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 be made to receive drugs.)
  - 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 drug replacement
  - 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