UPMC Health Plan

MEDICARE PART D HOSPICE
Prior Authorization Form
IF THIS IS AN URGENT REQUEST, Please call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:
UPMC HEALTH PLAN PHARMACY SERVICES PHONE: 800-979-UPMC (8762) FAX: 412-454-7722

PLEASE TYPE OR PRINT NEATLY
Incomplete responses may delay this request.

Office contact:	**Provider specialty:**
Provider first name:	**Provider last name:**
Provider phone #:	**Provider fax #:**

Patient name:	**Patient UPMC Health Plan member ID #:**	**Patient DOB:**	**Patient age:**

Drug requested: ☐ **Brand** ☐ **Generic**	**Strength:**	**Frequency:**	**Quantity dispensed (including units):**

Generic equivalent drugs will be substituted for brand name drugs unless you specifically indicate otherwise.

☐ **New medication** ☐ **Ongoing medication**	**If ongoing, please provide start date:**	**If ongoing, did the member show improvement while on therapy?**	☐ **Yes** ☐ **No**

Diagnosis:

Please indicate place of administration:	☐ Physician office ☐ Hospital/Clinic ☐ Patient home	**Will the medication be (select one):** ☐ Billed directly by the provider via JCODE JCODE: _____ ☐ Billed by a pharmacy and delivered to the provider ☐ Billed by a pharmacy and delivered to the patient
Please provide hospital/facility name and address:		

Please provide all of the following information:

Is the member currently enrolled in Hospice? ☐ **Yes** ☐ **No**
- If no, please provide date of disenrollment: _____
- If yes, please provide the hospice name and contact information:
  - Name: _____
  - Phone #: _____
  - Secure fax #: _____

Is the requested medication related to the terminal illness or related conditions and covered under the hospice benefit? ☐ **Yes** ☐ **No**
- If no, is the medication not covered by hospice because…
  - It is being used for a condition unrelated to the terminal illness or related conditions? ☐ **Yes** ☐ **No**
    - If so, please attach an explanation of why the condition being treated is unrelated to the terminal illness or related conditions and therefore not covered under the hospice benefit and may be covered under Medicare Part D.
  - It is being used for a condition related to the terminal illness or related conditions but the medication is not included on the hospice formulary, is not medically necessary, or is waived through the hospice election? ☐ **Yes** ☐ **No**
    - Note: Medicare Part D will not cover this medication.

Is the prescriber of the medication affiliated with the hospice provider? ☐ **Yes** ☐ **No**
- If no, has the hospice provider confirmed that the medication is unrelated to the terminal illness or related conditions? ☐ **Yes** ☐ **No**