# 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 | Allwell | Hospice Name | |
| PBM Name | | Address | |
| Phone # | 1-833-260-4124 | Phone # | |
| Fax # | 1-866-226-1093 | Fax # | |
| Secure E-Mail | | NPI | |
| Contact Name | | Contact Name | |

Plan website: allwell.magnoliahealthplan.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 ☐ 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 ☐

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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 |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |

**Signature of Hospice Representative**

Representative_____Date____/_____/_____

**Signature of Beneficiary or Beneficiary Authorized Representative**

Beneficiary/Representative_____Date____/_____/_____