PATIENT ASSISTANCE CHECKLIST FOR MEDICARE ONLY 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:

________________________________________________________________________

- 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 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:
______________________________________________________________

Does the patient qualify for charity care from my clinic, cancer center, hospital, or healthcare system?

☐ YES  ☐ NO

If yes, identify program:
______________________________________________________________

I have completed all the forms and paperwork necessary to apply for this charity care.

☐ 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