

Medicines Approval Section

Request Form for the supply of Free Drugs in terms of Schedule V (Part II) of Social Security Act (2012)

Patient Name		Date of Birth	
Address			
ID. Card No.		Telephone No.	

Please tick Schedule V condition accordingly:

<input type="checkbox"/> Addiction Disorders <input type="checkbox"/> Addison's Disease <input type="checkbox"/> Benign Prostatic Enlargement <input type="checkbox"/> Cardiac Arrhythmias <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cerebrovascular disease <input type="checkbox"/> Chronic Asthma <input type="checkbox"/> Chronic Eating Disorders <input type="checkbox"/> Chronic Heart Failure <input type="checkbox"/> Chronic Immunobullous Disorders <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Chronic Liver Disease <input type="checkbox"/> Chronic Mood Disorders <input type="checkbox"/> Chronic Neurotic Disorders <input type="checkbox"/> Chronic Obstructive Pulm. Disease <input type="checkbox"/> Chronic Osteomyelitis <input type="checkbox"/> Chronic Psychiatric Disorders starting in Childhood <input type="checkbox"/> Chronic Respiratory Failure <input type="checkbox"/> Coeliac Disease <input type="checkbox"/> Congenital Ichthyosis <input type="checkbox"/> Congenital indifference to pain <input type="checkbox"/> Crystal Deposition Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Dementia <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Other Types of Diabetes <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Dermatomyositis/Polymyositis <input type="checkbox"/> Diverticular Disease requiring Stoma Care <input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Endometriosis and Adenomyosis <input type="checkbox"/> Enzyme Disorders <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Gastric/Duodenal Ulcers <input type="checkbox"/> Gastro-Oesophageal Reflux Disease <input type="checkbox"/> Gender Identity & Sex Characteristics Related Conditions <input type="checkbox"/> Genetic Dyslipidaemia <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hepatitis B & C <input type="checkbox"/> Hidradenitis Suppurativa <input type="checkbox"/> Hirschsprung's Disease <input type="checkbox"/> HIV/AIDS and HIV Related Diseases <input type="checkbox"/> Hospital Acquired Infections <input type="checkbox"/> Huntington's Chorea <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypogonadism <input type="checkbox"/> Hypoparathyroidism <input type="checkbox"/> Hypopituitarism <input type="checkbox"/> Imperforate Anus <input type="checkbox"/> Inborn errors of Metabolism <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Inherited Bleeding Disorders <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Inherited Haemoglobinopathies <input type="checkbox"/> Leprosy <input type="checkbox"/> Lupus Erythematosus <input type="checkbox"/> Malignant Diseases <input type="checkbox"/> Motor Neurone Disease	<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Myalgic Encephalomyelitis <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Neuromyelitis Optica <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Paget's Disease <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Pituitary Adenomas <input type="checkbox"/> Polio and Post-Polio <input type="checkbox"/> Polyarteritis Nodosa <input type="checkbox"/> Polymyalgia Rheumatica <input type="checkbox"/> Prader-Willi Syndrome <input type="checkbox"/> Precocious Puberty <input type="checkbox"/> Primary Immunodeficiency Disorder <input type="checkbox"/> Psoriasis <input type="checkbox"/> Psychosis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Secondary Immunodeficiency Disorder <input type="checkbox"/> Severe Chronic Urticaria <input type="checkbox"/> Severe Refractory Atopic Dermatitis <input type="checkbox"/> Small Intestinal Failure <input type="checkbox"/> Spinal Cord Pathologies <input type="checkbox"/> Spondyloarthritis <input type="checkbox"/> Systemic Sclerosis <input type="checkbox"/> Trigeminal Neuralgia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Turner Syndrome <input type="checkbox"/> Vascular Disease of the Retina
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By marking this box, I am accepting that previously approved treatment may be added to the patient's entitlement document.

i. PLEASE NOTE that in line with current Policy Direction in order to enable a patient to access his / her medication, the following documentation must be attached to this Form, as appropriate:

- | | | |
|----------------------------|--------------------------|------------------------|
| Rosuvastatin | <input type="checkbox"/> | LDL report |
| Calcium & Vit. D tabs/caps | <input type="checkbox"/> | Bone density report |
| Donepezil | <input type="checkbox"/> | Form D1 |
| Gluten-free diet | <input type="checkbox"/> | Duodenal biopsy report |
| Gliptins/SGLT2 inhibitor | <input type="checkbox"/> | HbA1c blood test |
- HbA1c results may not be older than 4 months**

Data Protection Statement: The Ministry for Health shall be responsible for the information compiled in this form. Every individual reserves the right to request in writing, to see all the information compiled on him/her. This information shall be used solely for the purpose of issuing medicines entitlement to beneficiaries in terms of the Schedule V legislation.

Patient Name		ID. Card No.	
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Drug & Dosage Form Requested:	Protocol Number (Where applicable)	Strength: (POYC records ONLY)	Dosage Regimen: (POYC records ONLY)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

RENEWAL OF PROTOCOL REGULATED MEDICINE	
Drug & Dosage Form Requested:	
1.	
2.	
3.	
4.	
5.	

I hereby certify that this treatment for free medicine entitlement is being requested according to the stated condition covered by the provisions of Schedule V (Part II) of the Social Security Act and that all details provided are true and correct. I confirm that I have read the specific protocol/s, and the clinical conditions and specific terms set by the specific protocol/s have been met.

Applicant's Signature

Applicant's Name (in block letters)

Medical Registration No.

Date

Rubber Stamp

ii. Please Note:

- a. Only Forms endorsed by the Government Consultants and designated Medical Practitioners will be recognized.
- b. An *Acknowledgement* will be sent to the prescriber upon receipt of the Application.
- c. In case of a **RENEWAL** of an expired Card, **PERMIT** or **CHANGE in TREATMENT**, the Sch V Card that needs to be amended must be attached to this Application.
- d. Any queries or requests should be addressed to the POYC Unit on email schedulev.poyc@gov.mt.