

## 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 INFORM	FROM: HOSPICE PROVIDER INFORMATION				
Plan Name		Hospice Name			
PBM Name		Address			
Phone Number		Phone Number			
( ) Fax Number		Fax Number			
rax Number ( )					
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			
Primary Diagnosis		Practice Fax Number			
Secondary Diagnosis		Hospice Affiliated YES NO NO			
Unrelated Diagnosis					
	HOSPICE PHARMACY BENEFIT	MANAGER (PBM)	INFORMA	ATION	
PBM Name	BIN			Cardholder ID	
PBM Phone Number	PCN	PCN		Group ID	
MEDICATIONS UNRELATED	TED TO TERMINAL ILLNESS AND/OF	R RELATED CONDI	TIONS: PI	RIOR AUTHORIZATION REQUIRED	
ledication Name and Strength Dosing Schedule		,		ationale to Support the Medication is nrelated to Terminal Illness (Optional)	
	SIGNATURE OF HOSPICE REPRESEI	NTATIVE OR PRES	CRIBER R	EQUIRED	
Representative	Date				
Prescriber		Date			
If the prescriber of the non-covered Hospice provider that the medicati				as the prescriber confirmed with the	
• •				ial information that is privileged and exempt	

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