PATIENT ASSISTANCE CHECKLIST FOR MEDICARE & SUPPLEMENTAL INSURANCE 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?

If there is no patient responsibility, treatment is started. If there is patient responsibility, continue through this form.

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

❑ Based on this meeting, does patient need assistance paying for treatment?

❑ YES ❑ NO

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

❑YES ❑ NO

If yes, identify drug and program:

❑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 assistance program.

❑ YES ❑ NO

If no, state reasons why:

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❑ Does the patient need drug(s) that are not available through a drug replacement program?

❑YES ❑ NO

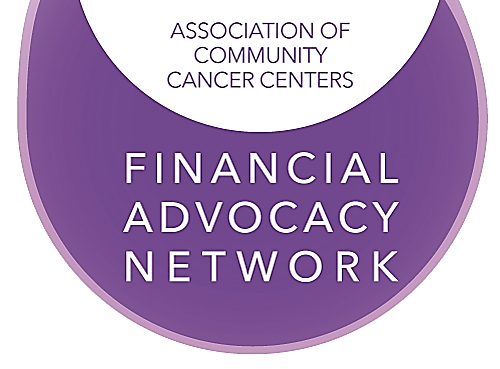
If yes, identify which drugs:

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❑ Is Foundation funding assistance available for any of these drug(s) or to help with other treatment-related costs?

❑ YES ❑ NO

If yes, identify Foundation(s) and drug(s):

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❑ I have completed all the necessary forms and paperwork for these Foundation funding program(s).

❑ YES ❑ NO

If no, state reasons why:

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❑ I have sent in EOB or other paperwork necessary to verify the amount the Foundation will pay towards the drug(s).

❑ 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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