NAME OF THE HOSPITAL: ____

1). Breast: M1K1

1. Name of the Procedures: Adriamycin/Cyclophosphamide (M1K1.1), 5- Flurouracil A-C (M1K1.2), AC (M1K1.3), Paclitaxel (M1K1.4), Cyclophosphamide / Methotraxate / 5flurouracil (CMF) (M1K1.5), Tamoxifen (M1K1.6), Aromatase Inhibitors (M1K1.7)

2. Indication: Breast Malignancy

3. Does the patient presented with signs & symptoms suggestive of breast malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of breast malignancy on Biopsy: Yes/No (Upload reports)

For Eligibility for any of the above packages the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

2). Multiple Myeloma: M1K10

1. Name of the Procedures: Vincristin, Adriamycin, Dexamethasone (VAD) (M1K10.1), Thalidomide+Dexamethasone (M1K10.2), Melphalan Prednisone Oral (M1K10.3)

2. Indication: Multiple Myeloma

3. Does the patient presented with signs & symptoms suggestive of Multiple Myeloma: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Multiple Myeloma on Biopsy, Radiological imaging, Protein electrophoresis: Yes/No (Upload reports)

For Eligibility for any of the above packages the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

3). Multiple Myeloma: M1K10

1. Name of the Procedures: Zoledronic Acid Along With Adjuvant Chemotherapy Of AS-I (M1K10.4)

2. Indication: Multiple Myeloma

3. Does the patient presented with signs & symptoms suggestive of Multiple Myeloma: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Multiple Myeloma on urine for bence jones protein, serum protein electrophoresis, bone marrow aspiration, biopsy: Yes/No (Upload reports)

5. If the answer to question 4 is Yes is there evidence of bone lesions on Radiological imaging/ Skeletal survey: Yes/No

For Eligibility for the above package the answer to question 5 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

4). Wilm'S Tumor: M1K11

1. Name of the Procedures: SIOP/NWTS Regimen (Stages I III) - Per month (M1K11.1)
2. Indication: Wilm'S Tumor
3. Does the patient presented with signs & symptoms suggestive of Wilm'S Tumor: Yes/No
4. If the answer to question 3 is Yes then is there evidence of Wilm'S Tumor on Biopsy, Radiological Imaging: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

5). Hepatoblastoma - Operable: M1K12

1. Name of the Procedures: Cisplastin Adriamycin (M1K12.1)

2. Indication: Hepatoblastoma

3. Does the patient presented with signs & symptoms suggestive of Hepatoblastoma: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Hepatoblastoma on Biopsy, Radiological imaging, Alpha-fetoprotein: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

6). Cervix - Operable: M1K13

1. Name of the Procedures: Cervical Cancer Weekly Cisplastin (M1K13.1)

2. Indication: Cervix malignancy

3. Does the patient presented with signs & symptoms suggestive of cervix malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of cervix malignancy on Biopsy, USG/CT: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

7). Childhood B-Cell Lymphomas: M1K14

1. Name of the Procedures: Variable Regimen Inv - Hematology - Payable maximum upto (M1K14.1)

2. Indication: Childhood B-Cell Lymphomas

3. Does the patient presented with signs & symptoms suggestive of Childhood B-Cell Lymphomas: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Childhood B-Cell Lymphomas on Bone marrow aspiration/ Biopsy, Peripheral blood smear, CSF/ CT Scan/ Lymph node Biopsy: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

8). Neuroblastoma Stage I –Iii: M1K15

1. Name of the Procedures: Variable Regimen Inv - X-Ray/CT Scan - Payable maximum upto/Per month (M1K15.1)

2. Indication: Neuroblastoma Stage I - III

3. Does the patient presented with signs & symptoms suggestive of neuroblastoma stage I - III: Yes/No

4. If the answer to question 3 is Yes then is there evidence of neuroblastoma on FNAC/biopsy, Radiological imaging: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

9). Retinoblastoma: M1K16

1. Name of the Procedures: Carbo/Etoposide/Vincristin (M1K16.1)
2. Indication: Retinoblastoma
3. Does the patient presented with signs & symptoms suggestive of Retinoblastoma: Yes/No
4. If the answer to question 3 is Yes then is there evidence of retinoblastoma on FNAC/biopsy, Radiological imaging: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

