PRIOR AUTHORIZATION for NUTRITIONAL SUPPORT

For authorization, please 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 (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

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

Enteral Tube/Route of Administration: *Please check all that apply.*

☐ Gastrostomy (PEG) ☐ Jejunostomy ☐ Nasoduodenal ☐ Nasoenteric ☐ Nasogastric (NG) ☐ Nasojejunal (NJ) ☐ Oroenteric ☐ Orogastric (OGT)

Enteral Feeding Frequency: *Please check all that apply.*	**Method of Administration:** *Please check all that apply.*	**Administration Rate:**
☐ Bolus ☐ Continuous ☐ Nocturnal ☐ Other_____	☐ Gravity ☐ Oral ☐ Pump ☐ Syringe	_____ mL/hr

How long will enteral support be needed?	**Enteral % of Daily Caloric Intake:**	**Total Calories/Day:**	**Total Enteral Calories/Day:**

Enteral Formula:

Enteral Formula: _____ NDC #: _____ Prescription: ☐ Refill ☐ New

Enteral Formula: _____ NDC #: _____ Prescription: ☐ Refill ☐ New

Enteral Formula: _____ NDC #: _____ 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.	☐	☐	
6. Will gravity feedings or syringe feedings be used?	☐	☐	
7. If "No" to #6, advise the reason below:			

Additional Comments:

Please fax completed form and medical records to 801-245-7774.