



Request to add medication to the approved medication list for a disease state

The TotalAssist program provides financial assistance for treatments that are FDA-approved, listed in official compendia, and published in evidence-based guidelines related to the patient's approved disease fund. *Medications that do not meet these criteria will not be added to the approved medication list. Submitting a medication request does not guarantee it will be added to the approved medication list.*

Fax the signed form to TotalAssist at (757) 952-3643.

Patient information (if applicable)

Patient name: _____ Patient ID: _____

Disease state/Fund name: _____

Medication(s) information

Medication name(s) (brand and/or generic): _____

Prescribing provider information

Provider name: _____ Provider NPI: _____

Facility/Practice name: _____ Phone number: _____

Fax number: _____ Email address: _____

Office contact name: _____ Office contact phone: _____

Office contact email: _____

Provider attestation

I hereby attest that the medication I'm requesting be added to the approved medication list **meets** the following criteria for the patient's approved TotalAssist disease fund:

- The medication is approved by the U.S. Food and Drug Administration (FDA) for treatment of the disease; and/or
- The medication is listed in an official compendium; and/or
- The medication is supported by published evidence-based clinical guidelines related to the patient's approved disease state/fund.

I hereby attest that the medication I'm requesting be added to the approved medication list **does not** meet any of the criteria listed above.

I understand that this medication request will be reviewed by the TotalAssist team for consideration. I certify that the information provided in this request is accurate and complete to the best of my knowledge. I understand that medications that do not meet these criteria are not eligible for inclusion on the approved medication list under the TotalAssist program. I further understand that this information is for the sole use of the Patient Advocate Foundation TotalAssist program, its representatives, and/or agents.

Printed name: _____ Title/Role: _____

Signature: _____ Date: _____