Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph

Case No. _____

Annex "C2 – ALL"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
Consolidation, Interim Maintenance and Delayed Intensification Phase

Tranche 2

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐ - ☐

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
A. Diagnostics	
1. CSF Analysis WBC differential count	
2. CBC with platelet count	
3. Creatinine	
4. Bilirubin	
5. Bone marrow aspirate examination, as needed	
6. Alanine aminotransferase (ALT), as needed	
7. PT/PTT, as needed	
B. Complete list of medicines given	
1. Chemotherapy	
a. Systemic	
i. vincristine	
ii. doxorubicin	
iii. L-asparaginase (as indicated)	
iv. cytarabine	
v. cyclophosphamide	
vi. methotrexate (IV and oral)	
vii. 6-mercaptopurine	

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
b. Intrathecal	
i. Single (methotrexate) OR	
ii. Triple (methotrexate, cytarabine, hydrocortisone)	
2. Other drugs (as indicated)	
a. MESNA	
b. dexamethasone	
c. hydrocortisone	
3. Anti-emetics (as indicated)	
a. ondansetron	
b. metoclopramide	
4. Antibiotics (as indicated)	
a. cotrimoxazole	
b. ceftriaxone	
c. ceftazidime	
d. amikacin	
e. Other antibiotics based on hospital antibiogram Specify: _____	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	