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 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 Asst. ☐ 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:

☐ 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 # (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:

Drug Name and Dosage: ______________________________

Duration of Therapy (specific dates): ______________________________

Response/Reason for Failure/Allergy: ______________________________

____

____

Enteral Nutrition Product #2:

Drug Name and Dosage: ______________________________

Duration of Therapy (specific dates): ______________________________

Response/Reason for Failure/Allergy: ______________________________

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____

Enteral Nutrition Product #3:

Drug Name and Dosage: ______________________________

Duration of Therapy (specific dates): ______________________________

Response/Reason for Failure/Allergy: ______________________________

____

____

Member Last Name: ____________________ First Name: ____________________

2. Diagnosis and ICD-10

List Diagnoses: ______________________________

____

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 of the *Medi-Cal Rx Provider Manual*.

Clinical Justification: ______________________________

____

____

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 > 2,000, clinical justification for larger caloric need: ____________________

____

____

____

____

☐ Oral

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

____

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