PRIOR AUTHORIZATION REQUEST: Enteral Products

Please fax form and required documents to Express Scripts: 1-877-251-5896

MEMBER INFORMATION	
Name:	Amida Care ID #:
Phone #:	Date of Birth:
PRESCRIBER INFORMATION	
Name/Title:	NPI:
Office Phone #:	Office Fax #:
Address:	
Contact Person:	
MEDICATION REQUEST	
Enteral Product Requested:	Dosing:
Is this the initial or maintenance treatment?	□ Initial □ Maintenance
CLINICAL CRITERIA	
****Please answer ALL of the following questions and provide most recent and relevant laboratory/physical exam results****	
Labs Required: **(Please include both baseline and current labs)**	□ Pt Ht: □ Pt Wt: □ BMI:

Question	Answer
1. Is the patient being fed via nasogastric, gastronomy or jejunostomy tube?	
2. Does the patient have a rare inborn metabolic disorder requiring specific medical formulas to provide essential nutrients not available through any other means?	
3. What is the patient's age? (Documentation is required for children under the age of 21 when caloric and dietary nutrients from food cannot be absorbed or metabolized to confirm weight loss assessment and nutritional risk)	
4. Has documentation been submitted which confirms weight loss assessment and nutritional risk?	
5. What is the patient's diagnosis?	
6. Is the patient's BMI less than 22?	
7. Does the patient have a BMI less than 18.5 AND require supplementation of up to 1,000 calories per day?	
8. Has the patient experienced a documented, unintentional weight loss of GREATER THAN 5%?	
9. Does the patient have a permanent structural limitation that prevents the chewing of food AND the placement of a feeding tube is contraindicated?	
10. Is the requested medication being used for boosting protein intake, weight reduction, body-building or performance enhancement; as a convenience to the provider of patient?	
11. Has documentation been submitted, which confirms patient compliance with an appropriate medical and nutritional plan of care AND the patient's previous and current weight?	

Please attach any additional supporting documentation and notes relevant to the diagnosis: *(Failure to provide clinical documentation or supporting rationale may result in a delay or denial in your request)*:

Please call 646-757-7979, M-F, 9:00AM – 6:00PM with questions or additional information. You may also provide us with your contact information and the best time to reach you in the space at the top of this document.

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Prescriber or Authorized Signature Date