



Complete this form & fax to:

Fax #: 1-518-641-3208

Phone #: 1-518-641-3784

SECTION I – HOSPICE INFORMATION TO OVERRIDE AN “HOSPICE A3 REJECT” OR TO UPDATE HOSPICE STATUS

A. Purpose of this form (Check all appropriate boxes)				
☐ Admission	☐ Proactive Rx	☐ A3 Reject Override	☐ Termination	
To: Medicare Part D Plan		From: Hospice Provider		
Plan Name	Capital District Physicians Health Plan	Hospice Name		
PBM Name	Capital Rx	Address		
Phone #	(518) 641-3784	Phone #	()	
Fax #	(518) 641-3208	Fax #	()	
Secure Email		NPI #		
Contact Name		Contact Name		
Plan Sponsor Website Link: https://www.cdphp.com				
B. Patient Information		Prescriber Information		
Patient Name		Prescriber Name:		
Patient DOB		Prescriber NPI		
Patient ID # (HICN)		Practice Name		
Hospice Admission Date		Practice Address		
Hospice Discharge Date		Contact Name		
Principal Diagnosis Code		Practice Phone Number	()	Ext:
Other Diagnosis Code (s)		Practice Fax #	()	
Unrelated Diagnosis Code (s)		Hospice Affiliated		
For Change In Hospice Status Update Documentation is Required (*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). Any Medication unrelated to Terminal Prognosis. *Drugs outside of these 4 classes do not require prior authorization)				
Medication Name	Dose	Dosing Schedule	Quantity/Month	Rationale to support the medications is unrelated to Terminal Prognosis
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	Dose	Hospice	Patient	Medication Name	Dose	Hospice	Patient
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Signature of Hospice Representative: _____ Date: ____/____/____							
Signature of Beneficiary or Authorized Representative: _____ Date: ____/____/____							