NYS MEDICAID PROGRAM- ENTERAL FORMULA PRIOR AUTHORIZATION
PRESCRIBER WORKSHEET

- To facilitate the process, be prepared to answer these questions when you call the interactive voice response (IVR) Enteral Prior Authorization Call Line at **1-866-211-1736, Option 1**.
- See additional instructions and FAQ tips on reverse side.
- 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.** Only the prescriber, employee of, or an employee supervised by the prescriber can call for an authorization.

1. Prescriber type (select one of the following options) ☐ Physician/PA/Resident ☐ Nurse Practitioner ☐ Nurse Midwife ☐ Dentist **For Medicaid Enteral coverage criteria—press or say 6**	
2. Transaction type (select one of the following): ☐ New Request ☐ Cancel an authorization ☐ Inquiry only	(for cancelling or inquiry only) (PA # __ __ __ __ __ __ __ __ __ __ __ __
3. Prescriber's National Provider ID # (NPI):	10 digit NPI: __ __ __ __ __ __ __ __ __ __
4. Beneficiary CIN (Client ID number is 2 alpha/5 numeric/1 alpha)	__ __ __ __ __ __ __ __
5. Beneficiary Date of Birth (MM/DD/YYYY)	__ __ / __ __ / __ __ __ __
6. Prescriber telephone number (where you can be reached)	(__ __ __) __ __ __ - __ __ __ __
7. Mode of administration (If tube fed is selected, the ICD-9 diagnosis code relating to medical need for formula will be requested)	☐ 1= Tube ICD-9 __ __ __. __ __ ☐ 2= Oral
8. If oral administration is selected at question #7, is the enteral formula being prescribed for an Inborn Metabolic Disease? (If yes, the ICD-9 diagnosis code will be requested)	☐ 1= Yes ICD-9 __ __ __. __ __ ☐ 2= No
9. If answered no at question #8, Is the enteral formula being prescribed an infant formula for lactose intolerance, a severe food allergy or gastroesophogeal reflux disease (GERD) that is not responding to an added rice formula?	☐ 1= Yes ☐ 2= No
10. If answered yes at question #9, Does the patient have a medical condition such as gastroesophogeal reflux disease, which requires added rice or other non-standard infant formula not provided by WIC? (If yes, the ICD-9 diagnosis code will be requested)	☐ 1= Yes ICD-9 __ __ __. __ __ ☐ 2= No
11. Are you prescribing more than one enteral formula?	☐ 1= Yes ☐ 2= No
12. Number of enteral formula calories prescribed per day.	__ __ __ __
13. Number of refills (see reverse side for allowables)	___
14. Patient height in inches	__ __ inches
15. Patient weight in pounds	__ __ __ lbs

The following questions are for oral administration in adults and children with a BMI less than 18.5

16. 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
17. Have alternatives such as dietary changes, instant breakfast drinks, rice cereal, etc., been tried but were not successful?	☐ 1 = Yes ☐ 2 = No
18. 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
19. 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.

INSTRUCTIONS

Please note: all qualified prescribing practitioners must be an enrolled NYS Medicaid provider. (click for how to enroll)

The following instructions are intended to provide clarification for the most frequently asked questions related to obtaining an enteral authorization via the interactive voice response (IVR) phone system.

- When **entering the beneficiary's Medicaid ID number (CIN)**, you will first be asked to enter the full 7 digit CIN. Letters will initially be entered using the corresponding numbers on your phone. After the full CIN is entered, you will then be asked to confirm the letters of the CIN based on the numbers 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", request the combined calories (question #12) under 1 authorization. If the products are not equivalent, you will be directed to obtain separate authorizations.
- **How many calories/day** will the IVR system allow for an authorization?
  -2,000 calories/day for individuals who are tube fed or have an inborn metabolic disorder (IBM).
  -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 IBM.
  - ✓ Children (under 21) who require more than 1,000 calories/day **or** have a BMI 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 beneficiary no longer has reasonable access to the pharmacy/vendor and refills remain on the prescription (e.g.: pharmacy closes, beneficiary 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 beneficiary who elects to change pharmacies/vendors when refills remain. If the current pharmacy/vendor is capable of filling the order, the beneficiary must use this provider until all refills are used.
- **How many refills** are allowed?
  -Tube fed, IBM, 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-9 diagnosis** is required. You will be asked to enter this in 1 of 3 places (either question 7, 8, or 10) depending on the type of administration, or qualifying condition.
- The **WIC program** is a valuable resource for obtaining infant formulas. If you are prescribing a formula for an infant (less than one year old), the IVR system will ask you to verify that the formula is not covered by WIC. The system will also give you the option to learn more about the WIC program.

For qualifying **oral fed individuals with a BMI under 18.5 requiring supplemental nutrition**, the following questions will be asked prior to the IVR system determining if an authorization can be issued. It is not required that you answer yes to **all** the questions below. Responses must be based on the individuals medical history file.

1. Does the patient 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 patient had a significant unintentional weight loss greater than five percent over the past two months, or has the pediatric patient had no weight or height 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 and B9998.
- Pharmacy Provider manual (Provider Communications section) for the enteral classification list.
- DME Provider manual (Procedure Codes section) for complete documentation requirements.

Questions may be directed to the Division of OHIP Operations, *Bureau of Medical Prior Approval @1(800) 342-3005, option 1*