10). Histocytosis: M1K17

1. Name of the Procedures: Variable Regimen Inv - CT, Biopsy - Payable maximum upto (M1K17.1)

2. Indication: Histocytosis

3. Does the patient presented with signs & symptoms suggestive of histocytosis: Yes/No

4. If the answer to question 3 is Yes then is there evidence of histocytosis on FNAC/Biopsy, Radiological imaging: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

11). Rhabdomyosarcoma: M1K18

1. Name of the Procedures: Vincristin- Actinomycin- Cyclophosphamide (VACTC) Based Chemo - Per month (M1K18.1)

2. Indication: Rhabdomyosarcoma

3. Does the patient presented with signs & symptoms suggestive of Rhabdomyosarcoma: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Rhabdomyosarcoma on FNAC/Biopsy, Radiological imaging: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

12). Ewing'S Sarcoma: M1K19

1. Name of the Procedures: Variable Regimen Inv - Hematology, Biopsy - Payable maximum upto (M1K19.1)

2. Indication: Ewing'S Sarcoma

3. Does the patient presented with signs & symptoms suggestive of Ewing'S Sarcoma: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Ewing'S Sarcoma on FNAC/Biopsy, Radiological imaging: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

13). Urinary Bladder: M1K2

1. Name of the Procedures: Bladder Cancer Weekly Cisplastin (M1K2.1)/ Methotraxate Vinblastin Adriamycin Cyclophosphamide (MVAC) (M1K2.2)

2. Indication: Urinary Bladder Malignancy

3. Does the patient presented with signs & symptoms suggestive of Urinary Bladder malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Urinary Bladder malignancy on Biopsy, Radiological imaging: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

14). Acute Myeloid Leukemia: M1K20

1. Name of the Procedures: Induction Phase - Payable maximum upto (M1K20.1)

2. Indication: Acute Myeloid Leukemia

3. Does the patient presented with signs & symptoms suggestive of Acute Myeloid Leukemia: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Acute Myeloid Leukemia on Bone marrow aspiration/Biopsy, Peripheral blood smear, CSF: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

15). Acute Myeloid Leukemia: M1K20

1. Name of the Procedures: Consolidation Phase - Payable maximum upto (M1K20.2)

2. Indication: Acute Myeloid Leukemia

3. Does the patient presented with signs & symptoms suggestive of Acute Myeloid Leukemia: Yes/No

4. If the answer to question 3 is Yes then is there evidence of remission on Bone marrow aspiration report: Yes/No (Upload report)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

16). Acute Myeloid Leukemia: M1K20

1. Name of the Procedures: Maintenance Phase - Per month (M1K20.3)

2. Indication: Acute Myeloid Leukemia

3. Does the patient presented with signs & symptoms suggestive of Acute Myeloid Leukemia: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Acute Myeloid Leukemia on Bone marrow aspiration/Biopsy, Peripheral blood smear, CSF/ Radiological imaging AND treatment details of induction & consolidation phase: Yes/No (Upload reports & previous treatment details)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

17). Acute Lymphatic Leukemia: M1K21

1. Name of the Procedure: Induction 1st And 2 nd Months - Payable maximum upto (M1K21.1)/ Induction 3rd, 4th, 5th months - Payable maximum upto (M1K21.2)

2. Indication: Acute Lymphatic Leukemia

3. Does the patient presented with signs & symptoms suggestive of Acute Lymphatic Leukemia: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Acute Lymphatic Leukemia on Bone marrow aspiration/Biopsy, Peripheral blood smear, CSF: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

18). Acute Lymphatic Leukemia: M1K21

1. Name of the Procedures: Maintenance Phase - Per month (M1K21.3)

2. Indication: Acute Lymphatic Leukemia

3. Does the patient presented with signs & symptoms suggestive of Acute Lymphatic Leukemia: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Acute Lymphatic Leukemia on Bone marrow aspiration/Biopsy, Peripheral blood smear, CSF AND treatment details of induction phase: Yes/No (Upload reports & previous treatment details)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

