PATIENT ASSISTANCE CHECKLIST FOR MEDICAID PATIENTS

❑ I have received the chemotherapy order written by the physician?

❑ I have verified the patient’s insurance coverage?

❑ I have verified that the drug(s) are indicated for the patient’s diagnosis?

❑ I have obtained prior authorization, if needed?

❑ I have identified the patient’s responsibility (an estimate in $) for treatment costs?

❑ I have met with the patient to assess his or her ability to pay for treatment?

❑ Based on this meeting, does patient need drug replacement?

❑ YES ❑ NO

❑ If yes, is a replacement drug program available? (Note: an appeal must to be made to receive drugs.)

❑ YES ❑ NO

If yes, identify drug and program:

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❑ Does the patient qualify for this program?

❑ YES ❑ NO

If no, state reason(s) why:

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❑ If yes, I have completed all the necessary forms and paperwork for the drug replacement ❑YES ❑ NO

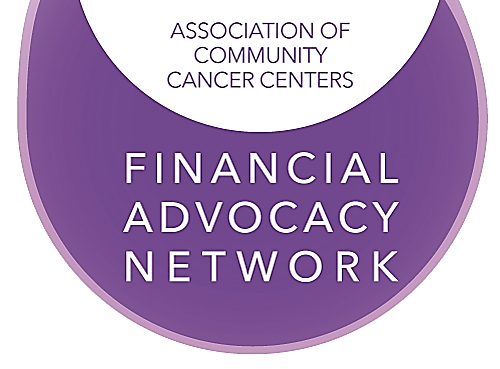
If no, state reasons why:

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❑ Is there a balance or money owed related to treatment?

❑ YES ❑ NO

If yes, identify balance:

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❑ If yes, I have worked with the patient and family to create a payment plan for the balance of

his or her treatment costs.

❑ YES ❑ NO



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