PRESBYTERIAN

Presbyterian Salud

Presbyterian Salud Prior Authorization Form for Oral Nutritional Supplements

FAX completed form to Presbyterian Pharmacy Services Department at **(505) 923-5540 or 1-800-724-6953**	Or If you have any questions about this Form, please call **(505) 923-5757 or 1-888-923-5757**
PATIENT INFORMATION	
Name:	Date of Birth:
Member ID Number:	SSN:
NUTRITIONAL SUPPLEMENT INFORMATION	
Oral Supplement Requested:	Diagnosis (related to medical necessity):
Length of Treatment:	Quantity Taken Per Day:
24-Hour Caloric Requirements:	Does patient have a G-Tube? ☐ Yes ☐ No (If yes, contact APRIA for Enteral Nutrition at 1-800-752-0445)
Current Height _____ Weight _____ Date _____ Previous Height _____ Weight _____ Date _____	**Activity Level:** ☐ Sedentary ☐ Moderately Active ☐ Active

INDICATIONS FOR APPROVAL

1. Patient must have a serious chronic disorder, which impedes adequate nutrition from oral intake and metabolism of traditional foods (inborn errors of metabolism or chronic malabsorption state); **AND**
2. Caloric and nutritional requirements consistent with essentially sole nutritional support for recipient's age, sex, height, weight, and activity level.
3. **Current dietary or nutritional consultation** stating the recipient's caloric and nutritional requirements based on sole nutritional support.
   - If no dietician or nutritionist is available, the provider may calculate the requirements by going to the following website (calorie levels are available for age 2 and above): **http://www.choosemyplate.gov/food-groups/downloads/MyPyramid_Calorie_Levels.pdf**
4. **Quantity Limits apply:** The daily authorized amount, at any given time, will not exceed the ADA caloric intake for a 24-hour period necessary to sustain life.
5. **Exclusions:** Lactose-free formulas; baby formula; oral electrolyte solutions; oral rehydration therapy; traditional foods available in the grocery store; blenderized or pureed foods; or patients who lack an appetite.

PHYSICIAN INFORMATION	
Name:	Specialty:
Phone **(required):**	Fax **(required)**:
Physician Signature:	Date:

ALL OF THE ABOVE INFORMATION and DOCUMENTATION MUST BE RECEIVED IN ORDER TO PROCESS THE REQUEST

FOR PRESBYTERIAN USE ONLY		
☐ **APPROVED**	☐ **DENIED**	PA:
Reviewed by:		Date:
Medical Director:		Date:
Comments:		

CONFIDENTIAL: PROTECTED HEALTH INFORMATION ENCLOSED. Protected Health Information (PHI) is personal and sensitive information related to a person's health care. It is being delivered to you after appropriate authorization from the patient/member or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure of failure to maintain confidentiality could subject you to penalties described in federal and state law.