Annex C.4.2: Checklist of Mandatory and Other Services for Hormonotherapy Tranche 2

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

CHECKLIST OF MANDATORY AND OTHER SERVICES
Breast Cancer – Hormonotherapy (Tranche 2)

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Place a (✓) in the appropriate tick box.

Laterality and Clinical Staging [a]	
☐ **Right**	☐ **Left**
☐ cStage 0	☐ cStage 0
☐ cStage IA	☐ cStage IA
☐ cStage IB	☐ cStage IB
☐ cStage IIA	☐ cStage IIA
☐ cStage IIB	☐ cStage IIB
☐ cStage IIIA	☐ cStage IIIA
☐ cStage IIIB	☐ cStage IIIB
☐ cStage IIIC	☐ cStage IIIC
☐ cStage IV	☐ cStage IV

[a] If bilateral, tick in the appropriate box both laterality and its corresponding clinical staging

Place a (✓) in the appropriate tick box if the services is done and indicate the date

SERVICES	**DATE OF PRESCRIPTION (mm/dd/yyyy)**
Tick one, whichever is applicable	7. Date: _____
	8. Date: _____
	9. Date: _____
☐ Tamoxifen [a b c] (Premenopausal/Postmenopausal)	10. Date: _____
	11. Date: _____
OR	12. Date: _____

☐ Anastrozole / Letrozole [b c] (Aromatase Inhibitor) (Postmenopausal)	7. Date: _____
	8. Date: _____
	9. Date: _____
	10. Date: _____
	11. Date: _____
	12. Date: _____

[a] Tamoxifen is given to premenopausal and postmenopausal women, particularly ER+/PR+/HER2neu- patients. For postmenopausal ER+/PR+/HER2neu+ patients, an aromatase inhibitor is preferred

[b] For cStage 0 – IIIC, prescription shall be given every 3 months

[c] For cStage IV prescription shall be given every month

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