HIGHMARK
NORTHEASTERN NEW YORK

**PLEASE FAX OR MAIL THIS FORM TO:**

| Toll Free Fax #: | Mailing Address: |
| --- | --- |
| 1-866-240-8123 | Medical Management & Policy • 120 Fifth Avenue, MC P4207 • Pittsburgh, PA 15222 |

# MEDICARE PART D HOSPICE PRIOR AUTHORIZATION INFORMATION

**This form should be used to request coverage of prescription medications under Medicare Part D when the member is in Hospice care when it is believed the drug should not be covered under the Part A hospice benefit. Please submit a separate form for each medication.**

| TO: MEDICARE PART D PLAN INFORMATION | FROM: HOSPICE PROVIDER INFORMATION |
| --- | --- |
| Plan Name | Hospice Name |
| PBM Name | Address |
| Phone Number<br>( ) | Phone Number<br>( ) |
| Fax Number<br>( ) | Fax Number<br>( ) |
| Secure E-Mail | NPI |
| Contact Name | Contact Name |

| PATIENT INFORMATION | PRESCRIBER INFORMATION |
| --- | --- |
| Patient Name | Prescriber Name |
| Patient DOB | Prescriber NPI |
| Patient ID # (HICN) | Practice Name |
| Admit Date | Practice Address |
| Discharge Date | Contact Name |
| ADMISSION OR DISCHARGE UPDATE ONLY ❑ | Practice Phone Number<br>( ) |
| Primary Diagnosis | Practice Fax Number<br>( ) |
| Secondary Diagnosis | Hospice Affiliated YES ❑ NO ❑ |
| Unrelated Diagnosis | |

| HOSPICE PHARMACY BENEFIT MANAGER (PBM) INFORMATION | | |
| --- | --- | --- |
| PBM Name | BIN | Cardholder ID |
| PBM Phone Number<br>( ) | PCN | Group ID |

| MEDICATIONS UNRELATED TO TERMINAL ILLNESS AND/OR RELATED CONDITIONS: PRIOR AUTHORIZATION REQUIRED | | | |
| --- | --- | --- | --- |
| Medication Name and Strength | Dosing Schedule | Qty/Month | Rationale to Support the Medication is Unrelated to Terminal Illness (Optional) |
| | | | |

## SIGNATURE OF HOSPICE REPRESENTATIVE OR PRESCRIBER REQUIRED

Representative ____________________ Date ____________

Prescriber ____________________ Date ____________

**If the prescriber of the non-covered medication is unaffiliated with the Hospice provider, has the prescriber confirmed with the Hospice provider that the medication is unrelated to the terminal illness and/or related conditions? YES ❑ NO ❑**

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