Prior Authorization for Home Enteral Nutritional Support

For authorization, complete this form, include patient chart notes to document information, and FAX to the PEHP Pharmacy Department at (801) 245-7774 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Pharmacy Department at (801) 366-7551 or toll free at (888) 366-7551.

Section I: PATIENT INFORMATION

Name:	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

Date Requested:	Ordering Physician:
Home Health Agency:	Home Health Agency Address:
Home Health Agency Provider NPI#:	Home Health Agency Tax ID#:

Contact Person:	Phone:	Facsimile:

Section III: PRE-AUTHORIZATION REQUEST

Requested Authorization Period:	**Primary Diagnosis/ICD-10 Code:**	**Secondary Diagnosis/ICD-10 Code:**

Enteral Mode of Administration: ☐ Oral ☐ Gastrostomy (PEG) ☐ Jejunostomy ☐ Nasoduodenal ☐ Nasogastric (NG) ☐ Nasojejunal (NJ)

% of Daily Caloric Intake of Enteral:	**Enteral Calories per Day:**	**Enteral Feeding Schedule:** ☐ Bolus ☐ Continuous ☐ Nocturnal ☐ Other	**Administration rate:** **ML/HR**
Enteral Formula:	**Enteral Formula NDC #:**	**Anticipated length of time enteral support will be needed:**	

Service (s) Requested: *list all requested services (CPT or HCPCS) codes regardless of pre-auth requirement*

Procedure/Service:_____ CPT/HCPCS code: _____

Procedure/Service:_____ CPT/HCPCS code: _____

Procedure/Service:_____ CPT/HCPCS code:_____

QUESTION	YES	NO	COMMENTS/NOTES
1. Is enteral nutrition needed to sustain life or health?	☐	☐	
2. Is enteral nutrition being used in the treatment of, or in association with, a demonstrable disease, condition, or disorder?	☐	☐	
3. Is enteral nutrition the sole source of nutrition, or a significant percentage of the daily caloric intake?	☐	☐	
4. Is enteral formula being given orally for treatment of inborn errors of metabolism, or an inherited metabolic disease?	☐	☐	
5. Does the patient have any of the following conditions that is expected to be permanent or of indefinite duration? *Check all that apply* ☐ An anatomical or motility disorder of the GI tract that prevents food from reaching the small bowel ☐ Disease of the small bowel that impairs absorption of an oral diet ☐ A central nervous system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition	☐	☐	
6. Will gravity feedings or syringe feedings be used?	☐	☐	
7. If 'No' to #6, advise the reason below:			

Additional Comments:

Fax completed form and medical records to 801-245-7774.