## Percutaneous coronary intervention (PCI)

# Funding request form

**Please complete this form to request funding for Bupa patients with stable coronary artery disease who need non-emergency PCI procedures. Please make sure that all diagnostic tests are complete and a definitive decision has been made to proceed to PCI before submitting this funding request.**

We'd be grateful if you could give us enough time before treatment begins. We may need to see a copy of the patient's full medical notes, which we'll request from you or the patient's GP, to confirm that the proposed procedure is covered by their health insurance policy. Otherwise we'll let you know within two working days of receiving your completed form whether the Bupa patient's treatment is covered.

Please type this form and complete all sections. Without the information requested, our funding decision may be delayed. Then send your completed form by secure email: **cardiacsupportteam@bupa.com**. Information you send to this email address may not be secure unless you send us your email through Egress. To sign up for a free Egress account, go to **https://switch.egress.com**

If you've any questions please call us on: **0345 600 7264** (between 8am to 8pm Monday to Friday, and 8am to 4pm Saturday) or: **0345 755 3333** (between 8am to 6pm Monday to Friday, and 8am to 1pm Saturday). We may record or monitor our calls.

## 1. About the patient

| | |
|---|---|
| Title (please tick) | ☐ Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Dr ☐ Other (please state) |
| Name | |
| Date of birth | D D M M Y Y Y Y |
| Bupa membership number | |
| Admission hospital | |
| Proposed date of procedure | D D M M Y Y Y Y |
| Code for proposed procedure | |

## 2. About the consultant

| | |
|---|---|
| Name | |
| Bupa provider number | |
| Phone number | |

## 3. About the patient's condition

Are the patient's symptoms stable? ☐ Yes ☐ No ☐ Asymptomatic

If no, please explain the patient's condition below

Has the patient had a previous:

Coronary artery bypass graft (CABG) ☐ Yes ☐ No

If yes, please give date of procedure and name of consultant who performed it

D D M M Y Y Y Y

Angiography ☐ Yes ☐ No

If yes, please give date of procedure and name of consultant who performed it

D D M M Y Y Y Y

Elective PCI for stable Coronary artery disease (CAD) ☐ Yes ☐ No

If yes, please give date of procedure and name of consultant who performed it

D D M M Y Y Y Y

Primary PCI for Coronary artery disease (ACS) ☐ Yes ☐ No

If yes, please give date of procedure and name of consultant who performed it

D D M M Y Y Y Y

Has medical therapy been optimised? ☐ Yes ☐ No

If no, please explain rationale below

What is the patient's

| Heart Rate | Blood pressure | Rhythm |
|---|---|---|

Please tick all the anti-anginal drugs the patient has tried, including dosages, and tick the duration the patient has been on this regime

| | | |
|---|---|---|
| ☐ Betablocker | ☐ Less than 2 weeks | ☐ More than 2 weeks |
| ☐ Calcium channel blocker | ☐ Less than 2 weeks | ☐ More than 2 weeks |
| ☐ Ivabradine | ☐ Less than 2 weeks | ☐ More than 2 weeks |
| ☐ Long-acting nitrate | ☐ Less than 2 weeks | ☐ More than 2 weeks |
| ☐ Nicorandil | ☐ Less than 2 weeks | ☐ More than 2 weeks |
| ☐ Ranolazine | ☐ Less than 2 weeks | ☐ More than 2 weeks |

Has a functional test been performed? ☐ Yes ☐ No

If yes, please tick all that apply

☐ Exercise (electrocardiogram) ECG ☐ Stress echocardiogram

☐ Myocardial perfusion scan ☐ Stress (magnetic resonance imaging) MRI

☐ Other, please state

Did the functional test(s) demonstrate evidence of inducible ischaemia? ☐ Yes ☐ No

Has a Fractional Flow Reserve (FFR) been performed (either invasive FFR or CT FFR)?

☐ Yes, if so was it an ☐ Invasive FFR ☐ CT-FFR

Please specify the FFR ratio

☐ Planned, please give date D D M M Y Y Y Y

☐ No

Has an Instantaneous Wave-free Ratio (IFR) been performed?

☐ Yes, please specify the IFR ratio

☐ Planned, please give date D D M M Y Y Y Y

☐ No

If neither functional testing nor FFR or IFR is to be performed, please explain why:

Is this a planned staged PCI of a non-culprit lesion following a primary PCI? ☐ Yes ☐ No

If the patient has a bifurcation lesion, triple vessel disease or left main stem (LMS) lesion, has the management of their care been discussed during a minuted multidisciplinary team meeting that includes a cardiothoracic surgeon? ☐ Yes ☐ No

Name of cardiothoracic surgeon

☐ Patient does not have a bifurcation lesion, LMS or triple vessel disease

Please give any other relevant information, including the proposed treatment plan (eg. ischaemic burden).

# 4. Declaration

**Please complete this section to confirm that the information in this form is accurate to the best of your knowledge.**

I understand that the clinical information I've supplied may be considered to be a medical report for insurance purposes. I confirm that my patient (or their legal representative) has given their permission for me to share this information and, where they've asked to review this information, they've been given an opportunity before I submitted this form.

Consultant cardiologist's name

General Medical Council number

Date D D M M Y Y Y Y