19). Unlisted Regimen: M1K22

1. Name of the Procedure: Palliative Chemotherapy - Unlisted Regimen - Payable maximum upto per cycle (M1K22.1)

2. Indication: Malignancy

3. Does the patient presented with signs & symptoms suggestive of malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of malignancy on Biopsy, Supportive documents: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

20). Terminally Ill: M1K23

1. Name of the Procedure: Palliative And Supportive Therapy - Per month (M1K23.1)

2. Indication: Malignancy

3. Does the patient presented with signs & symptoms suggestive of malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of malignancy on Biopsy, Radiological imaging, CBC, LFT, KFT: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

21). Vulval Cancer: M1K24

1. Name of the Procedure: Cisplastin/5-FU (M1K24.1)

2. Indication: Vulval malignancy

3. Does the patient presented with signs & symptoms suggestive of vulval malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of vulval malignancy on Biopsy, Radiological imaging: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

22). Rectal Cancer Stage 2 And 3: M1K25

1. Name of the Procedure: Xelox Along With Adjuvant Chemotherapy Of AS-I (M1K25.1)

2. Indication: Rectal Malignancy

3. Does the patient presented with signs & symptoms suggestive of rectal malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of rectal malignancy on Biopsy, Radiological imaging, CEA: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

23). Febrile Neutropenia Fn High Risk 2: M1K27

1. Name of the Procedure: 1st Line Iv Antibiotics And Other Supportive Therapy (Third Generation Cephalosporin, Aminoglycoside Etc.,) (M1K27.1)

2. Indication: Febrile Neutropenia Fn High Risk 2

3. Does the patient presented with signs & symptoms suggestive of Febrile Neutropenia: Yes/No

4. If the answer to question 3 is Yes then is there evidence of febrile neutropenia on CBC: Yes/No (Upload reports)

5. If the answer to question 4 is Yes is there evidence of mild/moderate neutropenia: Yes/No

   For Eligibility for the above package the answer to question 5 must be Yes

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NAME OF THE HOSPITAL: ____

24). Febrile Neutropenia Fn High Risk 2: M1K27

1. Name of the Procedure: 2nd Line Iv Antibiotics And Other Supportive Therapy (Carbapenems, Fourth Generation Cephalosporins, Piperacillin, Anti-Fungal . Azoles Etc.,) (M1K27.2)

2. Indication: Febrile Neutropenia Fn High Risk 2

3. Does the patient presented with signs & symptoms suggestive of Febrile Neutropenia: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Febrile Neutropenia on CBC: Yes/No (Upload reports)

5. If the answer to question 4 is Yes is there evidence of severe neutropenia: Yes/No

   For Eligibility for the above package the answer to question 5 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

25). Vaginal Cancer: M1K28

1. Name of the Procedure: Cisplastin/5-FU (M1K28.1)

2. Indication: Vaginal Malignancy

3. Does the patient presented with signs & symptoms suggestive of vaginal malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of vaginal malignancy on Biopsy, Radiological imaging: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

26). Ovary: M1K29

1. Name of the Procedure: Carboplastin/ Paclitaxel (M1K29.1)

2. Indication: Ovary Malignancy

3. Does the patient presented with signs & symptoms suggestive of ovary malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of ovary malignancy on Biopsy/ FNAC/Ascitic tapping, Radiological imaging, CA 125: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

27). Small Cell Lung Cancer: M1K3

1. Name of the Procedure: Cisplastin/Etoposide (IIIB) (M1K3.1)

2. Indication: Small Cell Lung Cancer

3. Does the patient presented with signs & symptoms suggestive of Small Cell Lung Cancer: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Small Cell Lung Cancer on FNAC/Biopsy, Radiological imaging: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

28). Ovary Germ Cell Tumour: M1K30

1. Name of the Procedure: Bleomycin-Etoposide-Cisplastin (BEP)(M1K30.1)

2. Indication: Ovary Germ Cell Tumour

3. Does the patient presented with signs & symptoms suggestive of Ovary Germ Cell Tumour: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Ovary Germ Cell Tumour on Biopsy/FNAC/Ascitic tapping, Radiological imaging, CA 125, Beta HCG, Alpha fetoprotein: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

