

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

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**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

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

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- 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

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**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

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## 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 = 3.4 gm/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 (nasogastric, 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: \_\_\_\_\_