Take Home Cancer Drugs

Application **For information phone: 1-866-599-2267, and select option 2**
Please fax completed application form to 902-425-3288

FAMILY INFORMATION (please print clearly)

Last Name	First Name	Middle initial	Date of Birth (YYYY/MM/DD)	Health Card Number
Patient			/ /	

Family Address

Address Line 1	Telephone
Address Line 2	Postal code

Family Net Income Calculation:*

Family Member Name	Relationship to patient	Tax form T1– Line 236	Other Documents	Funding amount (each year)
				Net Income _____
				X 4%
Total net income				Family contribution = _____

*please attach documentation for all contributing family members

Funding Evaluation: Diagnosis: _____

Medication	Duration (if unknown estimate to end of fiscal year)	Start Date (YYYY/MM/DD)	Estimated Total Cost (To end of year)

Funding Source(s):	Description (identify type)	Coverage provided
Private insurance		
Pt assistance program		
Other		
Pharmacare		

****Applicant: By signing this form, you are consenting to healthcare professionals assisting with your drug coverage application to contact programs associated with funding as above.**

Application date (yyyy/mm/dd): _____

Print name and sign _____

_____

MRS/ HCP (print) _____

Notes:

Preferred pharmacy:
Alternate contact:

☐ Patient Q&A provided

Form updated 2018-04-18