

Musella Foundation For Brain Tumor
 Research & Information, Inc.
Patient Co-Pay Assistance Program
 Application Form For Patients version 2.0

Overview

This program can help pay for your medications, if you qualify and if we have funds remaining. There is never any cost to you. You can use any doctors and treatments you like—we never will ask you to switch. Visit our website <http://BrainTumorCoPays.org> to learn more.

First, let’s see if you qualify. To qualify for the program, you **must** be able to answer “yes” to the following questions:

1. Do you have a **glioblastoma multiforme**?
2. Do you have **health insurance** (Medicare or another type) that pays for at least a portion of your drug bill?
3. Do you need help paying your portion of your medication bills?
4. Financial need: Is your family income below 5 times (500%) the federal poverty level? (See chart below for amounts.).

If you answered “yes” to all of these questions, you may be eligible. Acceptance into the program is on a first-come-first-served basis, until we run out of money for each cycle. If you are accepted, we will cover up to \$5,000 (this limit may be changed with no notice) of your share of the cost of drugs used to treat your brain tumor over a 9-month period: 3 months before you submit your application and 6 months after. [Note: this was changed from 1 year] At the end of your benefit period, you can apply again.

IF you answered NO to the question about having a Glioblastoma Multiforme or the Insurance question, do NOT send in this application and do not call us. We can not help you.

Persons in Family or Household	Max. Family Income Last Year
1	\$54,150
2	\$72,850
3	\$91,550
4	\$110,250
5	\$128,950
6	\$147,650
7	\$166,350

[To be filled out by the Patient, Caregiver or Patient Advocate]

Patient Copayment Assistance Program Application
Details at <http://braintumorcopays.org>

Patient:

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State (2 letters): _____ Zip: _____

Phone: _____ Email: _____

Sex: Male Female Date of Birth _____

Social Security Number (last 4 digits) _____ Veteran? Yes No

Alternate Contact Person or Person Filing Out The Application :

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State (2 letters): _____ Zip: _____

Phone: _____ Email: _____

Relation to Patient: _____

*Should we contact the: **patient** or the **alternate contact person** with questions and decisions?*

Prescribing Doctor:

First Name: _____ Last Name: _____ Degree(s): _____

Address: _____

City: _____ State (2 letters): _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Qualifications: DO NOT APPLY IF YOU ANSWER NO TO ANY QUESTION!

Does the patient have a **Glioblastoma Multiforme**: Yes No

Does the patient have **health insurance** that usually covers at least part of treatment you are applying for? : Yes No

Is the patient a **resident** of the United States? Yes No

of people in household? _____ **Gross Family Income** Last Year: \$ _____

Special Circumstances? (Like loss of job / disability?): _____

By signing, I certify that:

- all of the responses are complete and accurate to the best of your knowledge
- that you consent to allowing the Musella Foundation contact all of the people named in this application for reasons of processing this application and processing claims?
- that you will not request reimbursement for expenses covered by another insurance company or assistance program?

Print Name: _____ Signature: _____ Date: _____
(Patient should sign – but if unable to or too young, the contact person may sign)

Attach a copy of:

- 1. Your most recent Tax Return (First 2 pages only) – if married and filed separately, and living with your spouse – please include a copy of your spouse’s return as well.**
- 2. Your insurance card, front and back**

<p>How did you hear about our program? Circle all that apply</p> <p>doctor nurse patient advocate pharmacist support group online support group friends Google Bing Yahoo Other Search Engine NeedyMeds.org Virtualtrials.org BrainTumorCopays.org</p> <p>Other: (specify): _____</p>

Please fax completed form to us at: 1-877-869-2333

If you have any questions, call us toll free at 1-855-426-2672

Or Mail to:
Musella Foundation
1100 Peninsula Blvd
Hewlett, NY 11557

[Ask your doctor to fill this out for you]
Musella Foundation For Brain Tumor
Research & Information, Inc
Patient Co-Pay Assistance Program
Certification Form For Physicians

Patient Name: _____ DOB: _____

Patient Address: _____

Patient City / State / Zip _____

The above-named patient is applying to our patient co-payment assistance program and has given permission for you to supply the following information so that we can help with the costs of the medicines you prescribed.

