

## 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   | Wellcare Prime by Absolute Total Care (MMP) | Hospice Name           |  |
| PBM Name  |   | Address                |  |
| Phone #   | 1-855-735-4398 (TTY: 711)                   | Phone #                |  |
| Fax #   | 1-877-941-0480                              | Fax #                  |  |
| Secure E-Mail   |   | NPI                    |  |
| Contact Name  |   | Contact Name           |  |
| Plan website: mmp.absolutetotalcare.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) |
|------------------------------|-----------------|-----------------|---|
|                              |                 |                 |   |
|                              |                 |                 |   |
|                              |                 |                 |   |
|                              |                 |                 |   |
|                              |                 |                 |   |
|                              |                 |                 |   |
|                              |                 |                 |   |
|                              |                 |                 |   |

**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                  |
|   | <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"/> |
|   | <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 \_\_\_\_/\_\_\_\_/\_\_\_\_