

~NUTRITIONALS ~
ORAL NUTRITION TAKEN BY MOUTH
 Prior Authorization Request Form

Effective February 2002, Vermont Medicaid established coverage limits and criteria for prior authorization of Nutritional supplements. These limits and criteria are based on concerns about appropriate use and medical necessity. In order for beneficiaries to receive coverage for nutritionals, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name: _____

Phone #: _____

Fax #: _____

Address: _____

Beneficiary:

Name: _____

Medicaid ID #: _____

Date of Birth: _____ Sex: _____

Contact Person at Office: _____

Diagnosis: _____

Baseline: Date: ___/___/___ Height: _____ Weight: _____ BMI: _____

Current: Date: ___/___/___ Height: _____ Weight: _____ BMI: _____

Children: Mid-Upper Arm Circumference: _____ Head Circumference: _____

Laboratory Values: Date: ___/___/___ Albumin: _____ Pre-Albumin: _____

Answer the following questions:

Caloric/protein intake is <u>not</u> obtainable through regular liquefied or pureed foods.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree						
Requested nutritional supplement will be taken by <u>mouth</u> (not administered via tube feeding)	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Oral nutritional supplement is being requested due to:	<input type="checkbox"/> Unplanned weight loss (see complete definition by age in clinical criteria manual) <input type="checkbox"/> Low serum protein levels (nutritional deficiency as defined by albumin or pre-albumin levels)						
Underlying cause of unplanned weight loss or low serum protein levels: Circle or describe specifics: <ul style="list-style-type: none"> ▪ Increased metabolic need resulting from severe trauma (i.e.: burns, infection, major bone fractures) ▪ Malabsorption syndrome (as related to cystic fibrosis, renal disease, short gut syndrome, Crohn's disease and other unspecified disorders of the gut) ▪ Nutritional wasting due to chronic disease (i.e.: cancer, AIDS, conditions resulting in dysphagia, pulmonary insufficiency, renal disease) ***** CONTINUED ON NEXT PAGE *****	<table border="0" style="width: 100%;"> <tr> <td align="center" colspan="2"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td align="center" colspan="2"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td align="center" colspan="2"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No							
<input type="checkbox"/> Yes <input type="checkbox"/> No							
<input type="checkbox"/> Yes <input type="checkbox"/> No							

<p>▪ Other: Explain:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Additional clinical information to support PA request:</p> 	

<p>Requested Supplement: _____</p>
<p>Strength & Frequency: _____</p>
<p>Anticipated duration of supplementation: _____</p>

Prescriber Signature: _____ **Date of this request:** _____