

**NEW YORK STATE MEDICAID PROGRAM
 ENTERAL FORMULA PRIOR AUTHORIZATION
 PRESCRIBER WORKSHEET- REVISED 8/03**

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**. Documentation must be kept in the patient's medical record.

PRESCRIBER IDENTIFIER	Complete one of the following prescriber identifiers: MMIS ID Number _____ 0 0 _____ F _____ 0 0 0 _____ _____ (state abbreviation in first two spaces)
Ordering Prescriber Medicaid ID # ----->	
NYS Physician/PA/Resident ----->	
NYS Nurse Practitioner/Midwife ----->	
NYS Dentist ----->	
Out of State Prescriber License ----->	
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. If less than one year of age, does the patient require an added rice formula?	1 = Yes 2 = No
6. Are you prescribing more than one enteral formula?	1 = Yes 2 = No
7. Number of enteral formula calories prescribed per day.	_____
8. Number of refills (up to 5)	_____

Answer the following questions for oral administration only:

9. 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?	1 = Yes 2 = No
10. Patient height in inches	___ inches
11. Patient weight in pounds	___ lbs

Coverage criteria for enteral formula explained on telephone system

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 adult patient had a significant unintentional weight loss (>5%) over the past two months or the pediatric patient had no weight or height 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 prior authorization number here (for your records) and on top of the patient's enteral formula order/prescription.	_____
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