

Pharmacy Prior Authorization Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

 This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Enteral/Parenteral Formulas Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Priority Health precertification requirements:

Parenteral Nutritional Therapy

- Patient has severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the patient's general condition.

Enteral Nutritional Therapy

- Patient has a functioning gastrointestinal tract who, due to pathology to, or nonfunction of, the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength commensurate with his or her general condition.

Criteria:

- Nutritional malabsorption associated with specific disease.
Diagnosis: _____
- Patient able to take regular solid food Yes No
- Extreme weight loss:
Amount of weight lost: _____
Dates: _____
- Patient unresponsive to other weight gaining measures:
List other measures attempted: _____
- Mechanical or physiological symptoms precluding normal diet.
Symptoms: _____
- Chronic disease restricting normal dietary intake.
Patient diagnosis: _____
- Temporary medical complication requiring interval of dietary supplementation.
Patient diagnosis: _____

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX