HIGHMARK.

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

Toll Free Fax #: 1-866-240-8123

Mailing Address: **Clinical Services** • 120 Fifth Avenue, MC **PAPHM -043B** • 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 ( ) | Phone Number ( ) |
| Fax Number ( ) | Fax 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 ☐ |
| Unrelated Diagnosis | |

## HOSPICE PHARMACY BENEFIT MANAGER (PBM) INFORMATION

| | | |
|---|---|---|
| PBM Name | BIN | Cardholder ID |
| PBM Phone Number ( ) | 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 ☐