BRITISH COLUMBIA | Health InsuranceBC

# PHARMACARE ORTHOTIC BENEFITS
# PLAGIOCEPHALY HELMET

**REQUIRED: (ORTHOTIST ONLY)** DATE OF DISPENSE (YYYY / MM / DD)

## INSTRUCTIONS

See page 2 for the clinical information worksheet, the criteria for helmets that do not require pre-approval, and the Freedom of Information and Protection of Privacy statement. ***Use this form ONLY if the patient meets the criteria.*** If the patient does not meet these criteria, apply for pre-approval using the Application for Financial Assistance – Orthotic Benefits form (HLTH 5400), which can be found at https://www.health.gov.bc.ca/exforms/pharmacare/5400fil.pdf.
Both pages of this form must be completed and the form must be signed by **both** a certified orthotist and the patient's agent.

## PATIENT INFORMATION

PATIENT LEGAL LAST NAME | PATIENT LEGAL FIRST NAME | PATIENT LEGAL SECOND NAME (OR INITIAL)

BIRTHDATE (YYYY / MM / DD) | PERSONAL HEALTH NUMBER (PHN) | AGE IN MONTHS

## REFERRING PRACTITIONERS: FOR PLAGIOCEPHALY AND/OR BRACHYCEPHALY PATIENTS

NAME OF REFERRING PHYSICIAN | MSP BILLING NUMBER

NAME OF TEAM LEAD FROM PLAGIOCEPHALY CLINIC

## FOR CRANIOSYNOSTOSIS PATIENTS

NAME OF REFERRING PEDIATRIC NEUROSURGEON

MSP BILLING NUMBER

## PATIENT CLINICAL INFORMATION

| ☐ **PLAGIOCEPHALY** | ☐ **BRACHYCEPHALY** | ☐ **PLAGIOCEPHALY AND BRACHYCEPHALY** | ☐ **CRANIOSYNOSTOSIS** |
|---|---|---|---|
| ☐ MEDICAL REFERRAL ON FILE | ☐ MEDICAL REFERRAL ON FILE | ☐ MEDICAL REFERRAL ON FILE | ☐ PRESCRIPTION OR REPORT FROM PEDIATRIC NEUROSURGEON ON FILE |
| CVAI = ________ % from page 2 | CI = ________ % from page 2 | CVAI = ________ % from page 2<br>CI = ________ % from page 2 | |
| DATE MEASUREMENTS TAKEN (YYYY / MM / DD) | DATE MEASUREMENTS TAKEN (YYYY / MM / DD) | DATE MEASUREMENTS TAKEN (YYYY / MM / DD) | DATE OF SURGERY (YYYY / MM / DD) |
| DATE OF HELMET SCAN/CAST (YYYY / MM / DD) | DATE OF HELMET SCAN/CAST (YYYY / MM / DD) | DATE OF HELMET SCAN/CAST (YYYY / MM / DD) | DATE OF POST-OPERATIVE HELMET SCAN/CAST (YYYY / MM / DD) |

## PATIENT AGENT'S CERTIFICATION – REQUIRED (see page 2 for details)

- I have read and understood the information being claimed on this form.
- I hereby certify that the information given on this form, and in any documents attached to or forming part of this application, is true and correct.
- I acknowledge receipt of the plagiocephaly helmet. I understand that the patient will be required to wear the helmet for 18 to 23 hours a day for months, as directed by the certified orthotist and other health care professionals involved in the patient's care.
- I understand that the patient is entitled to a limit of one plagiocephaly helmet.
- The health care provider's 90 day warranty and proper care and maintenance of the helmet has been explained to me.
- I understand that if the patient does not have any other PharmaCare Plan coverage and the family has not registered for Fair PharmaCare **before** the helmet is dispensed to the patient, the family will be responsible for the full price of the helmet and associated treatment costs.
- I understand that I am responsible for any outstanding balance not covered by PharmaCare (e.g., if Fair PharmaCare does not cover the full cost of the helmet because the family's deductible and/or family maximum has not been met).
- I understand that PharmaCare will recover any costs that exceed the amount to which an individual or family is entitled under the PharmaCare plan or benefit eligibility requirements.

