

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049



Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Total Parenteral Nutrition: Prior Authorization Request Form: Please respond.

- Please complete the attached Total Parenteral Nutrition Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Total Parenteral Nutrition

Total parenteral nutrition is covered under the Medicare Part B benefit in the presence of permanent dysfunction of the gastrointestinal tract and approved conditions. Recertification will be required every three months to assess Medicare Parts B or D coverage.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

Prior Authorization Request Form



Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Total Parenteral Nutrition Criteria

- 1 Please specify product requested:
 Dextrose: _____
 Amino Acid: _____
 Protein: _____
 - 2 Please indicate the patient's diagnosis and specify the ICD-9 code(s) supporting the necessity for the requested agent. This question must be completed.

 - 3 Specify expected duration of TPN therapy:
 > 90 days
 < 90 days
 unable to be determined at this time
 - 4 In the setting of a chronic illness, has the patient been unable to meet nutritional requirements via oral intake with documented malnutrition as evidence by 10% weight loss over three months or less and serum albumin < or = 3.4gm/dl?
 Yes No Not applicable
 - 5 In the setting of an acute illness, has the patient been unable to tolerate PO intake for at least 7 days?
 Yes No Not applicable
 - 6 If appropriate, has the patient previously attempted or failed an enteral nutrition trial (nasoenteric, gastrostomy, jejunostomy) or was unable to meet nutritional requirements with enteral nutrition?
 Yes No Not applicable
 - 7 Does the patient have, or is expected to have permanent dysfunction of the GI tract?
 Yes No Not applicable
- For all requests: documentation of medical necessity from a nutrition support team and evidence of monitoring via a nutrition support must be provided.

Medical Justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____