NYS MEDICAID PROGRAM- ENTERAL FORMULA PRIOR AUTHORIZATION
PRESCRIBER WORKSHEET- Revised 2/24

To facilitate the process, be prepared to answer these questions when using the Enteral Prior Authorization portal at https://MEDICAIDENTERALPORTAL.health.ny.gov/portal/ or Interactive Voice Response System at **1-866-211-1736**. Do not block your Caller ID. For audit purposes, Caller ID is recorded by the call line. Documentation must be maintained in the member's medical record. Dispensers may not initiate a prior authorization for enteral formulas.

1. Prescriber type (select one) ☐ NYS Physician/PA/Resident ☐ Nurse Practitioner/ Midwife

2. Prescriber's 10-digit National Provider ID # (NPI): __ __ __ __ __ __ __ __ __ __

3. Prescriber's email address and telephone number _____ (__ __ __) __ __ __- __ __ __ __

4. Transaction type (select one) (PA# required for cancelling an authorization or inquiry only)
☐ New Request ☐ Cancel an Authorization ☐ Inquiry only PA#__ __ __ __ __ __ __ __ __ __ __ __

5. Member's Medicaid ID (2 alpha/5 numeric/1 alpha) __ __ __ __ __ __ __ __

6. Member's Date of Birth (MM/DD/YYYY) __ __ /__ __ /__ __ __ __

7. Mode of administration: ☐ Tube ☐ Oral

8. If oral administration was selected at question #7, is the enteral formula being prescribed for an Inborn Metabolic disease? If yes, the ICD-10 diagnosis code will be requested. ☐ Yes ☐ No ICD: _____

9. Are you prescribing more than one enteral formula? ☐ Yes ☐ No

10. Number of enteral formula calories prescribed per day. ____ Number of refills (up to 5) ____

Answer the following questions for oral administration only:

11. Is the enteral formula prescribed for an inborn metabolic disease or an infant formula for lactose intolerance, severe food allergy or gastroesophageal reflux disease that is not responding to an added rice formula? ☐ Yes ☐ No

12. Member's height in inches and weight in pounds _____inches _____lbs

13. Does this member have a medical condition that prevents him/her from consuming normal table foods or softened, mashed, pureed, or blenderized foods? ☐ Yes ☐ No

14. Have alternatives such as dietary changes, instant breakfast drinks, rice cereal, etc., been tried but were unsuccessful? ☐ Yes ☐ No

15. Has the adult member had a significant unintentional weight loss (>5%) over the past two months, or the pediatric member had no weight gain in the past six months? ☐ Yes ☐ No

16. Is there objective medical evidence in the medical record to support the need for enteral nutrition (e.g., malnutrition documented by serum protein levels, albumin levels or hemoglobin, changes in skin or bones, physiological disorders resulting from surgery)? ☐ Yes ☐ No

Record the 11-digit prior authorization number here and on top of the member's enteral formula order/prescription. _____

INSTRUCTIONS

Please note: all qualified prescribing practitioners must be an enrolled NYS Medicaid provider. The prescriber worksheet should only be used as a guide when accessing the automated systems. Do not submit this form as a prior approval request or as medical documentation.

- **Entering the member's Medicaid ID number (CIN)**, you will be asked to enter the CIN in the Portal/IVR Systems. When using the IVR, letters will be entered using the corresponding numbers on your phone. After the full CIN is entered, you will be asked to confirm the letters based on the numbers that you entered (e.g.: #2 was entered, press 1 for A, 2 for B).
- **How many products are being prescribed**? If more than 1 product but they are "generically equivalent" (same HCPCS code/B code), request the combined calories under 1 authorization. If the products are not equivalent, you will be directed to obtain separate authorizations.
- **How many calories/day** will the Portal/IVR system allow for an authorization?
  -2,000 calories/day for individuals who are tube fed or have an inborn metabolic disorder.
  -1,000 calories/day for adults and children with a BMI under 18.5.
- **Paper prior approval is required** if any of the following apply:
  - ✓ More than 2,000 calories/day are required for an individual who is tube fed or has an Inborn Metabolic Disorder.
  - ✓ Children (under 21) who require more than 1,000 calories/day **or** have a BMI of 18.5 or over.
  - ✓ An oral fed adult requiring supplemental nutrition with a BMI between 18.5 and 21.9 (up to 1,000 calories/day). The medical record must show evidence of at least a 5% unintentional weight loss over the previous 6 months.
  - ✓ An oral fed adult with a BMI under 18.5 who requires a 3rd authorization within a 365-day period.
  - ✓ An adult with a permanent structural limitation (1,000 calorie limit does not apply).
  - ✓ If the pharmacy/vendor being used can no longer fill the order or the member no longer has reasonable access to the pharmacy/vendor and refills remain on the prescription (e.g.: pharmacy closes, member moves considerable distance)
- **Paper prior approval is not allowed** if any of the following apply:
  - ✓ For oral fed adults requiring supplemental nutrition above 1,000 calories/day (Benefit limit).
  - ✓ For a member who elects to change pharmacies/vendors when refills remain. If the current pharmacy/vendor is capable of filling the order, the member must use this provider until all refills are used.
- **How many refills are allowed**?
  -Tube fed, Inborn Metabolic Disorders, and children are allowed up to 5 refills.
  -Adults with BMI under 18.5 are allowed up to 2 refills and can receive 2 authorizations (each with up to 2 refills) per year. Paper prior approval is required for additional approvals.
- A qualifying **ICD diagnosis** is required for a member with an Inborn Metabolic Disorder.
- **Some products may be covered by the Women, Infants and Children (WIC) program. If a product is covered by WIC, authorizations can be obtained through Medicaid prior to members enrolling with WIC.**

For qualifying oral fed individuals with a BMI under 18.5 requiring supplemental nutrition, the following questions will be asked when determining if an authorization can be issued. Responses must be based on the member's medical record.

1. Does the member have a medical condition that **prevents** consuming normal **table foods or softened, mashed, pureed or blenderized** foods?
2. Have **alternatives** such as dietary changes, instant breakfast drinks, rice cereal, etc., been tried but were unsuccessful?
3. Has the adult member had a significant unintentional weight loss greater than five percent over the past two months, or has the pediatric member had no weight gain in the past 6 months?
4. Is there **objective medical evidence** in the medical record to support the need for enteral nutrition? (e.g.: Malnutrition documented by serum protein levels, albumin levels or hemoglobin, changes in skin or bones or physiological disorders resulting from surgery).

Important References:

- Benefit limit citation: Title 18 NYCRR Section 505.5(g)(3).
- Enteral nutritional formula codes: B4149- B4162.
- Refer to the DME Provider Manual/ DME Provider Communications at eMedny.org for the link to the current Enteral Classification list.
- DME Provider Manual (Procedure Codes section) for complete documentation requirements.

Questions may be directed to the Division of Medical and Dental Directors, Bureau of Medical Review
@1(800) 342-3005, Option 1