| PRINT FULL NAME | RELATIONSHIP TO PATIENT | AGENT SIGNATURE | DATE SIGNED (YYYY / MM / DD) |
|---|---|---|---|
| | | | |

## ORTHOTIST CERTIFICATION – REQUIRED

- The information on this form is true, correct and complete to the best of my knowledge. I have taken and recorded all the measurements as required.
- I am the professional responsible for assessing, fitting and caring for this patient and, as such, will complete the patient's assessment, casting, fitting and follow-up care. Any services provided to the patient by a Canadian Board for Certification of Prosthetists and Orthotists resident will be under my direct supervision.
- A plagiocephaly helmet has been supplied to my patient, and I will be providing follow-up care as appropriate, or that I will arrange and compensate a different orthotist to provide the follow-up care.
- I have explained the helmet and services to the patient's agent.

| PRINT FULL NAME | CBCPO CERTIFICATION NUMBER | ORTHOTIST SIGNATURE | DATE SIGNED (YYYY / MM / DD) |
|---|---|---|---|
| | | | |

## PATIENT AGENT

The patient agent may be a parent, guardian, social worker or other person authorized to act on behalf of the patient.

## CLINICAL INFORMATION WORKSHEET

| INDEX TYPE | FORMULA | CALCULATED RESULT % |
|---|---|---|
| **Cranial Vault Asymmetry Index (CVAI)** | [( ____________ - ____________ ) ÷ ____________ ] x 100 =<br>*Diagonal A* *Diagonal B* *Diagonal A*<br>*Note: diagonal "A" must be the longer of the two measurements and must be taken at 30° from the anterior-posterior pole.* | ____________ % |
| **Cranial Index (CI)** | ( ____________ ÷ ____________ ) x 100 =<br>*Cranial Width* *Cranial Length* | ____________ % |

## CRITERIA FOR HELMETS THAT DO NOT REQUIRE PRE-APPROVAL

Patients with **plagiocephaly** must

- be between the ages of 5 months and 1 year at the start of helmet treatment, **and**
- have a written referral for the helmet from a recognized plagiocephaly clinic, **and**
- have a cranial vault asymmetry index (CVAI) equal to or greater than 6.25%.

Patients with **brachycephaly** must

- be between the ages of 5 months and 1 year at the start of helmet treatment, **and**
- have a written referral for the helmet from a recognized plagiocephaly clinic, **and**
- have a cranial index (CI) equal to or greater than 95%.

Patients with **both plagiocephaly and brachycephaly** must

- be between the ages of 5 months and 1 year at the start of helmet treatment, **and**
- a written referral for the helmet from a recognized plagiocephaly clinic, **and**
- a cranial vault asymmetry index (CVAI) equal to or greater than 6.25% and a cranial index (CI) equal to or greater than 90%.

Patients with **craniosynostosis** must

- be between the ages of 4 months and 1 year at the start of helmet treatment, **and**
- have had surgery for the condition, **and**
- have a written referral or prescription for the helmet from a pediatric neurosurgeon, **and**
- have had a post-operative helmet cast or scan.

## FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY

Personal information on this form is collected, used and disclosed under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act* and *Freedom of Information and Protection of Privacy Act*. It will not be disclosed to any persons without the patient's consent.

The information you provide will be relevant to and used solely to (a) provide PharmaCare benefits for the plagiocephaly helmet requested, (b) to implement, monitor and evaluate this and other Ministry programs, and (c) to manage and plan for the health system generally.

If you have any questions about the collection or use of this information, call Health Insurance BC from Vancouver at 1-604-683-7151 or from elsewhere in BC toll free at 1-800-663-7100.