29). Gestational Trophoblast Ds. Low Risk: M1K31

1. Name of the Procedure: Weekly Methotrexate (M1K31.1)/ Actinomycin (M1K31.2)

2. Indication: Gestational Trophoblast Ds. Low Risk

3. Does the patient presented with signs & symptoms suggestive of Gestational Trophoblast Ds. Low Risk: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Gestational Trophoblast on Biopsy/FNAC, Radiological imaging, Beta HCG (compulsory): Yes/No (Upload reports)

   For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

30). Gestational Trophoblast Ds. High Risk: M1K32

1. Name of the Procedure: Etoposide - Methotrexate - Actinomycin / Cyclophosphamide Avincristine (EMA-CO) (M1K32.1)

2. Indication: Gestational Trophoblast Ds. High Risk

3. Does the patient presented with signs & symptoms suggestive of Gestational Trophoblast Ds. High Risk: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Gestational Trophoblast on Biopsy/ FNAC, Radiological imaging, Beta HCG (compulsory): Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

31). Testis: M1K33

1. Name of the Procedure: Bleomycin-Etoposide-Cisplastin (BEP) (M1K33.1)

2. Indication: Testis Malignancy

3. Does the patient presented with signs & symptoms suggestive of testis malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of testis malignancy on Biopsy/ FNAC, Radiological imaging, Beta HCG (compulsory), Alpha fetoprotein, LDH: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

32). Prostate: M1K34

1. Name of the Procedure: Hormonal Therapy - Per month (M1K34.1)

2. Indication: Prostate malignancy

3. Does the patient presented with signs & symptoms suggestive of prostate malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of prostate malignancy on Biopsy/ FNAC, PSA: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

33). Oncologyoesophagus: M1K4

1. Name of the Procedure: Cisplastin- 5FU (M1K4.1)

2. Indication: Oesophagus malignancy

3. Does the patient presented with signs & symptoms suggestive of oesophagus malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of oesophagus malignancy on FNAC/ Biopsy, Radiological imaging/ Endoscopy: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

34). Stomach: M1K5

1. Name of the Procedure: 5-Fu Leucovorin (MCDONALD Regimen) (M1K5.1)

2. Indication: Stomach malignancy

3. Does the patient presented with signs & symptoms suggestive of stomach malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of stomach malignancy on FNAC/ Biopsy, Radiological imaging/ Endoscopy: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

35). Colon Rectum: M1K6

1. Name of the Procedure: Monthly 5-FU (M1K6.1)/ 5- Flurouracil-Oxaliplastin Leucovorin (Folfox) (Stage III Only) (M1K6.2)

2. Indication: Colon/Rectum malignancy

3. Does the patient presented with signs & symptoms suggestive of colon/rectum malignancy: Yes/No

4. If the answer to question 3 is Yes then is there evidence of colon/rectum malignancy on FNAC/Biopsy, Radiological imaging/ Colonoscopy, CEA: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

36). Bone Tumors/Osteosarcoma: M1K7

1. Name of the Procedure: Cisplastin/Adriamycin (M1K7.1)

2. Indication: Bone Tumors/Osteosarcoma

3. Does the patient presented with signs & symptoms suggestive of bone tumors/osteosarcoma: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Bone Tumors/Osteosarcoma on FNAC/Biopsy, Radiological imaging: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: ____

37). Lymphoma, Hodgkin'S: M1K8

1. Name of the Procedure: Adriamycin Bleomycin Vinblastin Dacarbazine (ABVD) (M1K8.1)

2. Indication: Lymphoma, Hodgkin'S

3. Does the patient presented with signs & symptoms suggestive of Lymphoma, Hodgkin'S: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Lymphoma, Hodgkin'S on FNAC/Biopsy, Radiological imaging, LDH/ Bone marrow: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

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NAME OF THE HOSPITAL: ____

38). Lymphoma Nhl: M1K9

1. Name of the Procedure: Cyclophosphamide Adriamycin Vincristin Prdnisone (CHOP) (M1K9.1)

2. Indication: Lymphoma Nhl

3. Does the patient presented with signs & symptoms suggestive of Lymphoma Nhl: Yes/No

4. If the answer to question 3 is Yes then is there evidence of Lymphoma Nhl on FNAC/Biopsy, Radiological imaging, LDH/ Bone marrow: Yes/No (Upload reports)

For Eligibility for the above package the answer to question 4 must be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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