Enteral Nutrition/Formula

Prior Authorization Form

Please Fax To (952) 853-8714 For Questions Call (888) 467-0774

Member Name:	Vendor:
Member ID #:	Address:
DOB:	Tax ID #:
Form completed by:	Phone #:
Date completed:	Fax #:

Please print the following information:

Ordering Practitioner (MD, PA, NP):_____ Specialty:_____

Provider Clinic: _____ Phone:_____ Fax:_____

Diagnosis:_____ ICD-9 or 10:_____

Member Height_____ Weight_____ Desired Weight_____

Date of last examination:_____

1. Does the member have a feeding tube? † Yes _____ † No ____

2. Does the member have a condition involving the gastrointestinal tract that prevents adequate ingestion of food?
If yes, please describe: _____
_____

3. What is the prescribed route of administration? (Check one)
† Feeding Tube _____ † Oral _____

4. Product (formula) name? _____

5. Calories per day: via tube? _____
orally from formula? _____
other sources? _____

6. Member's current place of residence: Home____ SNF/TCU_____ Assisted Living _____ Other_____

7. If this request is for amino acid based elemental formula, check any of the following that apply:
□ IgE mediated allergies to food proteins □ †Food protein induced enterocolitis syndrome
□ Eosinophilic esophagitis □ Eosinophilic gastroenteritis
□ Eosinophilic colitis □ Cystic Fibrosis
□ Amino acid, organic acid, and fatty acid metabolic and malabsorption disorders

8. Additional information:
_____
_____

Treating Practitioner Signature and date: _____