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 ☐ 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? Yes ☐ No ☐

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Section 2 – 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____/_____/_____