Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

MyGoldCare
PALLIATIVE CARE PROGRAM

PALLIATIVE CARE PREAUTHORIZATION REQUEST FORM

☐ URGENT (72 hours) ☐ Routine ☐ RETRO

FAX TO: 1-855-883-1552 PHONE: 1-888-301-1228 www.goldcoasthealthplan.org

TO PROCESS YOUR REQUEST, THIS FORM MUST BE COMPLETED AND LEGIBLE

PROVIDER: Authorization Does Not Guarantee Payment. Eligibility Must Be Verified At Time Services Are Rendered.

Patient Name: _____ _____ Date: _____
Last First

Mailing Address: _____ City: _____ Zip: _____

CIN Number: _____ ☐ Male ☐ Female Date of Birth: _____ Age: _____

Name of PCP: _____ Location: _____

ORDERING PROVIDER:

☐ In-Network ☐ Out-of-Network ☐ Out-of-Area

Provider Name:: _____

Specialty: _____

TIN: _____ NPI: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Office Contact: _____

PROVIDER RENDERING SERVICE (Physician, Facility, Vendor):

☐ In-Network ☐ Out-of-Network ☐ Out-of-Area

Provider Name:: _____

Specialty: _____

TIN: _____ NPI: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Office Contact: _____

REFERRING PROVIDER'S ORDER MUST BE SUBMITTED

Date(s) of Service: _____ Retro Date(s) of Service: _____

List ALL procedures requested along with appropriate CPT code

Diagnosis: _____ ICD-10: _____

CPT/HCPCS Code(s)	Requested Procedure(s)	Quantity	CPT/HCPCS Code(s)	Requested Procedure(s)	Quantity

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PALLIATIVE CARE ELIGIBILITY CRITERIA (Check all that apply)

Must meet ALL of Criteria A & ONE of Criteria B

A. General Eligibility Criteria *(Must meet ALL)*

☐ The beneficiary is likely to, or has started to, use the hospital or emergency department as a means to manage his/her advanced disease. This refers to unanticipated decompensation and does not include elective procedures.

☐ The beneficiary has an advanced illness, as defined in Section B, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.

☐ The beneficiary's death within a year would not be unexpected based on clinical status.

☐ The beneficiary has either received appropriate patient-desired medical therapy or is a beneficiary for whom patient-desired medical therapy is no longer effective. Patient is not in reversible acute decompensation.

☐ The beneficiary and, if applicable, the family/patient-designated support person, agrees to:

a. Attempt, as medically/clinically appropriate, in-home, residential-based or outpatient disease management/ palliative care instead of first going to the emergency room; AND

b. Participate in Advance Care Planning discussions.

B. Disease Specific Eligibility Criteria *(Must meet ONE)*

☐ Congestive Heart Failure (CHF): must meet (a) & (b)

a. The beneficiary is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; AND

b. The beneficiary has an Ejection Fraction of less than 30 percent for systolic failure or significant co-morbidities.

☐ Obstructive Pulmonary Disease (COPD): must meet (a) OR (b)

a. The beneficiary has a Forced Expiratory Volume (FEV) 1 less than 35 percent or predicted and a 24-hour oxygen requirement of less three liters per minute; OR

b. The beneficiary has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

☐ Advanced Cancer: must meet (a) & (b)

a. The beneficiary has a stage III or IV solid organ cancer, lymphoma, or leukemia; AND

b. The beneficiary has a Karnofsky Performance Scale (KPS) score less than or equal to 708 or has a failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

☐ Liver Disease: must meet (a) **&** (b) combined, **OR** (c)

a. The beneficiary has evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, AND

b. The beneficiary has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; OR

c. The beneficiary has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

PERTINENT HISTORY (SUBMIT RELEVANT MEDICAL RECORDS, TEST RESULTS, X-RAYS, ETC.)