/planned date of surgical intervention for management of spasticity/increased tone, or the date/planned date of the most recent evaluation of your patient's spasticity/ increased tone, if it may make bracing difficult.

If there is a pending appointment or surgical date, include additional information in the Rationale for Request box.</td></tr>
<tr><td>Date of Intervention</td><td colspan="2">Date of any known intervention. Provide additional details in the Rationale for Request box if necessary.</td></tr>
<tr><td>Cause /Diagnosis</td><td colspan="2">Indicate relevant medical reason for this orthosis.</td></tr>
<tr><td>Current Device</td><td colspan="2">Identify any orthosis that the patient is currently using, and/or the last orthosis dispensed to the patient.
Note: See acceptable abbreviations/acronyms in Detailed Information section below.</td></tr>
<tr><td>Date Supplied</td><td colspan="2">Date that the last orthosis was supplied to the patient (in YYYY/MM/DD format).</td></tr>
<tr><td>Referring Physician/Team Lead</td><td colspan="2">Name of the Referring Physician or the name of the Team Lead if the patient was seen by a Team. Ensure that the patient is still under the care of the physician who is listed on the form, or that the physician listed was responsible for prescribing the requested orthosis.

A Team may consist of two or more health care professionals. Teams may include the orthotist with a family physician who is knowledgeable about the patient's needs; a specialist physician; a physiotherapist and/or an occupational therapist.

The Team Lead should be the clinician most responsible for the patient.</td></tr>
</table>

Service Information (continued)

Rationale for Request – Include description of biomechanical problems to be corrected	Provide a thorough relevant description of the rationale for requesting this orthosis or service from PharmaCare. This should include justification for the need for a new orthosis versus the need for a repair. Please be very specific about your choices, any previous complications or problems with orthoses supplied, and any specific information about the orthosis being requested. Was the replacement requested by a physician or Team Lead? If so, please include a physician prescription or note explaining why the orthosis is required. **NOTE:** This area may be completed by typing directly on the form or in legible hand-writing. Note that information typed or written *outside the box or in the margin* will not be visible when the form is faxed and therefore will not be seen by the reviewer. Please attach a separate page if required, so that all the information can be reviewed in a timely manner.

Field-by-Field Instructions for Page 2

Side Being Fitted	**Check the appropriate box if you are requesting a lower limb orthosis.**
Attachments?	Check the appropriate box to indicate if a health care provider work order or a prescription (Rx) is being submitted with this application. **Note:** This field assists in ensuring all the appropriate information is accounted for.
Work Order #	If you attached a work order, enter the work order number for cross reference.

Detailed Information

Type of Orthosis	This line should include details about the type of orthosis being requested (i.e., is this an Ankle Foot Orthosis; if so, is it articulated?). **See example below.** The following is a list of acceptable abbreviations and acronyms:

Abbreviation	Meaning
Art.	Articulated
AFO	Ankle Foot Orthosis
Bil.	Bilateral
GRAFO	Ground Reaction Ankle Foot Orthosis
HKAFO	Hip Knee Ankle Foot Orthosis
KAFO	Knee Ankle Foot Orthosis
LSO	Lumbar Sacral Orthosis
PTB	Patella Tendon Bearing
RGO	Reciprocating Gait Orthosis
SMO	Supramalleolar Orthosis
TLSO	Thoracic Lumbar Sacral Orthosis

Example

Type of Orthosis: Right Art. AFO

Number & Type of Straps or Parts Required: Large tamarack joint; plantar flexion stops and bumpers; tibial strap (non-custom); custom-made valgus control ankle strap with padding; custom-made toes strap with padding; and medial pullover ankle straps and pads.

Detailed Information (continued)

Number & Type of Custom Straps or Parts Required	Provide details about each customized strap and/or component being requested. Include any part numbers, if applicable. **See example above.** **Note:** "Custom Strap" indicates a strap that is custom-made for the individual. Where design elements for the strap require a higher than average level of control and accuracy, it may require the combination of several types of material to achieve the desired control while maintaining patient comfort. This strap would most often be used for dynamic control of a limb or limb segment (i.e., pull back valgus control ankle strap, mounted through medial slot and attached with lateral buckle. Strap made from leather and Velcro with 3mm Aliplast liner.)
Cost	All costs should be based on approved PharmaCare prices.
Quantity	Quantity of orthoses for each Product Identification Number (PIN). **Note:** Enter a quantity of "2" for bilateral requests.
Product Identification Number (PIN)	A list of Product Identification Numbers (PINs) is available from the PharmaCare website at www.health.gov.bc.ca/pharmacare/pins/prospins.html. You may request approval for up to two separate PINs on each application.
Estimated Total	Enter the total estimated cost for each PIN separately.

Patient/Agent Certification

This form is to be signed by the patient. An agent may sign on behalf of a patient who is a minor, or who is not capable of signing on their own. This is important because this signature certifies that the patient:

- understands that the health care provider is providing a service or orthosis to them, and that they are **not entitled to another orthosis for at least one year**;
- understands that they are liable to the Minister of Finance for the costs of any benefits that PharmaCare paid on their behalf that they were not entitled to receive;
- accepts responsibility for any additional costs to the health care provider; and
- confirms that the information provided on this form is true and correct to the best of their knowledge.

Orthotist Certification

This form is to be signed by the certified orthotist submitting the request. By signing, the orthotist confirms that:

- the information they have provided is true and correct, to the best of their knowledge;
- they are the certified orthotist responsible for assessing, fitting and caring for this patient and, as such, will complete the patient's assessment, casting, fitting and follow-up care; and
- they have explained the request to the patient.

