

Prior Authorization Form

NOTE: Refer to the Provider Manual for additional services requiring **Prior Authorization**



Fax Form To: Grand Rapids – 616 942-0024 Holland – 616 392-7626 ASO – 616 395-4090 Traverse City – 231 932-9505 Farmington Hills – 888 647-6152

Enteral Nutrition Therapy

Member

Last Name: _____ First Name: _____

Contract #: _____ DOB: _____ Sex: _____

Plan/Product Type: EPO HMO POS SF-POS PPO Medicaid

Medicare is prior authorized through Pharmacy

Primary Care Physician: _____ PCP Phone: _____ PCP Fax: _____

Requested By:

(Durable Medical Equipment)

DME Provider Name: _____ Phone: _____ Fax: _____

Address: _____ Contact Name: _____

Provider Name: _____ Phone: _____ Fax: _____

Address: _____ Contact Name: _____

Diagnosis: _____

Solution/Formula: _____ Code: _____ Start Date: _____ Duration: _____

CHECK ONE

- Per diem – provide appropriate documentation as outlined in contract agreement.
- Dispensing Fee

ENTERAL NUTRITION THERAPY IS A COVERED BENEFIT WHEN ALL OF THE FOLLOWING APPLY

(Please mark appropriate boxes)

- The patient has a functioning gastrointestinal tract and, due to pathology or dysfunction of the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength commensurate with the patient's general condition; **and**
- The solution being administered is the primary source of nutrition; **and**
- The route of administration is through a tube (e.g. nasogastric, gastrostomy, jejunostomy).

NOTE: Enteral nutrition therapy by mouth (po, orally) is not a covered benefit, unless member is a **Medicaid** member and meets **Medicaid** criteria below.

MEDICAID CRITERIA

Enteral nutritional therapy by mouth may be covered for **Medicaid** members when the following applies.

(Please mark appropriate boxes)

For members under the age of 21 when (must meet **one** of the following criteria):

- A chronic medical condition exists that prohibits eating or absorbing of food, resulting in nutritional deficiencies and a three-month trial is required to prevent gastric tube placement.
- A chronic medical condition exists that the member's weight to height ratio has fallen below the fifth percentile on the standard growth grids and supplementation to regular diet or meal replacement is required. **Weight to Height Ratio** _____
- Physician documentation details low percentage increase in growth pattern or trend directly related to the nutritional intake and associated diagnosis/medical condition.

For members over the age of 21 when (must meet **all** of the following criteria):

- The member must have a medical condition that requires the unique composition of the formulae nutrients that the member is unable to obtain from food.
- The nutritional composition of the formulae represents an integral part of treatment of the specified diagnosis/medical condition.
- The member has experienced significant weight loss of 10% or greater of their body weight. **Current Height:** _____ **Weight:** _____

*****ALL FIELDS MUST BE COMPLETE AND LEGIBLE FOR PRIOR AUTHORIZATION REVIEW*****

For Pharmacy Use Only

Date Entered: _____

Status: _____

Reviewed By: _____

Last Revision: December 2009