

PLEASE FAX OR MAIL THIS FORM TO:

Toll Free Fax #: Mailing Address:

1-866-240-8123 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		
		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) 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	l •		ale to Support the Medication is ted 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 \(\sigma\) NO \(\sigma\)				
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