

Medi-Cal Rx Enteral Nutrition Prior Authorization Request

Instructions: Fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review to support the prior authorization (PA), such as chart notes or lab data.

Information contained in this form is Protected Health Information (PHI) under HIPAA.

Member Information

Last Name: _____ First Name: _____

Date of Birth: _____ Phone Number: _____

Beneficiary ID Number: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Male Female Height (in/cm): _____ Weight (lb/kg): _____

Allergies: _____

Prescriber Information

Last Name: _____ First Name: _____

Prescriber: Physician Nurse Practitioner Physician Assistant

Other: _____

Prescriber Specialty: _____

Prescriber NPI Number: _____

Prescriber Phone Number: _____ Prescriber Fax Number: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Requestor Information *(if different than Prescriber)*

Requestor (Business Name or First/Last): _____

Requestor NPI Number: _____

Requestor Phone Number: _____ Requestor Fax Number: _____

Member Last Name: _____ Member First Name: _____

Formulation/Medical and Dispensing Information

Product Name: _____

Product 11-Digit NDC: _____

Dose/Strength: _____ Frequency: _____

Length of Therapy/Number of Refills: _____ Quantity: _____

New Therapy

Renewal

If Renewal:

Date Therapy Initiated _____ Duration of Therapy (specific dates): _____

How did the patient receive the formula?

Paid Under Insurance Name: _____

PA Number (if known): _____

Other: _____

Administration Location:

Patient’s Home

Long Term Care

Physician’s Office

Home Care Agency

Outpatient Hospital Care

Ambulatory Infusion Center

Other: _____

1. Enteral Nutrition Product Use History

Has the patient tried any other enteral nutrition products for this condition? Yes No

If yes, complete the following fields:

Enteral Nutrition Product 1:

Product Name and Dosage:

Duration of Therapy (specific dates): _____

Response/Reason for Failure/Allergy:

Member Last Name: _____ Member First Name: _____

Enteral Nutrition Product 2:

Product Name and Dosage:

Duration of Therapy (specific dates): _____

Response/Reason for Failure/Allergy:

Enteral Nutrition Product 3:

Product Name and Dosage:

Duration of Therapy (specific dates): _____

Response/Reason for Failure/Allergy:

2. Diagnosis and ICD-10

List the diagnoses and the associated ICD-10:

Diagnosis:

ICD-10:

3. Required Clinical Information

Provide any additional clinical information or medical documentation supporting the patient’s need for the requested enteral nutrition product to support a PA, including if the patient has a medical condition that causes severe difficulty with swallowing or chewing for orally fed patients. Detailed information regarding PA requirements can be found in the *Enteral Nutrition Products* section in the *Medi-Cal Rx Provider Manual*.

Member Last Name: _____ Member First Name: _____

Will the patient need multiple flavors of this product? Yes No

Administration:

Tube-fed

Patient’s Daily Caloric Requirements (kcal/day) of requested enteral nutrition product:

- If kcal/day is > 800 for infant products; **OR**
- If kcal/day is > 2,000 for all other products

Provide clinical rationale for why additional calories are needed:

Oral

Patient’s Daily Caloric Requirements (kcal/day) of requested enteral nutrition product:

- If kcal/day is > 800 for infant products; **OR**
- If kcal/day is > 1,200 for patients 22 years of age and older; **OR**
- If kcal/day is > 1,000 for patients 21 years of age and younger

Provide clinical rationale for why additional calories are needed:

Attestation

I attest the information provided is true and accurate to the best of my knowledge. I understand that Medi-Cal Rx or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Provider Signature: _____ Date: _____

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Fax this form to: 1-800-869-4325

Mail requests to:

Medi-Cal Rx Customer Service Center
ATTN: PA Request
P.O. Box 730
Rancho Cordova, CA 95741-0730
Phone: 1-800-977-2273