VERMONT

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

Nutritionals

Prior Authorization Request Form

In order for members 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 GHS Helpdesk at 1-844-679-5363.

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

Prescribing physician:

Name: _____
Physician NPI: _____
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? ☐ Yes ☐ No **(Proceed to diagnosis question)**

Patient Diagnosis/Condition:

☐ AIDS ☐ Cancer ☐ Cerebral Palsy ☐ Cystic Fibrosis
☐ Severe Dementia (resulting in a loss of motor skills) ☐ Neuromuscular Disease ☐ Short Gut
☐ Request is for weight loss/low weight or serum protein (complete appropriate section below)
☐ Other: _____

Unplanned Weight Loss/Extremely Low Weight:

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

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

Children: Age and sex corrected weight-for-age percentile:_____
Weight-to-length percentile: _____
Has there been a sustained decrease in growth velocity demonstrated by weight-for-age or weight-for-length fall by two major percentiles (percentile markers 95, 90, 75, 50, 25, 10, and 5) over time (defined by the WHO for children less than 2 years of age and the CDC for children greater than 2 years of age) ☐ Yes ☐ No

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:** _____

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