AMIDA CARE
ABOVE AND BEYOND FOR YOU

ENTERAL PRODUCT PRIOR AUTHORIZATION REQUEST

Please fax form to Express Scripts: 1-800-357-9577

If you have any questions, please call 1-800 753-2851

PRESCRIBER INFORMATION	MEMBER INFORMATION
RX Name:	Member Name:
RX NPI:	Amida Care ID#:
RX address:	Address:
Office Phone#:	Member Phone #:
Office Fax#:	
Contact Person:	

ENTERAL PRODUCT REQUESTED

Enteral Product Requested (dosing, frequency): QTY:

Total # of calories requested:

Date Enteral Therapy Started (if reauthorization):

MEDICAL DIAGNOSIS AND CLINICAL CRITERIA

*Please Answer **ALL** of the following questions

* All laboratory/physical exam results must be dated within 45 days of request

1. Pt Height (inches):	2.*Pt weight (lbs):	3.*BMI:	Date of eval:

4. Is the patient fed via nasogastric, gastrostomy or jejunostomy tube? YES NO
5. Does the patient suffer from an inborn metabolic disorder? YES NO
6. Is the patient 21 years of age or younger? YES NO
7. Has the patient experienced an unintentional weight loss of >5% over the past two months or has the pediatric patient had no weight gain in six months? YES NO
8. Does the patient have a BMI of <18.5? *YES NO
9. Does the patient have an inability to sustain adequate nutrition as a result of a clinical condition?
   YES NO (IF YES complete next two steps)
   - Medical Diagnosis: ICD9 Code:
   - Provide clinical rationale supporting your request for coverage of an enteral product

REQUIRED EXPLANATION:

10. Has the patient been evaluated by a registered dietician within the past 2 months? YES NO

Failure to provide clinical documentation or supporting rationale may result in a delay or denial in your request.

Amida Care may request a referral for specialty services (ie Gastroenterology, Dental, Endocrinology, Nutrition) in order to approve enteral products.