HIGHMARK.

PLEASE FAX OR MAIL THIS FORM TO:

Toll Free Fax #: 1-866-240-8123

Mailing Address: **Clinical Services** • 120 Fifth Avenue, MC **PAPHM -043B** • Pittsburgh, PA 15222

MEDICARE PART D HOSPICE PRIOR AUTHORIZATION INFORMATION

This form should be used to request coverage of prescription medications under Medicare Part D when the member is in Hospice care when it is believed the drug should not be covered under the Part A hospice benefit. Please submit a separate form for each medication.

TO: MEDICARE PART D PLAN INFORMATION	FROM: HOSPICE PROVIDER INFORMATION
Plan Name	Hospice Name
PBM Name	Address
Phone Number ( )	Phone Number ( )
Fax Number ( )	Fax Number ( )
Secure E-Mail	NPI
Contact Name	Contact Name

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name	Prescriber Name
Patient DOB	Prescriber NPI
Patient ID # (HICN)	Practice Name
Admit Date	Practice Address
Discharge Date	Contact Name
ADMISSION OR DISCHARGE UPDATE ONLY ☐	Practice Phone Number ( )
Primary Diagnosis	Practice Fax Number ( )
Secondary Diagnosis	Hospice Affiliated YES ☐ NO ☐
Unrelated Diagnosis	

HOSPICE PHARMACY BENEFIT MANAGER (PBM) INFORMATION

PBM Name	BIN	Cardholder ID
PBM Phone Number ( )	PCN	Group ID

MEDICATIONS UNRELATED TO TERMINAL ILLNESS AND/OR RELATED CONDITIONS: PRIOR AUTHORIZATION REQUIRED

Medication Name and Strength	Dosing Schedule	Qty/Month	Rationale to Support the Medication is Unrelated to Terminal Illness (Optional)

SIGNATURE OF HOSPICE REPRESENTATIVE OR PRESCRIBER REQUIRED

Representative _____ Date _____

Prescriber _____ Date _____

If the prescriber of the non-covered medication is unaffiliated with the Hospice provider, has the prescriber confirmed with the Hospice provider that the medication is unrelated to the terminal illness and/or related conditions? YES ☐ NO ☐