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:

______________________________________________________________________________

☐ 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

________________________________________________________________________________