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 client meets the criteria.*** If the client 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://www2.gov.bc.ca/assets/gov/health/forms/5400fil.pdf.
Both pages of this form must be completed and the form must be signed by **both** a certified orthotist and the client's agent.

CLIENT INFORMATION - ENTER LEGAL NAME AND PHN AS IT APPEARS ON THE BC SERVICES CARD

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

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

REFERRING PRACTITIONERS: FOR PLAGIOCEPHALY AND/OR BRACHYCEPHALY CLIENTS

NAME OF REFERRING PHYSICIAN | MSP BILLING NUMBER

NAME OF TEAM LEAD FROM PLAGIOCEPHALY CLINIC

FOR CRANIOSYNOSTOSIS CLIENTS

NAME OF REFERRING PEDIATRIC NEUROSURGEON

MSP BILLING NUMBER

CLIENT CLINICAL INFORMATION

☐ PLAGIOCEPHALY

☐ PRESCRIPTION FROM PHYSICIAN ON FILE

CVAI = _____ % from page 2

DATE MEASUREMENTS TAKEN (YYYY / MM / DD)

DATE OF HELMET SCAN/CAST (YYYY / MM / DD)

☐ BRACHYCEPHALY

☐ PRESCRIPTION FROM PHYSICIAN ON FILE

CI = _____ % from page 2

DATE MEASUREMENTS TAKEN (YYYY / MM / DD)

DATE OF HELMET SCAN/CAST (YYYY / MM / DD)

☐ CRANIOSYNOSTOSIS

☐ PRESCRIPTION OR REPORT FROM PEDIATRIC NEUROSURGEON ON FILE

DATE OF SURGERY (YYYY / MM / DD)

DATE OF POST-OPERATIVE HELMET SCAN/CAST (YYYY / MM / DD)

CLIENT 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 client 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 client's care.
- I understand that the client 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 the client must register for Fair PharmaCare before a helmet is dispensed for the costs to be eligible for Fair PharmaCare Coverage.
- I understand that if PharmaCare pre-approval is required and not received for a helmet before it is dispensed, the client and their family is responsible for the full cost of the helmet and associated treatment costs.
- I understand that the client and their family is responsible for any outstanding balance if the cost of the helmet exceeds PharmaCare coverage. The provider has explained the billing to me.
- 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 CLIENT | 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 client and, as such, will complete the client's assessment, casting, fitting and follow-up care. Any services provided to the client 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 client, and I will be providing follow-up care as appropriate, or I will arrange and compensate a different orthotist to provide the follow-up care.
- I have explained the helmet and services to the client's agent.

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

PLAGIOCEPHALY HELMET

CLIENT AGENT

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

CLINICAL INFORMATION WORKSHEET

INDEX TYPE	FORMULA	CALCULATED RESULT %
Cranial Vault Asymmetry Index (CVAI)	[(_____ - _____) ÷ _____] x 100 = *Diagonal A* *Diagonal B* *Diagonal A* *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 = *Cranial Width* *Cranial Length*	_____ %

CRITERIA FOR HELMETS THAT DO NOT REQUIRE PRE-APPROVAL

Clients with **plagiocephaly** must

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

Clients with **brachycephaly** must

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

Clients 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 by the Ministry of Health under s.22 of the *Pharmaceutical Services Act* for the purpose of determining eligibility for financial assistance.

If you have questions about the collection of personal information on this form, contact the Health Insurance BC (HIBC) Chief Privacy Officer at PO Box 9035 STN Prov Govt, Victoria BC V8W 9E3; or call 604 683-7151 (Vancouver) or 1 800 663-7100 (toll free).

This information will be collected, used and disclosed in accordance with the *Freedom of Information and Protection of Privacy Act* and the *Pharmaceutical Services Act*.

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