**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 |  | | | | 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 Affiliated  YES 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 | | | | | | | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | C. Hospice Pharmacy Benefit Manager (PBM) Information | | | | | | | PBM Name |  | BIN |  | Cardholder ID |  | | PBM Phone # | ( ) - | PCN |  | Group ID |  | | | | | | | | | | | | |
| 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) | | | |
|  | | |  |  | | |  | | | |
|  | | |  |  | | |  | | | |
|  | | |  |  | | |  | | | |
|  | | |  |  | | |  | | | |
|  | | |  |  | | |  | | | |
|  | | |  |  | | |  | | | |
| 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 | / / |

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

Signature of Hospice Representative

Representative Date / /

Signature of Beneficiary or Beneficiary Authorized Representative

Beneficiary/Representative Date / /