



HRSA Health & Recovery
Services Administration

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)			
CLIENT INFORMATION			
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)
PROVIDER INFORMATION			
VENDOR NAME			VENDOR NPI
VENDOR TELEPHONE NUMBER			FAX NUMBER
SERVICE REQUEST INFORMATION			
NUTRITION PRODUCT REQUESTED	QUANTITY IN HCPCS UNITS PER DAY	LENGTH OF NEED	HCPCS CODE
NUTRITION PRODUCT REQUESTED	QUANTITY IN HCPCS UNITS PER DAY	LENGTH OF NEED	HCPCS CODE
Provide all applicable diagnoses (ICD-9-CM Codes and description)	MEDICAL DIAGNOSIS		
	NUTRITIONAL DIAGNOSIS		
CLIENT			
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 _____			
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.			
Please explain the nutritional history as it relates to their 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Length of time
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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.