



Department of Vermont Health Access
 NOB 1 South, 280 State Drive
 Waterbury, Vermont 05671-1010

Nutritionals 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 complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:

Name: _____
 Physician NPI: _____
 Specialty: _____
 Phone#: _____
 Fax#: _____
 Address: _____
 Contact Person at Office: _____

Beneficiary:

Name: _____
 Medicaid ID#: _____
 Date of Birth: _____ Sex: _____
 Pharmacy Name: _____
 Pharmacy NPI: _____
 Pharmacy Phone: _____ Pharmacy Fax: _____

Nutritional supplement will be administered via Tube Feeding? <input type="checkbox"/> Yes <input type="checkbox"/> No (Proceed to diagnosis question)
<u>Patient Diagnosis/Condition:</u> <input type="checkbox"/> AIDS <input type="checkbox"/> Chronic Diarrhea <input type="checkbox"/> Dementia(includes Alzheimer's) <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Developmental Delays <input type="checkbox"/> Parkinson's <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Difficulty with chewing/swallowing food <input type="checkbox"/> Short Gut <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Request is for weight loss/low weight or serum protein (complete appropriate section below) <input type="checkbox"/> Other: _____
<u>Unplanned Weight Loss/Extremely Low Weight:</u> Baseline: Date ____/____/____ Height: _____ Weight: _____ BMI: _____ Current: Date ____/____/____ Height: _____ Weight: _____ BMI: _____ Children: Mid-Upper Arm Circumference: _____ Head Circumference: _____
Laboratory Values: Date ____/____/____ Albumin: _____ Pre-Albumin: _____
Additional clinical information to support PA request:
Requested Supplement: _____ Strength & Frequency: _____ Anticipated duration of supplementations: _____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

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

