

**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	MCS Classicare	Hospice	
PBM Name	Elixir Rx Solutions	Address	
Phone #	1.844.633.1064	Phone #	( ) -
Fax #	787.200.2858	Fax #	( ) -
Secure E-Mail	PharmacyMedicarePartD@medicalcardsystem.com	NPI	
Contact Name	Pharmacy	Contact	
Plan Sponsor Website Link: <a href="https://www.mcsclassicare.com/es/Paginas/Inicio.aspx">https://www.mcsclassicare.com/es/Paginas/Inicio.aspx</a>			

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

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

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