Enteral Nutrition Products (Special Formula)
Tufts Health RITogether

Fax form to: 857.304.6404

You must submit this form with your request for prior authorization. The form must be completed by the prescriber and have a copy of the prescription attached. Prior authorization requests with incomplete medical necessity documentation may be returned or denied.

Today's date: _____/_____/_____

FAX INSTRUCTIONS

Tufts Health Plan
Attn: Medical Management Intake Services
705 Mount Auburn Street
Watertown, MA 02471
Fax: 857.304.6404

MEMBER INFORMATION

1. Name:_____ 2. Member ID#: _____

3. DOB: _____/_____/_____ Age: ____ If applicable, # of weeks gestation for premature infant: ____

4. Member/Family's primary language: _____

5. Address: _____

6. Member's current location:

☐ Home ☐ Hospital Phone number of location: _____

☐ NICU ☐ Other _____

7. Primary Diagnosis name and ICD-10 code: _____

8. Secondary Diagnosis name and ICD-10 code: _____

9. Anthropometric measures (complete all items):

☐ Height: _____

☐ Weight: _____

10. Laboratory tests (attach results):

☐ Type of blood tests, specify: _____

☐ Type of urine tests, specify: _____

☐ Allergy testing, specify: _____

11. Risk factors: (use attachments as needed)

☐ Anatomic structure of gastrointestinal tract

☐ Neurological disorder (specify): _____

☐ Inborn errors of metabolism (specify): _____

12. Route of treatment:

☐ Anatomic structure of gastrointestinal tract

☐ Neurological disorder (specify): _____

☐ Inborn errors of metabolism (specify): _____

13. Treatment regimen initiated (attach explanation)

☐ Past

☐ Current (last 6 months)

☐ None

Note: Specific dates of duration of usage and signs and symptoms of complications of any past used formulas

14. Expected outcome of treatment (attach explanation):

☐ Expected to improve within 3 months

☐ Expected to improve within 6 months

☐ Expected to improve within 12 months

☐ Not expected to improve

15. Location where member will use items:

☐ Home ☐ Work ☐ Hospital ☐ Other: _____

16. Expedited service authorization request (Must attach detailed explanation)

☐ Could seriously jeopardize the member's life or health

☐ Ability to maintain, attain or regain maximum function

☐ Other, specify: _____

Note: MCO Plan to provide notice to provider no later than 3 business days after request

17. Duration of need:

Number of months: _____ Start date: ___/___/____ End date: ___/___/____ 18. # of refills: _____

19. Enteral formula and supplies (include HCPCS)

☐ _____ ☐ _____

☐ _____ ☐ _____

20. Volume/fluid oz. and Calories per day (list all)

☐ Volume/fluid oz. per day: _____

☐ Calories per day: _____

☐ Calories per fluid oz.: _____

21. Quantity per month (total units requested per HCPCS code): _____

22. Type of formula requested:

☐ Powder

☐ Ready-to-use

☐ Concentrate

23. DME provider name: _____ NPI provider ID #: _____(if available)

DME provider address: _____

Phone #: _____ (if available) Fax #: _____ (if available)

24. Prescriber name: _____ NPI provider ID #: _____

Prescriber address: _____ Prescriber phone #: _____

25. Name of person completing form on behalf of provider: _____

Title: _____

Phone #:_____ Fax #: _____

Organization: _____

ATTESTATION

I certify that the clinical information provided on this form is accurate and complete to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may be subject to civil or criminal liability.

