

## Oral Enteral Nutrition Worksheet Prior Authorization Request

TO BE SUBMITTED BY MEDICAL VENDOR OR PHARMACY  
Fax: 1-866-668-1214

<input type="checkbox"/> New Request <input type="checkbox"/> Extension Request (Prior Authorization Number or EPA Number)			
<b>CLIENT INFORMATION</b>			
Client Name		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) <input type="checkbox"/> Yes <input type="checkbox"/> No (Attach WIC statement of denial)			
<b>PROVIDER INFORMATION</b>			
Vendor Name		Vendor 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 _____			
<b>All oral enteral nutrition products or formulas require expedited or prior authorization. Request for prior authorization must be accompanied by clinical documentation that supports appropriate medical use of the product.</b>			
Please explain the nutritional history as it relates to the client's medical diagnosis and why this client is at-risk for developing malnutrition. Include results of laboratory tests already done.			

What is the client's weight loss history (or growth history for children)?

Has the client already been on an oral enteral nutrition product?  Yes  No

Length of time

Please explain why calorically enhanced traditional foods (or foods that can be blenderized if there is a chewing or swallowing problem) cannot meet their nutritional needs. A letter from the client's family or caregiver to help explain why the client needs the oral enteral nutrition supplement may be attached to this request but is not required.

For extension requests, please provide all of the following information:

1. Current weight and BMI \_\_\_\_\_
2. Weight and BMI when the product was started \_\_\_\_\_
3. Has the client's condition changed?  Yes  No  
If yes, please explain:

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

Provider NPI

**Please provide all necessary information along with supporting documentation to expedite this request.**

**Without this information, the request may be delayed or denied. A copy of this form must be kept in the client's chart. The provider must retain copies of all documentation for six years. Complete and send to Medical Vendor or Pharmacy.**