What you need to know about...

PharmaCare Prosthetic Benefits:
Application for Financial Assistance
(Health Form #5402)

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 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.
- 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 Services

Fax: **250 405-3590**

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

Note: Any notes written outside the boxes of 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 stop multiple copies of numerous page(s) being faxed back and forth.

Field-by-Field Instructions for Page 1

Date of Application	Date you are completing the form in the **YYYY/MM/DD** format. **YYYY** = the year; **MM** = the two digits for the month (e.g., 01 = January); and **DD** = the two digits for the day.

Patient Information

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

Patient Name	Patient's name as shown on his or her CareCard.
Birth Date	Patient's full birth date (in **YYYY/MM/DD** format).
Personal Health (CareCard) Number	Patient's Personal Health Number from their CareCard.
Patient Weight	Patient's current weight, without any prostheses. Indicate if you are providing the patient's weight in pounds or kilograms. **Note:** Patient weight can be calculated by weighing the patient while wearing light clothing and with shoes on, then deducting the weight of any prostheses.
Date Taken	Date the patient's current weight was taken (in **YYYY/MM/DD** format).

Health Care Provider Information

Facility	Name of the prosthetic 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, where forms may be faxed back to once they have been reviewed.

Service Information

Request	Initial	• Check here if this is the **first request** for fitting this patient for a prosthesis for this limb. • Requests for an initial prosthesis must be accompanied by a physician's prescription. • The request for a prescription will meet two requirements: 1) medical need – to show that the patient is receiving appropriate medical care under a physician, and is now ready to be fitted with a prosthesis; and 2) ethical need – to show that there is another health care provider involved as per the requirements under the Canons of Ethical Conduct. • An *Application* for an initial prosthesis may also include the costs of supplies that may be required such as liners, shrinkers, etc. that will be dispensed with, or just before, the new prosthesis.
	Replacement	• Check here if this request is for the **replacement of an existing prosthesis** and the replacement prosthesis does not include components that are substantially different from the components in the last prosthesis supplied. • Replacements of an existing prosthesis should be accompanied by a physician prescription. • The request for a prescription will meet two requirements: 1) medical need – to show that the patient is still receiving appropriate medical care under a physician; and 2) ethical need – to show that there is another health care provider involved as per the requirements under the Canons of Ethical Conduct. • An *Application* for a replacement may also include the costs of supplies that may be required such as liners, socks, etc. that will be dispensed with the replacement prosthesis.

Service Information (continued)

Request (continued)	Upgrade	• Check here if this request includes **upgraded components** for the patient's current device. An upgrade would include components that have substantially different functionality for the patient (i.e., knee or foot that provides a much higher level of mobility for the patient or a switch to a myo-electric arm from a passive arm). • Requests for an upgraded prosthesis must be accompanied by a physician prescription. • The request for a prescription will meet two requirements: 1) medical need – to show that the patient is receiving appropriate medical care under a physician; and 2) ethical need – to show that there is another health care provider involved as per the requirements under the Canons of Ethical Conduct. • An Application for an upgraded prosthesis may include the costs of supplies that may be required such as liners, socks, etc., that will be dispensed with the upgraded prosthesis.
	Cosmesis	• Check here if you are requesting a **cosmesis** on a previously approved PharmaCare-funded (or partially-funded) prosthesis. • Requests for a cosmesis should occur after a prosthesis has been dispensed to a patient and they are content with the final product. The cosmesis should only be requested for the final product, and should not be requested for the initial prosthesis and/or sockets where there are likely to be many adjustments and possibly even replacement sockets requested before the patient is ready for their final product.
	Repair	• Check here if this funding request is for a **repair to an existing prosthesis** that PharmaCare has approved and has provided funding towards. Work on a prosthesis or component of a prosthesis (i.e., a C-leg) that was not provided by PharmaCare will not be approved. • Requests will be considered for repairs that will substantially increase the useful life of the current device. • The amount of time that this repair is expected to extend the useful life of the device should be noted under the ***Detailed Rationale for Request*** section. • Pre-approval is required for all repairs of $400 or more. PharmaCare will not cover any item at or above that value unless pre-approval was granted. • This does not include any repairs to the device during the 90-day health care provider warranty period.

