Please complete BOTH the Outpatient Prior Authorization Request form and the Nutritional Supplement form and fax to 1-800-953-8856.

maryland physicians care
Medicaid with a Heart

PRESCRIBER STATEMENT OF MEDICAL NECESSITY
NUTRITIONAL SUPPLEMENT PRE-AUTHORIZATION FORM

Incomplete forms may result in delay of decision or denial of services.

1. Patient's Name: _____ Phone: _____
Patient's Address: _____
Patient's Medicaid ID#: _____ DOB: _____
Patient Location: ☐ Resident ☐ Nursing Home ☐ Hospital Date of Last Doctor's Visit: _____
Body Weight: _____ kg or _____ lbs Height: _____ ft _____ in Date Measured: _____

2. **Justification for nutritional supplement need**

a) Diagnosis _____ Date of onset _____
b) Does recipient have an inborn error of metabolism? ☐ Yes ☐ No
c) Is the patient **currently tube-fed**? ☐ Yes ☐ No
If partially tube-fed, only amount that is actually tube-fed will be approved. Please check the % of tube-feeding:
☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ < 25%
Anticipated duration of tube feeding: ☐ (# of days) ☐ (# of months) ☐ Indefinitely
Place G-tube inserted: _____ Date G-tube inserted: _____
d) Calories prescribed initially verified by _____ Ph: _____ Fax: _____
The cost saving powder or concentrate form must be used. List valid reasons why these forms are not used:
_____

3. **RX Nutritional Supplement Order. Must prescribe in calories to be converted to billable units (gm/ml/pkt, etc.)**

Product & Dosage Form: _____ Package Size: _____ #cans/case: _____
Dose & Dosage Frequency: _____
Must specify the following:

a. Total calories required per day: _____ % daily requirement: _____ %
b. Total calories derived from nutritional supplements: _____ % daily requirement: _____ %
c. Total calories derived from nutritional supplements: _____ % daily requirement: _____ %
d. # calories per each unit dispensed: _____ calories per _____ *(specify unit below)*
☐ gram ☐ ml (concentrate) ☐ ml (ready-to-use) ☐ packet ☐ Other _____
Specify: _____ gram/per can (ie., 423g-480g) or _____ ml/per can; or _____ gram/packet
e. # of units per day (e=c:d) _____ x 30 days = _____ (Total quanity billed on-line/month)
f. _____ cans/day Specify: _____ ml/can # _____ gm/day _____ #packet/day
g. Calories prescribed: _____ cal/Kg/day Body Weight: _____ kg Date Measured: _____

4. Prescriber's Signature: _____ NPI # _____
Prescriber's Name: _____ Degree: _____
Address: _____
Phone: _____ Fax: _____ Date: _____

5. Name of Pharmacy or Supplier verifying calorie conversion into proper units billed: _____
Address: _____ Ph. _____ Fax _____ Date: _____