HOSPICE INFORMATION FOR MEDICARE PART D PLANS

SECTION I -HOSPICE INFORMATION TO OVERRIDE AN "HOSPICE A3 REJECT" OR TO UPDATE HOSPICE STATUS

Member no longer under Hospice Care, the hospice provider/member/prescriber confirming discharge/revocation dates. Complete/review information, sign and date. Fax signed forms to CVS/Caremark at 1-844-242-0904. This fax machine is located in a secure location as required by HIPAA regulations.

A. Purpose of the form (please check all appropriate boxes) :

Admission ☐ Proactive Rx Communication ☐ A3 Reject Override ☐ Termination ☐

To: Medicare Part D Plan		From: Hospice Provider	
Plan Name		Hospice Name	
PBM Name		Address	
Phone #		Phone #	
Fax#		Fax#	
Secure E-Mail		NPI	
Contact Name		Contact Name	
Plan Sponsor Website Link:			

B. Patient Information		Prescriber Information	
Patient Name		Prescriber Name	
Patient DOB		Prescriber NPI	
Patient ID # (HICN)		Practice Name	
Hospice Admit Date		Practice Address	
Hospice Discharge Date		Contact Name	
Principal Diagnosis Code		Practice Phone Number	
Other Diagnosis Code (s)		Practice Fax #	
Unrelated Diagnosis Code (s)		Hospice Affiliated	

For change in hospice status update documentation is required. Please check to indicate which document is attached.

Notice of Election ☐ Notice of Termination /Revocation ☐

C. Hospice Pharmacy Benefit Manager (PBM) Information

PBM Name		BIN		Cardholder ID	
PBM Phone #		PCN		Group ID	

D. Prior Authorization Process: Enter a separate line for each Analgesic, Antinauseant (antiemetic), Laxative, and Antianxiety drug (anxiolytic) Medication that is Unrelated to Terminal Prognosis . Drugs outside of these four classes do not require prior authorization.

Medication Name and Strength	Dosing Schedule	Quantity/ Month	Rationale to Support the Medication is Unrelated to Terminal Prognosis (Optional)

E. Signature of Hospice Representative or Prescriber (Required).

Representative _____ Date ___/___/_____ Title _____ Prescriber* _____ Date ___/___/_____	
*If the prescriber of the medication is unaffiliated with the Hospice provider, has the prescriber confirmed with the Hospice provider that the medication is unrelated to the terminal prognosis?	Yes ☐ No ☐

HOSPICE INFORMATION for MEDICARE PART D PLANS

SECTION II –PLAN OF CARE (OPTIONAL)

Hospice Name		Hospice NPI	

Patient Name		Patient ID# (HICN)		Patient DOB	/ /

Additional Medications Under Hospice Plan of Care and Designation of Financial Responsibility					
Medication Name and Strength	Hospice	Patient	Medication Name and Strength	Hospice	Patient
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
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	☐	☐		☐	☐
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	☐	☐		☐	☐
	☐	☐		☐	☐

Signature of Hospice Representative

Representative _____ Date ____ / ____ / _____

Signature of Beneficiary or Beneficiary Authorized Representative

Beneficiary/Representative _____ Date ____ / ____ / _____