



PLEASE FAX OR MAIL THIS FORM TO:
 Toll Free Fax #: 1-866-240-8123 Mailing Address: 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 ()		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 <input type="checkbox"/>		Practice Phone Number ()	
Primary Diagnosis		Practice Fax Number ()	
Secondary Diagnosis		Hospice Affiliated YES <input type="checkbox"/> NO <input type="checkbox"/>	
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

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