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

Agency of Human Services

# 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 Change Healthcare Provider Helpdesk at 1-844-679-5363.

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

Prescribing physician:

**Name:** _____
**Phone#:**_____
**Fax#:** _____
**Address:** _____
**Contact Person at Office:** _____

Beneficiary:

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

Nutritional supplement will be administered via Tube Feeding? ☐ Yes ☐ No (**Proceed to diagnosis question**)

Patient Diagnosis/Condition:

☐AIDS ☐ Chronic Diarrhea ☐Dementia(includes Alzheimer's) ☐ Inflammatory Bowel Disease ☐ Cancer

☐ Cognitive Impairment ☐ Developmental Delays ☐ Parkinson's ☐ Celiac Disease ☐ Cystic Fibrosis

☐Difficulty with chewing/swallowing food ☐Short Gut ☐ Cerebral Palsy ☐ Request is for weight loss/low weight or serum protein **(complete appropriate section below)** ☐ Inborn error of metabolism (please specify): _____

☐Other: _____

Unplanned Weight Loss/Extremely Low Weight:

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:**_____



CHANGE HEALTHCARE