PharmaCare Use Only

This area will be completed by the Prosthetic and Orthotic Committee members and/or Health Insurance British Columbia (HIBC) staff. Please read it carefully. **No services should be provided until the application is approved** by PharmaCare. Any requests for additional information should be forwarded to HIBC at your earliest convenience.

Note: The patient's PharmaCare Plan should be noted in the box labelled ***PharmaCare Plan***. Coverage under various plans is subject to change without notice so always confirm the plan coverage with your patient before billing. If the plan is noted as N/R or N/Reg (Not Registered), the patient **must be registered** with Fair PharmaCare **before** receiving the orthosis or service in order to receive PharmaCare assistance.

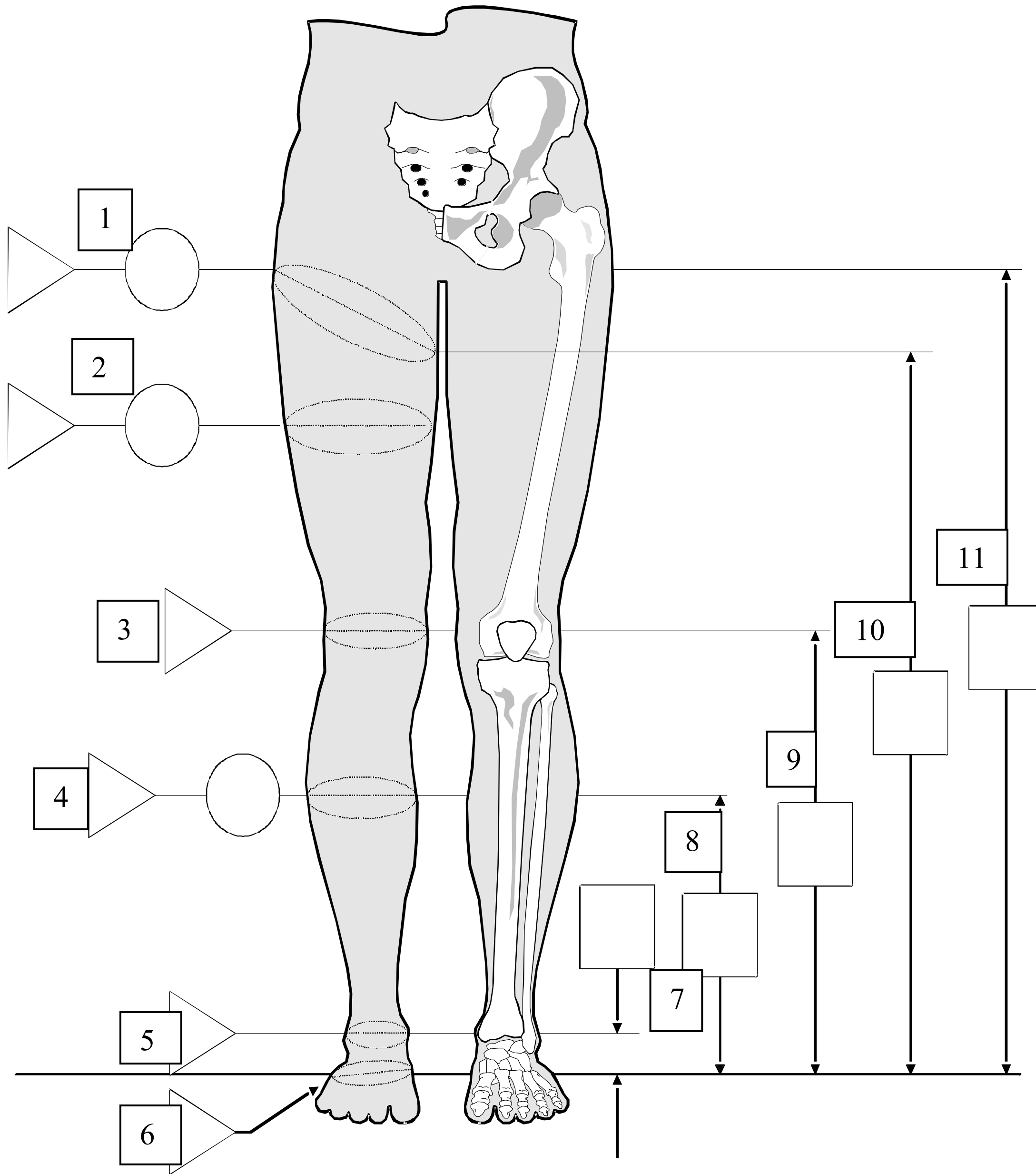
Field-by-Field Instructions for Page 3

Instructions for Lower Limb Orthotic Measurement Page*

- The Lower Limb Orthotic Measurement page **MUST** be completed and submitted with **EACH** lower limb orthosis request.
- The numbers on the Lower Limb Orthotic Measurement diagram (page 8) identify the various measurements.
- For all ankle-foot orthosis (AFO) applications, include the following measurements: Areas 4, 5, 6 and 9.
- For all knee-ankle-foot orthosis (KAFO) applications, include the following measurements: Areas 1, 2, 3, 4, 5, 6, 9 and 11.
- You do not need to include the Lower Limb Orthotic Measurement page for **spinal orthoses or helmets**. However, you must indicate specific measurement changes or weight differences in the ***Rationale for Request*** field of the application form if growth is the reason for replacement.

***See page 7 of these instructions for annotated diagram.**

Lower Limb Orthotic Measurement



Distance

Circumference

Diameter

Degree of toe out:__________ Shoe size:__________

Tibial Torsion:

Distance to Medial Malleolus:__________

Distance to Lateral Malleolus:__________