

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 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:

- If yes, I have completed all the necessary forms and paperwork for the assistance program.
 YES NO
If no, state reasons why:

- Does the patient need drug(s) that are not available through a drug replacement program?
 YES NO
If yes, identify which drugs:

FINANCIAL ADVOCACY NETWORK

- 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):

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

YES NO

If no, state reasons why:

- 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:

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

YES NO

If yes, identify balance:

- 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
