PacificSource Medicare

Date:
To: [Hospice Provider/ Prescriber]

FAX TRANSMISSION

PRIOR AUTHORIZATION INFORMATION			
Member Name:			
Member DOB:	Member ID Number:		
Is the member currently enrolled in hospice? YES ☐ NO ☐ If "No," date of disenrollment:_____			
Hospice Name:	Contact Name:		
Phone Number:	Secure Fax Number:		
Provider/Prescriber Name:			
Address:	City:	State:	ZIP:
Phone Number:	Fax Number:		
Requested Medication:			
Is the requested medication related to the terminal illness or related conditions, and is it covered under the hospice benefit? YES ☐ NO ☐ If "No," is the medication not covered by hospice because: a. It is being used for a condition unrelated to the terminal illness or related conditions? (If so, please provide an explanation of why the condition being treated is unrelated to the terminal illness or related conditions and therefore is not covered under hospice benefit and may be covered under Medicare Part D.) Reason: b. 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? (Medicare Part D will not cover this medication.)			
If the prescriber of the 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 ☐			

If you have any questions regarding the above authorization, or additional information, please fax to (866) 805-5750 or call us directly at (888) 437-7728.

Thank You,

[Name]
Pharmacy Services
PacificSource Community Health Plans

PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract.