# Hospice Prior Authorization — For Medicare Part D Plans

## Section I — Hospice Information to Override an "Hospice A3 Reject"

CareOregon Advantage

**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#v |
| Fax#: | Fax#: |
| Secure Email: | NPI: |
| Contact Name: | Contact Name: |

Plan Sponsor Website Link: _____

**B: Patient Information**

| | |
|---|---|
| Patient Name: | Prescriber Name: |
| Patient DOB: | Prescriber NPI: |
| Patient ID# (HICN / MBI): | Practice Name: |
| Hospice Admit Date: | Practice Address: |
| Hospice Discharge Date: | Contact Name: |
| Principal Diagnosis Code: | Practice Phone#: |
| Other Diagnosis Code (s): | Practice Fax#: |
| Unrelated Diagnosis Codes: | Hospice Affiliated? ☐ Yes ☐ 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

# 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 |
| | ○ | ○ | | ○ | ○ |
| | ○ | ○ | | ○ | ○ |
| | ○ | ○ | | ○ | ○ |
| | ○ | ○ | | ○ | ○ |
| | ○ | ○ | | ○ | ○ |
| | ○ | ○ | | ○ | ○ |
| | ○ | ○ | | ○ | ○ |
| | ○ | ○ | | ○ | ○ |
| | ○ | ○ | | ○ | ○ |
| | ○ | ○ | | ○ | ○ |
| | ○ | ○ | | ○ | ○ |
| | ○ | ○ | | ○ | ○ |

**Signature of Hospice Representative**

Representative: _____ Date: _____

**Signature of Beneficiary or Beneficiary Authorized Representative**

Beneficiary/ Representative: _____ Date: _____