Prior Authorization Request
5802 Benjamin Center Dr., Suite 105
Tampa, FL 33634

ColoradoPAR Program
Medical Review Department

Phone: 1-888-801-9355
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QUESTIONNAIRE #10
ORAL & ENTERAL NUTRITION FORMULA

Client Name:			Medicaid ID #:		
Length of Need:		Height:		BMI:	
Start Date:		Weight:			

(For pediatric clients 2 years or under, please attach growth chart)

The information requested below is required to determine medical necessity. After you have completed this form, attach it to the completed Prior Authorization Request (PAR).

1) What is the complete diagnosis with complicating factors: a. List reasons why client cannot consume a regular diet to meet their nutrition needs.	
2) For clients age 5 and under: has client been referred to the Women, Infants, and Children (WIC) Program? a. Is the client receiving WIC services? If receiving formula from WIC, how many calories per day?	☐Yes ☐No ☐Yes ☐No
b. Last 2 years weight history:	☐Stable ☐ Increase ☐ Decrease ☐Unknown **Amount Change:**
3) If the client has received supplement feeding in the past two years, what was the weight and BMI when product previously started?	**Weight:** **BMI:**
4) Does client have difficulty chewing/swallowing: a. If yes, describe: 5) Has swallow study been completed? Include results with PAR.	☐Yes ☐No ☐Yes ☐No
6) For adults **over the age of 20**, is therapy intended to serve as a protein supplement? a. If yes, what is the serum albumin level? Date of lab value? b. ***Note:** Excludes wound care clients.	☐Yes ☐No **Serum Albumin Level:** **Date of Lab Value:**
7) Brand formula (s) requested: ***Note**: Adjust calories per day to reflect WIC allotment. a. Route of Administration:	**Name:** **Cal/day:** **Name:** **Cal/day:** ☐ Oral ☐ Tube Feeding
8) Is formula:	☐ Supplement ☐ Total Nutrition
9) Please supply any additional information that will assist us in determining **medical necessity** for your request:	

Print Prescriber Name _____

Prescriber Signature _____ Date _____

Revision Date: 12/15