

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 <input type="checkbox"/> Proactive Rx Communication <input type="checkbox"/> A3 Reject Override <input type="checkbox"/> Termination <input type="checkbox"/> | | | |
| To: Medicare Part D Plan | | From: Hospice Provider | |
| Plan Name | Allwell Medicare | Hospice Name | |
| PBM Name | | Address | |
| Phone # | (855) 766-1452 | Phone # | |
| Fax # | (866) 226-1093 | Fax # | |
| Secure E-Mail | | NPI | |
| Contact Name | | Contact Name | |
| Plan Sponsor Website Link: allwell.homestatehealth.com | | | |

| 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) |
|------------------------------|-----------------|-----------------|---|
| | | | |
| | | | |
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| | | | |
| | | | |

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"/> |
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| | <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 ____/____/____