

# 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: \_\_\_\_\_

**Note:** If none of the above is applicable to this member, please check which, if any, of the following apply:

- All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
- The number of doses available under a dose restriction for the prescription drug:
  - Has been ineffective in the treatment of the enrollee's disease or medical condition or,
  - Based on both sound clinical evidence and medical and scientific evidence, the known

relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance

- The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
  - Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
  - Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
- None of the above apply

\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*  
**Please fax this request to: (877)974-4411 toll free or (616)942-8206**  
**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**