

## HOSPICE INFORMATION FOR MEDICARE PART D PLANS

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

**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	<input type="checkbox"/> YES <input type="checkbox"/> NO

**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

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**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
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

**Signature of Hospice Representative**

Representative \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signature of Beneficiary or Beneficiary Authorized Representative**

Beneficiary/Representative \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please return signed and completed forms to:  
 Fax: 844-328-1906  
 Mail: MeridianComplete  
 1 Campus Martius, Suite 750  
 Detroit, MI 48226