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Medicare Part D Prescription Coverage Request Form - ***PART D COVERAGE REVIEW FOR HOSPICE UNRELATED DRUGS***
View our formulary online at blueshieldca.com/medformulary2024
Notice: We only accept coverage requests from the prescriber, the prescriber's office staff, the member, and the member's authorized representative. We do not accept requests from pharmacies or third party vendors unless a valid representative form has been submitted. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.
Important Note: Expedited Decisions *If the standard decision time of 72 hours or less may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, an expedited (fast) decision can be requested.* ☐ *CHECK THIS BOX IF A DECISION NEEDS TO BE GIVEN WITHIN 24 HOURS.*

Physician Information	**Patient Information**
Physician's Name: ☐ PCP; ☐ Specialist: _____ Office contact:_____ _____ Phone#: ( ) Facsimile #: ( ) Hospice Affiliated ☐ YES ☐ NO	Patient's Name: Patient's Address: Blue Shield ID#: Birthdate: Patient's height/weight: Drug Allergies:

PRINCIPAL DIAGNOSIS:	**ICD-10 CODE:**	**HOSPICE DIAGNOSIS:**	**ICD-10 CODE:**

Prior Authorization Process: Enter a separate line for each analgesic, antinauseant (antiemetic), laxative, and antianxiety (anxiolytic) medication that is Unrelated to Terminal Prognosis.		
Medication Name & Strength	Directions (dosing schedule)	Quantity per Month

FAX form to: 1 (888) 697-8122	**Pharmacy Services Phone #: 1 (800) 535-9481**

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1. If the prescriber of the non-covered medication is unaffiliated with the Hospice provider, has the Hospice provider confirmed that the medication is unrelated to the terminal illness or related conditions? ☐ YES ☐ NO

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Explanation for Part D Consideration of Hospice Non-covered/Unrelated Medications

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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Provider Signature:	Date:

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