Service Information (continued)

Request (continued)	Adjustment	• Check here if you are requesting an **adjustment to an existing prosthesis**. Work on a prosthesis that was not provided by PharmaCare will not be approved. • This does not include any adjustments to the device during the 90-day health care provider warranty period.
	Supplies	• Check here if you are requesting **supplies** for a patient that exceed the $400 pre-approval limit. • Please include a complete description of the requested supplies under Detailed Information on Page 2 or a company work order (in substantially the same format), and detailed justification for the need in the ***Detailed Rationale for Request*** section.
Level of Amputation	Enter the correct code for the **level** of amputation. • Descriptions of the level of amputations and their acceptable abbreviations are included in a table below. • This information should be completed for all amputations that the patient has undergone, as applicable. If more space is required, please include the additional information in the ***Detailed Rationale for Request*** box below or include it in the ***Past Medical History*** section, as appropriate.	

Level of Amputation

Enter the correct code for the **level** of amputation, as noted in the following abbreviations:

Lower Limbs

TM	Trans-metatarsal
TC	Trans-tarsal
SY	Symes
TT	Trans-tibial (Below Knee)
RP	Rotation Plasty
KD	Knee Disarticulation
TF	Trans-femoral (Above Knee)
PD	Proximal Femoral Focal Deficiency
HD	Hip Disarticulation
HP	Hemipelvectomy

Upper Limbs

PH	Partial Hand
WD	Wrist Disarticulation
TR	Trans-radial (Below Elbow)
ED	Elbow Disarticulation
TH	Trans-humeral (Above Elbow)
SD	Shoulder Disarticulation

Note: Enter the cause or diagnosis for all amputations that the patient has undergone, as applicable. If more space is required, please include the additional information in the ***Detailed Rationale for Request*** box below or include it in the ***Past Medical History*** section, as appropriate.

Service Information (continued)

Cause /Diagnosis	Indicate the cause or diagnosis that led to the amputation.
Date	Enter the date of the amputation in **YYYY/MM** format.
Primary Means of Mobility	Identify, and prioritize the patient's methods of mobility in the community and in their home (e.g., **1 = primary** means of mobility; **2 = second** most common means of mobility, etc.). The priorities should be based on the length of time (number of hours and the number of days per week) that they use each method. • "Prosthesis" includes walking on their prosthesis with or without the use of an aid, such as a cane or walker; "wheelchair" means sitting in a wheelchair (not walking) and moving it themselves or with assistance - the prosthesis may be worn in the wheelchair and may be used for transferring. Note: This information will not be available for new amputees.
Team Assessment	If the patient was evaluated by a Team, check this box and provide the name of the physician or Team Lead, in the Referring Physician/ Team Lead box. **Note:** See description of Team Lead under Referring Physician/Team Lead.
Amputee Clinic Visit	Check this box if the patient attended an Amputee Clinic.
Patient Visit	Check this box if the patient was not seen by a Team or at an Amputee Clinic. In these cases, the assessment was done by the prosthetist during a patient visit.
Date of Visit	The date (in **YYYY/MM/DD** format) of the last Amputee Clinic visit, OR if there was no Amputee Clinic visit, the date the patient was last seen by the Team OR leave blank if "Patient Visit" was selected.
Attachments	Check the appropriate box if you are including a medical report, prescription (Rx) or work order with this application. **Note:** This assists in ensuring all the appropriate information is accounted for.
Referring Physician/ Team Lead	The 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 prosthesis, component(s) or supplies. The Team Lead should be the clinician most responsible for the patient. **Note:** A Team may consist of two or more health care professionals. Teams may include the prosthetist with the family physician who is knowledgeable about the patient's needs or who specializes in prosthetics, a physiatrist or other specialist physician, a physiotherapist and/or occupational therapist.
List other Funding Agencies Involved	List all other funding agencies (i.e., Veterans Affairs Canada (VAC), Non-Insured Health Benefits (NIHB), or the Insurance Corporation of British Columbia (ICBC)), that are involved with funding services or prosthesis for the patient. Include information on why this agency is not being requested to provide funding for this Request. **Note:** This does not include funding from your patient's extended health or third party insurers such as Pacific Blue Cross, Champs or War Amps.

Detailed Rationale for Request

Include a relevant justification for the need for an initial prosthesis or the required upgrade. Please be very specific about your choices by including any previous complications or problems that led to this decision/choice and any specific information about the prosthesis or patient.

