Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Hospice - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. According to Centers for Medicare & Medicaid Services (CMS) records, this patient is identified as being cared for by hospice. Is this information correct?

☐ Yes ☐ No

Q2. Is the drug being used for a hospice-related condition?
(Medications used for end-of-life conditions for a patient in hospice are paid as part of a per diem payment to the hospice provider under Medicare Part A.)

☐ Yes ☐ No

Q3. Is the prescriber the hospice physician?

☐ Yes ☐ No

Q4. Has the prescriber confirmed with the hospice physician that the medication is unrelated to the terminal illness or related conditions?

☐ Yes ☐ No

Q5. Will the following information be provided: reason drug being prescribed is unrelated to the hospice terminal diagnosis AND not waived through the hospice election and therefore is reimbursable under Medicare Part D?

☐ Yes ☐ No

Q6. Will the diagnosis for the requested drug be provided?

☐ Yes ☐ No

Q7. Additional Information:

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Patient Name:	**Prescriber Name:**

Q8. Requested Duration:

☐ 12 Months

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request