univera HEALTHCARE

Enteral

Drug Prior Authorization FAX Form

☐ Pharmacy **(Self-admin)**
Fax: 1-800-956-2397
Phone: 1-800-499-1275

IF YOU PREFER TO CALL THIS INFORMATION INTO THE PHARMACY HELP DESK DIRECTLY; PHONE # 1-800-363-4658

Complete ALL the following Patient/Prescriber information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

Location of Infusion:
☐ Prescriber office ☐ Home/Homecare agency:____________________
☐ Outpatient facility ☐ Other: _________________

Servicing Prescriber NPI (if different from the ordering prescriber):

Provide address of infusion location above for medication shipping:

Medication/Medical and Dispensing Information

1. Indicate product and amount to be used daily

Product Name	Amount Used Daily	Height	Weight (lbs. or kg)	Procedure Code

Diagnosis/ICD-10:

Is this request for a: ☐ New Start **OR** ☐ Continuation of Therapy (recertification)? Start Date: ___________

Questions/Indications for Medical Necessity

****Submit Clinical Notes & Growth Chart with each request where appropriate****

Select all which apply to patient's diagnoses:
- ☐ Crohn's Disease
- ☐ Gastroesophageal Reflux with failure to thrive
- ☐ List any other diagnosis which apply: ______________________________
- ☐ PKU
- ☐ Ulcerative Colitis

Question	Response
1. Is the patient being followed by one of the following? ☐ Qualifies Dietician ☐ Pediatric Allergist ☐ GI Specialist	☐ Yes ☐ No
2. Check all which apply:	
☐ Patient has inherited disorders of metabolism	☐ Yes ☐ No
☐ Patient has permanent malabsorption/GI impairment	☐ Yes ☐ No
☐ Patient has multiple severe food allergies requiring pediatric allergist or GI specialist evaluation: * **Attach specialist notes**	☐ Yes ☐ No
☐ Patient has swallowing disorder (*may require dysphagia evaluation) * **Attach progress notes**	☐ Yes ☐ No
3. Does the patient have or will be getting a G or J Tube?	☐ Yes ☐ No
4. Is the patient able to take nutrients by mouth? Estimate % of calories through oral intake: _______________%	☐ Yes ☐ No

Provide any other comments/clinical justification:

ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.

***Prescriber Signature:** ____ **Date:** ______________________

I certify the above is true and accurate to the best of my knowledge.