PEHP Health & Benefits

PRIOR AUTHORIZATION for HOME ENTERAL NUTRITIONAL SUPPORT

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Name (Last, First MI):	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

Nature of Request: *Please check.*

☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth ☐ Urgent

Requested Authorization Period:

Primary Diagnosis/ICD-10 Code:

Secondary Diagnosis/ICD-10 Code:

Enteral Formula Mode of Administration: *Please check all that apply.*

☐ Oral ☐ Gastrostomy Tube (PEG) ☐ Jejunostomy Tube ☐ Nasoduodenal Tube ☐ Nasogastric Tube (NG) ☐ Nasojejunal Tube (NJ)

How long will enteral support be needed?	Enteral % of Daily Caloric Intake:	Enteral Feeding Schedule: *Please check all that apply.*
		☐ Bolus ☐ Continuous ☐ Nocturnal ☐ Other_____

Enteral Formula:

Enteral Formula: _____ NDC #: _____ Calories/Day: _____ Prescription: ☐ Refill ☐ New

Enteral Formula: _____ NDC #: _____ Calories/Day: _____ Prescription: ☐ Refill ☐ New

Enteral Formula: _____ NDC #: _____ Calories/Day: _____ Prescription: ☐ Refill ☐ New

Other Service (s) Requested: *Please 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? *Please 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.	☐	☐	

Additional Comments:

Please fax completed form and medical records to 801-366-7449.