**HOSPICE INFORMATION FOR MEDICARE PART D PLANS**

**SECTION I -HOSPICE INFORMATION TO OVERRIDE AN “HOSPICE A3 REJECT” OR TO UPDATE HOSPICE STATUS**

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| **A. Purpose of the form (please check all appropriate boxes) :**   |
|  **Admission**  **Proactive**  **Rx Communication**  **A3 Reject Override Termination**  |
| To: Medicare Part D Plan  | From: Hospice Provider  |
| Plan Name |  | Hospice Name |  |
| PBM Name |  | Address |  |
| Phone # | ( ) - | Phone # | ( ) - |
| Fax # | ( ) - | Fax # | ( ) - |
| Secure E-Mail |  | NPI |  |
| Contact Name |  | Contact Name |  |
|  Plan Sponsor Website Link: |
| B. Patient Information | Prescriber Information |
| Patient Name |  | Prescriber Name |  |
| Patient DOB |  | Prescriber NPI |  |
| Patient ID # (HICN) |  | Practice Name |  |
| Hospice Admit Date |  | Practice Address |  |
| Hospice Discharge Date |  | Contact Name |  |
| Principal Diagnosis Code |  | Practice Phone Number |  **( ) -** |
| Other Diagnosis Code (s) |  | Practice Fax # | **( ) -** |
| Unrelated Diagnosis Code (s) |  | Hospice AffiliatedYES NO |
| **For change in hospice status update** **documentation is required**. **Please check to indicate which document is attached**.Notice of Election to indicate a Notice of Election Notice of Termination /Revocation  |
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| C. Hospice Pharmacy Benefit Manager (PBM) Information |
| PBM Name |  | BIN |  | Cardholder ID |  |
| PBM Phone # | ( ) - | PCN |  | Group ID |  |

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| D. Prior Authorization Process: Enter a separate line for each Analgesic, Antinauseant (antiemetic), Laxative, and Antianxiety drug (anxiolytic) Medication that is Unrelated to Terminal Prognosis . Drugs outside of these four classes do not require prior authorization.  |
| Medication Name and Strength | Dosing Schedule | Quantity/Month | Rationale to Support the Medication is Unrelated to Terminal Prognosis (Optional) |
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| E. Signature of Hospice Representative or Prescriber (Required).  |  |  |  |

Representative Date / /

Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescriber\* Date / / \_

 **\***If the prescriber of the medication is unaffiliated with the Hospice provider, has the prescriber confirmed with the Hospice provider that the medication is unrelated to the terminal prognosis?

No

Yes

**SECTION II – PLAN OF CARE (Optional)**

|  |  |  |  |
| --- | --- | --- | --- |
| Hospice Name |  | Hospice NPI |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient Name |  | Patient ID# (HICN) |  | Patient DOB | / / |

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| Additional Medications Under Hospice Plan of Care and Designation of Financial Responsibility |
| Medication Name and Strength | Hospice | Patient | Medication Name and Strength | Hospice | Patient |
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Signature of Hospice Representative

Representative Date / /

Signature of Beneficiary or Beneficiary Authorized Representative

Beneficiary/Representative Date / /