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 - Chemotherapy

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.

MANDATORY SERVICES			**OTHER SERVICES as indicated/ as needed**
Chemotherapy* (any one of the following treatment protocols):			
	☐ **Neoadjuvant therapy**	**Date (mm/dd/yyy)**	
Protocol A: AC+T	**Z021M11** ☐ Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C)	1._____ 2._____ 3._____ 4._____	
	Z021M12 ☐ Docetaxel (T)	1._____ 2._____ 3._____ 4._____	
Protocol B: AC+Pacli	**Z021N11** ☐ Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C)	1._____ 2._____ 3._____ 4._____	
	Z021N12 ☐ Paclitaxel (Pacli)	1._____ 2._____ 3._____ 4._____ 5._____ 6._____ 7._____ 8._____ 9._____ 10._____ 11._____ 12._____	

Protocol C: T+Cb	**Z0210I** ☐ Docetaxel (T) + Carboplatin (Cb)	1._____ 2._____ 3._____ 4._____ 5._____ 6._____	
☐ **Adjuvant therapy**		**Date (mm/dd/yyy)**	
Protocol A: AC+T	**Z021M21** ☐ Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C)	1._____ 2._____ 3._____ 4._____	
	Z021M22 ☐ Docetaxel (T)	1._____ 2._____ 3._____ 4._____	
Protocol B: AC+Pacli	**Z021N21** ☐ Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C)	1._____ 2._____ 3._____ 4._____	
	Z021N22 ☐ Paclitaxel (Pacli)	1._____ 2._____ 3._____ 4._____ 5._____ 6._____ 7._____ 8._____ 9._____ 10. _____ 11._____ 12._____	
Protocol C: T+Cb	**Z0210I2** ☐ Docetaxel (T) + Carboplatin (Cb)	1._____ 2._____ 3._____ 4._____ 5._____ 6._____	
☐ Granulocyte colony-stimulating factor (G-CSF)			
			☐ Anti-emetic, specify
			☐ Antimicrobials, specify
			☐ Pain relievers, specify
			☐ Other medicines, specify

*not required for Stage 0 DCIS

HEALTH FACILITY (HF)		
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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 ☐☐-☐☐☐☐☐☐☐☐-☐	

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