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 dollars) 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:

- 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:
____________________________________________________________________________

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