TUFTS Health Plan

Hospice Information for Medicare Part D Plans

SECTION 1– HOSPICE INFORMATION TO OVERRIDE A "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		Hospice name	
PBM name		Address	
Phone #	( ) -	Phone #	( ) -
Fax #	( ) -	Fax #	( ) -
Secure email		NPI	
Contact name		Contact name	
Plan sponsor website link:			

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

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
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	☐	☐		☐	☐
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Signature of Hospice Representative					
Representative _____ Date ___ /___ /____					
Signature of Beneficiary or Beneficiary Authorized Representative					
Beneficiary/Representative_____ Date ___ /___ /____					

MAILING INFORMATION

Tufts Health Plan
Attention: Pharmacy Utilization Management Department
1 Wellness Way
Canton, MA 02021-1166
Fax: 617.673.0956