## 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 F	Part D Plan			From	From: Hospice Provider								
Plan Name					ice Name								
PBM Name					ess								
Phone #	( ) -				ne#	( ) -	-						
Fax #	( )	-		Fax #	ŧ	( ) -	-						
Secure E-Mail	,			NPI		,							
Contact Name				Cont	act Name								
Plan Sponsor V	Vebsite Link	•		•									
B. Patient Info					Prescriber	Information							
Patient Name					Prescriber								
Patient DOB			Prescriber NPI			NPI							
Patient ID # (HICN)			Practice Name			ame							
Hospice Admit Date				Practice Address									
Hospice Discha				Contact Name									
Principal Diagn	osis Code			Practice			(	)	-				
Other Diagnos					Practice Fa	x #	i	)	-				
	, ,						`	•					
Unrelated Diag	gnosis				Hospice Af	filiated	•						
Code (s)							YES [	ES 🗌 NO					
For change in I	nospice stat	us update do	cumentation is r	equired. F	Please chec	k to indicate which	n docume	nt is atta	iched.				
Notice of Elect	ion 🔲	Notice of Ter	mination /Revoca	ation									
C. Hospice Pharm	acy Benefit N	/lanager (PBM)											
PBM Name			BIN			Cardholder ID							
PBM Phone #	( )	-	PCN			Group ID							
D. Prior Authoriza	tion Process	: Enter a separ	ate line for each A	nalgesic. Ant	tinauseant (a	ntiemetic), Laxative,	and Antian	xietv dru	g (anxiolytic)				
						do not require prior			5 (				
									to Townsings				
Medication Name and Strength		tn	Dosing Schedule	Quantity/   Month	Quantity/ Rationale to Support the M Month Prognosis (Optional)			Jnrelated	to rerminal				
				IVIOIILII	Progrios	is (Optional)							
		$\exists$											
E Cianatura of	Uocnico Des	rocontativo	Prescriber (Requ	irod)		,							
E. Signature of	nospice Kep	resentative or	rrescriber (Requi	irea).									
							D	ate	//				
Title													
Prescriber* Date													
*If the prescrib	er of the med	dication is unaf	filiated with the Ho	ospice provid	der, has the p	rescriber confirmed		—	, —				
the Hospice pro	vider that the	e medication is	unrelated to the te	erminal prog	nosis?			Yes	No				

## **HOSPICE INFORMATION for MEDICARE PART D PLANS**

## SECTION II – PLAN OF CARE (Optional)

Hospice Name			Hospice NF	P		
Patient Name		Patient	ID# (HICN)	Patient DOB /	/	
Additional Medication Medication Name and Strength	ns Under H Hospice	lospice Pla Patient	an of Care and Designation of Fir Medication Name and Strength	nancial Responsibi n	lity Hospice	Patient
Signature of Hospice Representative						
Representative				Date	//_	
Signature of Beneficiary or Beneficiary Author	rized Repi	esentati <u>v</u> e				
Reneficiary/Representative				Date	/ /	