_____ ___/___/____

Prescriber attestation signature **Date**

INSTRUCTIONS KEY

Item 1	Member's name	Enter the member's name as it appears on the MCO Plan card.
Item 2	Member's MCO ID no.	Enter the member's MCO Plan identification number, which appears beside the member's name on the MCO card.
Item 3	Member's DOB/Age	Enter the member's date of birth in month/day/year order and age. Also include weeks of gestation for preemies if applicable.
Item 4	Member/family's primary language	Enter the member/family's primary language. (If other than English, this will flag the possible need for translator and/or interpreter services).
Item 5	Member's address	Enter the member's permanent legal address (street address, town, and zip code), including telephone where can be reached.
Item 6	Member's current location	Place a checkmark beside the member's current location (include telephone number). *Note: If NICU (Neonatal Intensive Care Unit) is checked off, the MCO and/or its designated DME or pharmacy vendor will flag the PA, process and track it expeditiously in order to ensure that the member's nutritional needs will be met as soon as the member is ready to be discharged to the community.*
Item 7 **Item 8**	Primary diagnosis Secondary diagnosis	Enter the primary diagnosis name and ICD-9-CM code that corresponds to the nutritional disorder for which the enteral product is being requested. Include evidence-based clinical data regarding disease processes (i.e., not just GERD – all the clinical data that confirms that diagnosis). Enter the secondary diagnosis name and ICD-9-CM codes (up to three codes) that further describe medical conditions associated with the primary diagnosis. Enter "N/A" if not applicable. Include evidence based clinical data regarding disease processes (i.e. not just GERD – all the clinical data that confirms that diagnosis).
Item 9	Anthropometric measures	Complete all items associated with signs and symptoms of nutritional risk. Enter the member's height in inches, weight in pounds, body mass index, basal metabolic rate, and ideal body weight. Enter the growth percentile for children, and attach a growth chart.

Item 10	Laboratory tests	Place a check mark beside all diagnostic laboratory tests that apply, and specify the type of tests (for example, serum albumin, and hematocrit and enzyme profiles) in the space provided. Attach the results for each test.
Item 11	Risk factors	Place a check mark beside all risk factors that may affect treatment of nutritional risk. When indicated, specify the risk factors in the risk space provided. Attach clinical information for items checked.
Item 12	Route of treatment	Place a check mark beside the primary method that enteral products will be administered. If checking "Other", specify the method (for example, gravity, pump, or syringe) in the space provided.
Item 13	Treatment regimen initiated	Place a checkmark beside treatments that have been tried to manage nutritional risk. Attach an explanation on other nutritional support products used and responsiveness to such
Item 14	Expected treatment	Place a checkmark beside the item that describes the prognosis for improvement with enteral treatment. Attach an explanation.
Item 15	Location where member will use items	Place a checkmark beside all locations that apply to use of this product. If checking "Other", specify the location where the product will be used (for example, skilled nursing facility or end stage renal disease facility) in the space provided.
Item 16	Expedited service authorization	Place a checkmark beside the reason for requesting an expedited service authorization request. Must attach a detailed explanation for any reason checked.
Item 17	Duration of need	Enter the total number of months that the prescriber expects the member to require use of the items requested. Specify 1 to 99 months, where 99 indicates lifetime use. Enter Start and end dates if known.
Item 18	No. of refills	Enter the number of monthly refills for this prescription.
Item 19	Enteral formula and supplies	Print the name of the enteral formula being requested and, if applicable, the supplies (for example, syringes or pump) required to administer the formula. Include HCPCS codes.
Item 20	Volume/fluid oz. per day and calories per day	Enter the volume/fluid oz. per day of reconstituted formula being recommended for the member; and enter the calories per day (i.e. 1 unit = 100 calories)
Item 21	Quantity per month/Total Units Requested per HCPCS code.	Enter the quantity of enteral products requested per month for items listed (for example, 30 8-oz. cans).
Item 22	Type of formula requested	Place a checkmark beside the type of formula requested.
Item 23	DME provider	Enter the company name and address of the provider who will supply the enteral product(s) being requested. If available, also provide the DME provider's telephone and fax numbers and provider National Provider Identifier (NPI) number.

Item 24	Prescriber	Enter the physician's/clinician's name, address, telephone and fax numbers where he or she can be contacted if more information is needed. Include the prescriber's MCO Plan provider's NPI number, or if the prescriber is not an MCO Plan provider, enter the prescriber's NPI number.
Item 25	Person completing form on behalf of prescriber	If a clinical professional other than the treating clinician (for example, home health nurse, dietician, physical therapist or nursing facility staff) or a physician employee answers any of the items on this form, he or she must print his or her name, professional title and name of employer (organization) where indicated.
Item 26	Attestation	The prescriber must attest that the clinical information provided on this form is accurate and complete to the best of the prescriber's knowledge by signing this field.