NEW YORK STATE MEDICAID PROGRAM
ENTERAL FORMULA PRIOR AUTHORIZATION
PRESCRIBER WORKSHEET- REVISED 08/2011

To facilitate the process, be prepared to answer these questions when you call the voice interactive Enteral Prior Authorization Call Line at **1-866-211-1736, Option 1**. Do not block your Caller ID. For audit purposes, Caller ID is recorded by the call line. Documentation must be maintained in the patient's medical record. Dispensers may not initiate a prior authorization for enteral formulas.

PRESCRIBER IDENTIFIER NYS Physician/PA/Resident -- press or say 1 NYS Nurse Practitioner/Midwife -- press or say 3 NYS Dentist -- press or say 5	Please enter your 10 digit National Provider Identification Number __ __ __ __ __ __ __ __ __ __
1. Recipient CIN (Client ID number is 2 alpha/5 numeric/1 alpha)	__ __ __ __ __ __ __ __
2. Recipient Date of Birth (MM/DD/YYYY)	__ __ / __ __ / __ __ __ __
3. Prescriber telephone number (where you can be reached)	(__ __ __) __ __ __ - __ __ __ __
4. Mode of administration	1 = Tube 2= Oral
5. ICD-9 Diagnosis code relating to medical need for formula	__ __ __ . __ __
6. If less than one year of age, does the patient require non-standard infant formula not provided by WIC?	1 = Yes 2 = No
7. Are you prescribing more than one enteral formula?	1 = Yes 2 = No
8. Number of enteral formula calories prescribed per day.	__ __ __ __
9. Number of refills (up to 5)	___

9a. Is the enteral formula prescribed for an inborn metabolic disease or an infant formula for lactose intolerance, severe food allergy or gastroesophageal reflux disease not responding to added rice formula? **(answer question a or b, age dependent)** 9b. Is the enteral formula prescribed for an inborn metabolic disease?	1 = Yes 2 = No
10. Patient height in inches	__ __ inches
11. Patient weight in pounds	__ __ __ lbs

Following questions are for oral administration in patients under 21 years of age

12. Does this patient have a medical condition that prevents him/her from consuming normal table, and softened, mashed, pureed, or blenderized foods?	1 = Yes 2 = No
13. Have alternatives such as dietary changes, instant breakfast drinks, rice cereal, etc., been tried but were not successful?	1 = Yes 2 = No
14. Has the patient had a significant unintentional weight loss (>5%) over the past two months or the pediatric patient had no weight gain in six months?	1 = Yes 2 = No
15. 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)?	1 = Yes 2 = No

Record the 11-digit prior authorization number here (for your records) and on top of the patient's enteral formula order/prescription.	__ __ __ __ __ __ __ __ __ __ __

You may be notified on the automated system that your authorization has been selected for medical review. This will require you to forward the medical record supporting the requested services within 30 days to: **OHIP Medical Prior Approval, 150 Broadway, Albany, NY 12204.**

Please note: This form should only be used as a guide when accessing the automated system. Do not submit this form as a prior approval request or as medical documentation. Do not use the above address for submitting a new Prior Approval request.