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

version 8

NOTE: Check our website at **braintumorcopays.org** to see if we have funding and to check for a newer version of this application before submitting the application!
Old versions of the application will be rejected.

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 (but we only cover the treatments listed on our website) —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 **primary (Not metastatic), GRADE 3 or 4, malignant brain tumor**?
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. 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 covered drugs 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 1 year after the start of your grant period. To reapply, 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.

Persons in Family or Household	Max. Family Income Last Year
1	$58,850
2	$79,650
3	$100,450
4	$121,250
5	$142,050
6	$162,850
7	$183,650

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: _____

Write CLEARLY or type. You can type into this form on your computer then print it to sign and fax.
We will notify you by email within 3 business days. If you do not hear back from us in 3 days, or if this is an emergency, call us!

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

Patient Copayment Assistance Program Application

Version 8

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?

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). Call us or check our website if you do not file taxes for other proof of income.**
   DO NOT SENT BANK RECORDS
2. **Your insurance card, front and back**

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 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

Version 8

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 medicines you prescribed.

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

What SPECIFIC GRADE and TYPE of Brain Tumor:

_____

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

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 *version 8*

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, Gliadel, 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.

Date Dispensed	Treatment Name	Charge	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: _____

Phone**:** _____

Attach a copy of the: Insurance Explanation of Benefits or receipts for charges you 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 3 business days after you fax (or 2 weeks after mailing) all required documents, or if this is an emergency, contact us toll free at 1-855-426-2672.

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 in a recent version of Adobe Reader and type in your responses, then print it, sign it and fax it to us. We had trouble reading handwritten applications - typing will greatly speed up the review process for your application.

If the fax doesn't work, use our alternate fax: 516-295-2870

Please try the manufacturer's assistance program first and use us as a last resort if they cannot help you since our funds are limited.

For Avastin, go to:
http://www.avastin.com/patient/resources/financial-assistance

For Temodar go to:
http://www.merck.com/merckhelps/act-program/enrollment.html

For the Novocure's Optune system go to:
http://www.novottftherapy.com/patients-contact.php

For Gliadel go to: http://www.gliadel.com/patient-assistance/