POYC
PHARMACY OF YOUR CHOICE

Medicines Approval Section

Reset form

Pharmacy Of Your Choice Unit
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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:

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

☐ **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:

a. The current Schedule V Card

b. The following additional documentation [as appropriate]:

Atorvastatin *and* Rosuvastatin	☐	LDL report
Clopidogrel	☐	Stent report and / or Admission dates
Donepezil	☐	Form D1
Gluten-free diet	☐	Duodenal biopsy report
Repaglinide	☐	eGFR blood test ***and/or*** BMI **[Height:_____ m, Weight:_____ kg, BMI:** NaN **kg/m²]** ***and/or*** post-prandial hyperglycaemia ***AND*** ☐ Part A: HbA1c blood test ***OR*** ☐ Part B: Intolerance to Metformin
Gliptins	☐	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.	

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.**

Email form

_____ _____

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.**