

**PRESCRIBER STATEMENT OF MEDICAL NECESSITY
 NUTRITIONAL SUPPLEMENT PRE-AUTHORIZATION FORM**

Incomplete forms will be returned for reprocessing

1. Patient's Name: _____ Phone: _____
 Patient's Address: _____
 Patient's Medicaid ID #: _____ DOB: _____
 Patient Location: Residence Nursing Home Hospital Date Last Doctor's Visit: _____
 Body Weight: _____ kg or _____ lb 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 patient **currently tube-fed**? Yes No
 If partially tube-fed, only amount that is actually tube-fed will be approved. Please check % of tube-feeding:
 100% 75% 50% 25% <25%
 Anticipated duration of tube feeding _____ (# days) _____ (# months) _____ indefinitely
 Place G-tube inserted: _____ Date G-tube inserted _____
 d) For REM recipients not tube-fed and without a metabolic disorder, the following documentation must be submitted to the Program for a determination of medical necessity for the nutritional supplement:
 a comprehensive metabolic panel including prealbumin and serum magnesium & phosphorus levels
 a BMI-for-age chart besides the standard or clinical growth chart. All plotted values on the chart must be legible
 a recent medical history documenting nutritional status and any weight loss over the prior 6 months with height/weight measurements and corresponding dates.
 e) 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 regular diet (if patient can eat): _____ % daily requirement: _____ %
 c. Total calories derived from nutritional supplements: _____ % daily requirement: _____ %
 a minus b must equal c. Explain reason for exceeding the average caloric 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. # units per day (e =c:d) _____ x 30 days= _____ (Total quantity 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 verifying calorie conversion into proper units billed _____
 Pharmacy Address _____ Ph. _____ Fax _____ Date _____

FOR INTERNAL USE ONLY

APPROVED (enter dates) from: _____ to _____

REJECTED Date: _____ Initials: _____