Was the replacement requested by a physician or Team Lead? If so, please include a physician prescription or note explaining why the prosthesis is required.

Please be very specific about what the functional problems are, why you have chosen replacement over repair, and any specific information about the prosthesis or required repairs.

If you are requesting a repair, please be specific about what will be repaired, and the cost associated with the expected repair, including the time that you expect the repair to add to the life of the device. **Repairs of $400 or more that are completed before pre-approval is granted will NOT be funded.**

Was the replacement or repair requested by a physician or Team Lead? (See description of Team Lead below under ***Referring Physician/Team Lead.)*** If so, please include a physician prescription or note explaining why the prosthesis or repair is required.

If the request is not the result of a physician request, please be specific about why the request is being made.

Note: You may refer to an attached work order if sufficient rationale is provided on the work order.

Field-by-Field Instructions for Page 2

Detailed Information

Detailed responses are required. If insufficient detail is provided, the health care provider may receive a call requesting clarification or the application may be returned with a request for additional information.

A work order may be submitted in place of writing all the information on the form; however, if a work order is supplied, the work order number needs to be provided to assure that the appropriate information is reviewed.

Last Supplied	Provide details of the last product or service that was supplied to the patient.
Date	Date that the last device or service was supplied to the patient (in **YYYY/MM/DD** format).
Side Being Fitted	Check the side being fitted in this Application.
Work Order #	If a work order is attached, enter the work order number for cross-reference. **Note:** You should have checked the Work Order box under Attachments on Page 1 of the form.
Cost	All costs should be based on the approved PharmaCare price lists and costing formulas.

Detailed Information (continued)

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 Product Identification Number (PIN) separately.

Note: Please leave the ***Approved Amount*** boxes for PharmaCare's use.

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 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 prosthesis or service in order to receive PharmaCare assistance.

Field-by-Field Instructions for Page 3

Past Medical History

This section only needs to be completed for INITIAL or UPGRADED requests.

Check any of the conditions listed that apply to this patient.

Note: You may complete this by asking the patient, or you may wish to have the patient complete this area. Please include any information that you may have obtained through medical records, and be specific wherever possible.

Previous Amputation(s): in this area you should note any amputations that are not listed under the service information (e.g., toe on right foot).

Upper Extremity Amputee – Supplementary Information

This section should be completed for **all upper extremity amputee** prosthesis applications.

Dominant Limb	Check the appropriate box to indicate if the prosthesis is for the patient's dominant limb.
Residual Limb Deformity	Check the appropriate box to indicate if there is any residual limb deformity, and provide an explanation if you check 'Yes.'
Prosthesis Type Requested	Check the appropriate box to indicate whether you will be requesting a conventional or electric prosthesis.
Rationale for Decision	Indicate what rationale was used to determine the request for either a conventional or electric limb.

Upper Extremity Amputee – Supplementary Information (continued)

Patient Returning to Work	Check the appropriate box to indicate whether your patient will be returning to work.
Patient Being Retrained	Check the appropriate box to indicate if your patient will be retrained.
Occupation	Enter the patient's current occupation or, if they are being retrained, enter the profession they are retraining for.

The following fields only need to be completed for **first electric-powered limb** applications.

Patient Assessed in Amputee Clinic	Indicate if the patient was assessed in an amputee clinic and, if yes, provide the location of the clinic and the date that they were seen (in **YYYY/MM/DD** format).
Electro/Myo-Electric Training by	This should only be completed if: 1) appropriate training has been completed; and 2) testing for myo signals confirmed the patient can use the signals. If both of the above statements are true then indicate who completed the electro/myo-electric training, their qualifications for providing this type of training and the date of the training (in **YYYY/MM/DD** format).
Functional Training by	Please indicate who will be providing your patient with functional training on the prosthesis, their qualifications for providing this type of training and the date they most recently took the training (in **YYYY/MM/DD** format).

Patient/Agent Certification

Only the patient should sign this form. 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 prosthesis to them, and that they are **not entitled to another prosthesis for at least three years**;
- understands that they are liable to the Minister of Finance for the cost 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.

Prosthetist Certification

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

- the information they have provided is true and correct, to the best of their knowledge;
- they are the certified prosthetist 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.