Please complete this form and fax along with Prior-Authorization form to 1-800-953-8856.

PRESECRIBER STATEMENT OF MEDICAL NECESSITY
NUTRITIONAL SUPPLMENT PRE-AUTHORIZATION FORM
Incomplete forms may result in delay of decision or denial of service.

1. Patient Name:

   Patient Medicaid ID#: DOB:

   Patient Location: Home Nursing Home Hospital Date of last Doctor's Visit:

   Body Weight: kg *or* lbs Height: ft in Date Measured:

2. <u>Justification for nutritional supplement need</u>

   a) Diagnosis: Date of onset:

   b) Does patient have an inborn error of metabolism? Yes No

   c) Is the patient <u>currently tube-fed</u>? Yes No

      If partially tube-fed, what %: 100% 75% 50% 25% < 25%

      Anticipated duration of tube-feeding: # of days # of months Indefinitely

      Type and Place tube inserted: Date tube inserted:

3. RX Nutritional Supplement Order:

Product Name:
a. Total calories required per day: # of calories per each unit:
b. # of units per day x 30 days = (Total monthly billed units)

4. Prescribers Signature (not required if order attached to request):

   Prescribers Name: NPI:

   Address:

   Phone: Fax: Date Order Written:

5. Name of Pharmacy or Supplier: NPI:

   Address:

   Phone: Fax: