

## Oral Enteral Nutrition Worksheet Expedited Prior Authorization (EPA) Request

<input type="checkbox"/> New Request <input type="checkbox"/> Extension Request (Prior Authorization Number or EPA Number)			
<b>CLIENT INFORMATION</b>			
CLIENT NAME			PROVIDER ONE CLIENT ID
CLIENT'S RESIDENCE <input type="checkbox"/> Adult Family Home <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Private Residence <input type="checkbox"/> Boarding Home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Other (Specify):			
Is client WIC (Women, Infants, and Children) program eligible? (Children less than 5 years) (Attach WIC statement of denial)			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>PROVIDER INFORMATION</b>			
VENDOR NAME			PROVIDER NPI
VENDOR TELEPHONE NUMBER			FAX NUMBER
<b>SERVICE REQUEST INFORMATION</b>			
NUTRITION PRODUCT REQUESTED	QUANTITY IN HCPCS UNITS PER DAY	LENGTH OF NEED	HCPCS CODE
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Provide all applicable diagnoses (ICD-9-CM Codes and description)	MEDICAL DIAGNOSIS		
	NUTRITIONAL DIAGNOSIS		
<b>CLIENT</b>			
0-36 months – Weight/length for age percentile on CDC growth chart _____			
3-17 years – Weight/height for age percentile on CDC growth chart _____ or BMI _____			
18 or older BMI _____			
<p><b>All oral enteral nutrition products or formulas require expedited or prior authorization. The client must meet the exact criteria in order to use an expedited prior authorization number. This form is required for use of EPA. The prescriber must have documentation in the client's record of reasons why trials of traditional foods did not meet the client's nutritional needs.</b></p>			
<p><b>Expedited Prior Authorization (EPA)</b></p>			
<input type="checkbox"/> The client meets the following criteria for EPA #870001103 for <b>Amino Acid, Fatty Acid, and Carbohydrate Metabolic Disorders</b> : <ul style="list-style-type: none"> <li>• Diagnosis is in the following range of ICD-9-CM codes: 270.0-270.8, 271.0-271.4, 271.8, 270.0-272.8; and</li> <li>• Requires a specialized nutrition product.</li> </ul>			

- The client meets the following criteria for EPA #870001100 for **Chronic Renal Failure:**
- Diagnosis is chronic renal failure ICD-9-CM code 585.6; and
  - Is currently on dialysis.
- The request is for **nutritional bars** CPT Procedure Code B9998 and the client meets the following criteria for EPA #870000868:
- Diagnosis is chronic renal failure ICD-9-CM code 585.6;
  - Is currently on dialysis; and
  - On a fluid restrictive diet.
- The client meets the following criteria for EPA #870001102 for **Decubitus Pressure Ulcers:**
- Diagnosis is decubitus ulcer code 707.00-707.09;
  - Has stage 3 or greater decubitus pressure ulcers; and
  - An albumin of 3.2 or below.
- The client meets the following criteria for EPA #870001101 for **Cancers:**
- Has cancer ICD-9-CM codes 140-208.91, 230-234.9; and
  - Currently receives chemotherapy and/or radiation therapy. Providers may also use this code to bill for the post therapy phase (up to 3 months following the completion of the chemotherapy or radiation therapy).
- The request is for **thickeners** Procedure Code B4100 and the client meets the following criteria for EPA #870001104:
- Has dysphagia ICD-9-CM codes 787.20-787.24, 787.29;
  - Requires thickeners to aid in swallowing or is currently transitioning from tube feedings to oral feeding; and
  - Has been evaluated by a speech therapist or an occupational therapist who specializes in dysphagia and the report is in the client's chart in the prescriber's office.
- NOTE: If the client is 20 or under and only requiring a thickener, an evaluation by a dietitian is not required.
- The client meets the following criteria for EPA #870001105 for **End Stage COPD or Emphysema:**
- Diagnosis of end stage COPD or emphysema, ICD-9-CM codes 491.20, 491.21, 492.8, or 496: and
  - A BMI of 18.5 or less or have an unintentional or unexplained weight loss of 5% in 1 month, or 7.5% in 3 months, or 10% in 6 months.

**Children 0 through age 4 (under age 5)**

The child meets the following criteria for EPA #870001106:

- Child is age 0-4 years (under age 5);
- Has a certified RD evaluation with recommendations (which support the prescriber's order) for oral enteral nutrition and products or formulas;
- Has a signed and dated written notification from WIC indicating one of the following:
  - Client is not eligible for the WIC program; or
  - Client is eligible for the WIC program but the need for product exceeded WIC's allowed amount; or
  - The requested oral enteral nutrition product or formula is not available through the WIC program. Specific and detailed documentation of the tried and failed efforts of similar WIC products, or the medical need for alternative products, must be in the prescriber's chart for the child; and
- Has one of the following criteria:
  - Low birth weight (less than 2500 grams); or
  - A decrease across 2 or more percentile lines on the CDC growth chart, once a stable growth pattern has been established; or
  - Failure to gain weight on 2 successive measurements, despite dietary interventions; or
  - Documented specific, clinical factors that place the child at risk for a compromised nutrition and/or health status.

**Children 5 through 20 years of age (under age 21)**

The client meets the following criteria for EPA #870001107:

- Age 5-20 years (under age 21);
- Has a certified RD evaluation for eligible clients, with recommendations (which support the prescriber's order) for medically necessary oral enteral nutrition products, and
- Has one of the following criteria:
  - A decrease across 2 or more percentile lines on the CDC growth chart, once a stable growth pattern has been established; or
  - Failure to gain weight on 2 successive measurements despite dietary interventions; or
  - Documented specific, clinical factors that place the client at risk for a compromised nutrition and/or health status.

Estimated length of time the oral enteral nutrition product is needed.

Less than 3 months     3-6 months     6-12 months

**REQUIRED PRESCRIBER CERTIFICATION STATEMENT**

*I certify that I am the prescriber identified on this form. I certify that the medical necessity information is true, accurate, and complete to the best of my knowledge.*

PRODUCT NAME

QUANTITY REQUESTED PER DAY

PRESCRIBER'S SIGNATURE (SIGNATURE AND DATE STAMPS ARE **NOT** ACCEPTABLE)

DATE

PRINTED NAME

**Complete and send to Medical Vendor or Pharmacy. A copy of this form must be kept in the client's record. The provider must retain copies of all documentation for six (6) years.**