Does this patient have a Glioblastoma Multiforme? Yes No

Have you prescribed or are you planning to prescribe any of the following treatments for this patient for the Glioblastoma Multiforme? (Check all that apply)

Temodar Avastin Gliadel NovoTTF-100A System

Dr. Name (Print or use stamp): _____

Dr. Address _____

Dr. City / State / Zip / Phone: _____

Signed: _____ Date: _____

Please fax completed form to us at: 1-877-869-2333
If you have any questions, call us toll free at 1-855-426-2672

[Ask your pharmacist or the dispensing provider to fill this out]
Musella Foundation For Brain Tumor
Research & Information, Inc
Patient Co-Pay Assistance Program
Certification Form For
Pharmacists or Dispensing Health Care Provider

Patient Name: _____ DOB: _____

Patient Address: _____

Patient City / State / Zip _____

The above-named patient is applying to our patient co-payment assistance program and has given permission for you to supply the following information so that we can help with the costs of his/her medicines. Currently, we can only help with these treatments: **Gliadel, Avastin, Temodar or the NovoTTF-100A System.** Visit our website at <http://braintumorcopays.org> for details.

When submitting claims, the receipt / invoice or explanation of benefits ***must include: Date Dispensed, Treatment Name, Amount Insurance Allowed and Paid, and Patient Responsibility.***

I certify that I have dispensed (or received a prescription for) at least one of the above named brain tumor treatments and that I have not and will not be sending these same receipts or invoices to any other assistance program – unless this application is denied.

Pharmacy OR Supplier Facility Name: _____

Address: _____

Phone: _____ Fax: _____

Name: _____ Date: _____

Signature: _____

Please fax completed form to us at: 1-877-869-2333
If you have any questions, call us toll free at 1-855-426-2672

[To be filled out by the Patient, Caregiver, Pharmacy or Patient Advocate]
Musella Foundation For Brain Tumor
Research & Information, Inc
Patient Co-Pay Assistance Program
Claim Form

Patient Name: _____ DOB: _____

Patient Address: _____

Patient City / State / Zip _____

Last 4 digits of SSN: _____

We can consider only your out of pocket expenses for these treatments: (Check our website for any changes): **Avastin, Gliadel, Novocure NovoTTF-100A System, and Temodar** that were dispensed during your approved claim period. You may submit as many claims as needed up to the total amount of your grant.

Date Dispensed	Treatment Name	Charge	Insurance Approved	Insurance Paid	Your Out of Pocket Cost
		\$	\$	\$	\$

Total out of pocket expenses :\$ _____

IF approved, whom should we make out the check to:

Name: _____

Address: _____

City State Zip: _____

Attach a copy of the: Insurance Explanation of Benefits, receipts for charges you paid, or invoices for charges that you owe! IT MUST SHOW HOW MUCH THE INSURANCE ALLOWED AND PAID!

Please **fax** completed form to us at: 1-877-869-2333
 If you have any questions, **call** us toll free at 1-855-426-2672

**Musella Foundation For Brain Tumor
Research & Information, Inc
Patient Co-Pay Assistance Program
Check List**

Keep this page as a record to make sure you sent all of the information. If you do not hear from us within 5 business days after you fax (or 2 weeks after mailing) all required documents, contact us toll free at 1-855-426-2672.

Required Item	Date Sent
Application Form	
Doctor's Certification	
Pharmacy Certification	
Insurance Card (Front and Back)	
Proof of Income	

You may (but do not have to) send in the Claim form, invoices and explanation of benefits at the same time as the application – that will speed up the process. Or you can wait until we approve you.

Make sure the application is legible. If your handwriting is hard to read, type out the information required on a cover sheet.

IF the person filing out the form is not listed as the patient or alternate contact person, include your name, facility, address, phone, fax and email and your position on a cover page.