Musella Foundation

Patient Co-Pay Assistance Program

Application Form For Patients

Version 16 Updated 4/5/25

READ THIS!

1. Check our website at **braintumorcopays.org** to see if we have funding, to check for a newer version of this application and any recent changes to the income qualification or treatments covered before submitting the application! Old versions of the application will be rejected.

2. Applications MUST be typed. We can no longer accept hand written applications because there were too many errors interpreting handwriting. If you can not type into the form then contact us before submitting it.

3. We respond only by email. Make sure to check your spam folder. If you do not get a reply within 2 business days, call us at 1-855- 2672. If you choose not to give us an email address, call us for the status 3 days after sending the application.

4. The first 2 pages of your most recent tax return is the best proof of income. **If you do not file taxes**, enclose a letter saying you do not file taxes, and list your sources of income last year and what you think you will earn this year. Send whatever proof you have and it will be considered – but it may slow down the process. Social Security or W2 forms by themselves are not enough.

5. IF it is difficult to get the doctor to fill out the "Certification form for physicians", you can send us a copy of your pathology report instead.

Overview

This program can help pay for your treatment, 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 (but we only cover the treatments listed on our website) —we never will ask you to switch. Visit our website https://BrainTumorCoPays.org to see the covered list of treatments and 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 **primary (Not metastatic), GRADE 3 or 4, malignant brain tumor**?
2. Do you have **health insurance** (Medicare or any other type) that may pay for at least a portion of your treatment bill?
3. Financial need: Is your family income below 5 times (500%) the federal poverty level? (See our website for current levels – the chart below is as of Feb 2024).

If you answered "yes" to all of these questions, you are eligible to apply. Acceptance into the program is on a first-come-first-served basis (of completed, typed applications), until we run out of money. If you are accepted, we will cover up to $5,000 of your share of the cost of covered treatments used to treat your brain tumor over a 12-month period: 3 months before your date of application and 9 months after. You can reapply for another grant when your grant expires. To apply for a renewal, send this entire application again on or after the expiration date of the original grant, but you do not need to include the certification form for physicians.

CLAIMS: We can pay the pharmacy directly OR reimburse the patient. We can not pay until the treatment is dispensed. We do paper claims only so there is NO electronic billing information. You must use our claim form which is in this packet, and also send the receipt. The receipt must show at least the patient's name, treatment name, date dispensed and amount the patient has to pay.

Persons in Family or Household	Max. Family Income Last Year
1	$78,250
2	$105,750
3	$133,250
4	$160,750
5	$188,250
6	$215,750
7	$243,250

Who is submitting this form:

☐ **Patient (or Family / Friends)**

☐ **Pharmacy Staff**

☐ **Provider Staff**

☐ **Manufacturer's Patient Assistance Program**

IF the person submitting this form is NOT listed on the next page, give us your contact information:

Name: _____

Phone: _____

Email: _____

Please type into this form on your computer then print it to sign and upload or fax.
We will notify you by email within 3 business days. If you do not hear back from us in 3 days call us!

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

Patient Copayment Assistance Program Application

Version 16

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) _____

Alternate Contact Person: (may be relative, friend, patient advocate)
This is required. We cannot approve application without this!

First Name: _____ MI: _____ Last Name: _____

Address: _____

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

Phone: _____ Email: _____

Relation to Patient: _____

Prescribing Doctor:

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

Hospital / Facility: _____

Address: _____

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

Phone: _____

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

Does the patient have a **PRIMARY GRADE 3 or 4 Malignant Brain Tumor**:
◯ Yes ◯ No

What Specific GRADE and TYPE of Tumor :_____

Does the patient have **health insurance**? ◯ 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?
- If you included an email address – you consent to us sending unencrypted email to that address. IF YOU DO NOT CONSENT THEN DO NOT GIVE US AN EMAIL ADDRESS!

Print Name: _____

Signature: _____ Date: _____
(Patient should sign – but if unable to or under 18 years old, the contact person may sign)

Attach a copy of:

1. **Your most recent Federal Tax Return (First 2 pages only) . or letter and other proof (see instructions). W2 / SS benefit letter is not sufficient!**
2. **Your insurance card, front only**

How did you hear about our program? **Circle all that apply**

doctor | nurse | patient advocate | pharmacist | support group | online support group | friends
Google | Bing | Yahoo | Other Search Engine | NeedyMeds.org | Virtualtrials.com |

Other: (specify): _____

Please upload completed forms to us at: braintumorcopays.org (Click on UPLOAD) or Fax to 1-877-869-2333

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

[Ask your doctor to fill this out for you]

Musella Foundation
Patient Co-Pay Assistance Program
Certification Form For Physicians

Version 16

Patient Name: _____ DOB: _____

Patient Address: _____

Patient City / State / Zip _____

Patient Phone: _____

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 treatments you prescribe.

1. **Does this patient have a Primary (Not Metastatic), Grade 3 or 4 Malignant Brain Tumors? ◯ Yes ◯ No**

2. **What SPECIFIC TYPE of Brain Tumor: (circle tumor or write it in if not listed!): Glioblastoma Multiforme, Anaplastic Astrocytoma, High Grade Oligodendroglioma, DIPG, DMG, Medulloblastoma,**

   OTHER: _____

Dr. Name (Print or use stamp):_____

Hospital / Clinic Name:_____

Dr. Address _____

Dr. City / State / Zip / Phone: _____

Signed: _____ Date: _____

Please fax completed form to us at: 1-877-869-2333
Or Upload at braintumorcopays.org

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

[A copy of the pathology report may be used instead of this form – if it is clear that the tumor is a primary malignant brain tumor]

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

Musella Foundation

Patient Co-Pay Assistance Program

Claim Form *version 16*

Patient Name: _____ DOB:_____

Patient Address: _____

Patient City / State / Zip _____

Last 4 digits of SSN: _____ Phone: _____

We can consider only your out of pocket expenses for these treatments: (Check our website for any changes): **Avastin, Lomustine, Optune and Temodar (or generics of these)** that were dispensed during your approved claim period. You may submit as many claims as needed up to the total amount of your grant. Items with a * are required!

*Date Dispensed	*Treatment Name	Charge (optional)	Insurance Paid (optional)	*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: _____

Direct Phone**: _____ Contact Person: _____**

Attach a copy of the: Insurance Explanation of Benefits or receipts for charges you paid. Circle the numbers, treatment name and dates you use!

Please **UPLOAD** completed form and receipt(s) to us at: **braintumorcopays.org**

Or Fax to 1-877-869-2333

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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 3 business days after you send (or 2 weeks after mailing) all required documents **contact us toll free at 1-855-426-2672**.

NOTE that we only notify you by email. If you choose not to give us an email address, contact us 3 days after sending the application!

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

You may (but do not have to) send in the Claim form and explanation of benefits at the same time as the application. Or you can wait until we approve you.

To fill out this form: open it on your computer and type in your responses, then print it, sign it and send it to us.

The best way to send it is to upload it to our website. Go to braintumorcopays.org and click UPLOAD. If you do not have a scanner, you can take photos of them on your phone and upload each photo directly from your phone!

If you can't scan it or take picture of it – then send via fax to: 1-877-869-2333