

Prior Authorization Form

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



Fax Form To: 616 942-0024

Enteral Nutrition Therapy (Medicare is authorized through Pharmacy)

Member

Last Name: _____ First Name: _____
Contract #: _____ DOB: _____ Sex: _____
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.

NOTE: Must be ordered by a Gastroenterologist and/or Developmental Pediatrician for members under the age of 21.

(Please mark appropriate boxes)

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

- A chronic medical condition exists that prohibits eating or absorbing of food, resulting in nutritional deficiencies and written documentation from the ordering specialist that 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** _____
- Specialist documentation details low percentage increase in growth pattern or trend directly related to the nutritional intake and associated diagnosis/medical condition.

For members age 21 and over (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