

**FORWARDHEALTH
PRIOR AUTHORIZATION / ENTERAL NUTRITION FORMULA ATTACHMENT (PA/ENFA)**

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Enteral Nutrition Formula Attachment (PA/ENFA) Instructions, F-11054A. Providers may refer to the Forms page of the ForwardHealth Portal at <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms> for the completion instructions. All required fields must be completed for accurate processing.

SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)

2. Member ID Number

3. Date of Birth – Member

SECTION II – PRESCRIBER INFORMATION

4. Name – Prescriber

5. Address – Prescriber (Street, City, State, Zip+4 Code)

6. Phone Number – Prescriber

7. National Provider Identifier – Prescriber

SECTION III – PRESCRIPTION OR ORDER INFORMATION (Submit a copy of the prescription or order not greater than one year old with each PA request.)

8. Indicate the date the prescription or order was written. Prescriptions or orders should not be greater than one year old.

9. Indicate the total amount of enteral nutrition formula(s) and/or food thickener(s) prescribed or ordered. Enter amounts for all applicable lines.

Calories of enteral nutrition formula per day _____

Milliliters of electrolyte-containing fluids per day _____

Ounces of food thickener per day _____

SECTION IV – DIETARY ASSESSMENT AND PLAN

10. Indicate the member's total daily caloric requirements. Total daily caloric requirements are the calculated caloric needs from all nutritional sources.

SECTION V – CLINICAL INFORMATION

11. Primary Diagnosis Code and Description as It Relates to Enteral Nutrition



12. Secondary Diagnosis Code and Description as It Relates to Enteral Nutrition (A secondary diagnosis is not required.)

13. Height and Weight Measurements

Current Height: _____ inches Date Measured _____

Current Weight: _____ pounds Date Measured _____

14. Indicate all medical conditions that apply to the member.

- Inborn errors of metabolism (for example, histidinemia, homocystinuria, phenylketonuria, hyperlysinemia, maple syrup urine disease, tyrosinemia, or methylmalonic acidemia)
- More than 50 percent of the member's caloric need must be met by specially formulated oral nutrition due to a medical condition (for example, epilepsy, food protein-induced enterocolitis, severe allergy, eosinophilic esophagitis, or eosinophilic gastritis)
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, or motility of the gastrointestinal tract (for example, short-gut syndrome, fistula, cystic fibrosis, inflammatory bowel disease, ischemic bowel disease)
- Central nervous system disease leading to interference with neuromuscular mechanisms of ingestion of such severity that the member cannot be maintained with regular oral feeding
- Nutritional deficiency (for example, failure to thrive or malnutrition)
- Chronic disease (for example, advanced AIDS, end-stage renal disease with or without renal dialysis)
- Ongoing cancer treatment or specific cancers (for example, gastrointestinal or head/neck)
- Swallowing or feeding difficulties (for example, dysphagia, oral motor/oral sensory dysfunction/disorder)
- Open wound(s) (for example, diabetic wounds, surgical wounds, pressure ulcers, burns)
- Other (If other is checked, describe the reason in the space below.)

15. Describe the specific details of the medical condition checked in Element 14 as it relates to enteral nutrition. Documentation should include treatment recommendations and any clinical changes that have occurred since previously approved PAs have been submitted.

16. If enteral nutrition formula is being requested, describe why a diet of regular- or altered-consistency table foods and beverages is not nutritionally sufficient for the member and why nutritional requirements necessitate the use of enteral nutrition formula.

17. If specially formulated enteral nutrition formula is being requested, describe why general purpose enteral nutrition formula does not meet the member's nutritional needs, is not tolerated, or is not clinically appropriate for the member.

18. If food thickeners are being requested, describe why a diet of regular-consistency table foods and beverages are not tolerated and how the member's health care team recommends the use of food thickeners (scoops, packets, or tablespoons per day and consistency level).

19. For diagnoses of failure to thrive or malnutrition, describe the member's anthropometric measurements (for example, height-for-length, progression along a growth chart, percentiles, or body mass index). Include any lab values or other clinical information to substantiate the member's nutritional deficiency.

SECTION VI – ADDITIONAL INFORMATION

20. Include any additional information in the space below, including a description of the member's dietary assessment and dietary plan.

SECTION VII – PA REQUEST INFORMATION FOR CALORIES PER DAY

	21. Procedure Code*	22. Modifiers	23. Calories Per Day Requested	24. Number of Days Requested	25. Units Requested (Element 23 x Element 24 / 100)
Example	BXXXX		1,000	365	3,650
A.					
B.					
C.					

SECTION VIII – PA REQUEST INFORMATION FOR MILLILITERS PER DAY (For PA requests for procedure codes where units are defined as milliliters only.)

	26. Procedure Code*	27. Modifiers	28. Milliliters Per Day Requested	29. Number of Days Requested	30. Units Requested (Element 28 x Element 29 / 500)
Example	BXXXX		1,000	365	730
A.					
B.					

SECTION IX – PA REQUEST INFORMATION FOR OUNCES PER MONTH (For PA requests for procedure codes where units are defined as ounces only.)

	31. Procedure Code*	32. Modifiers	33. Ounces Per Month Requested	34. Number of Months Requested	35. Units Requested (Element 33 x Element 34)
Example	BXXXX		34	12	408
A.					
B.					

SECTION X – AUTHORIZED SIGNATURE OF BILLING PROVIDER

By signing below, I agree to the truthfulness, accuracy, timeliness, and completeness of this PA request and that any clinical information (for example, medical records, other documentation) submitted with this request was obtained from the prescriber.

36. SIGNATURE

37. Printed Name

38. Position Title

39. Date Signed

FOR FORWARDHEALTH USE ONLY

* Providers may refer to the Healthcare Common Procedure Coding System code book for procedure code descriptions.