HOSPICE INFORMATION FOR MEDICARE PART D PLANS

SECTION I -HOSPICE INFORMATION TO OVERRIDE AN "HOSPICE A3 REJECT" OR TO UPDATE HOSPICE STATUS

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		Hospi	ce Name								
PBM Name		Addre									
Phone # ()	-	Phone	e #	()	-						
Fax # ()	-	Fax #		()	-						
Secure E-Mail		NPI									
Contact Name			ict 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			Llagrica Affiliate d								
Unrelated Diagnosis Code (s)			Hospice Affiliated YES NO								
For change in hospice status up	date documentation is r	equired. P	lease chec			nent is attac	ched.				
	e of Termination /Revoca			ic to mandate mine.	. accan						
Notice of Election	e or remination/Nevoca										
C. Hospice Pharmacy Benefit Manag	er (PBM) Information										
PBM Name	A Name BIN			Cardholder ID							
PBM Phone # () -	- PCN			Group ID							
D. Prior Authorization Process: Ente	er a separate line for each A	nalgesic, Anti	nauseant (a	antiemetic), Laxative,	and Ant	ianxiety drug	(anxiolytic)				
Medication that is Unrelated to Terr	minal Prognosis . Drugs outs	ide of these f	our classes	do not require prior	authoriz	ation.					
Medication Name and Strength	Strength Dosing Schedule Quant			y/ Rationale to Support the Medication is Unrelated to Terminal							
		Month		sis (Optional)	aicación	is officiated	to reminar				
				75 (Optional)							
E. Signature of Hospice Represen	tative or Prescriber (Requi	ired).									
Representative						Date /	. /				
							—— <i>'</i> ———				
Title						-					
Prescriber*					Dα	ite /	/				
	on is unaffiliated with the Un	osnica provida	ar has the r	prescriber confirmed							
*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? Yes No											
the Hospice provider that the medication is unrelated to the terminal prognosis?											

SECTION II – PLAN OF CARE (Optional)

Hospice Name	Hospice NPI									
Patient Name		Patient	ID# (HICN)	Patient D	OB / /					
Additional Medi Medication Name and Strength	Hospice		an of Care and Designment Medication Name	gnation of Financial Re and Strength	Hospice	Patien				
	I				<u> </u>					
ignature of Hospice Representative										
				_						
epresentative					oate//					
ignature of Beneficiary or Beneficiary A	uthorized Repr	esentative	9							
eneficiary/Representative				r)ate//					