Magellan COMPLETE CARE®

# Nutritional Authorization Form

| PCP Information | | |
|---|---|---|
| **Name:** | **Phone number:** | **Address:**<br>**City/State/Zip:** |

| Patient Information | | | |
|---|---|---|---|
| **Name:** | **Date of birth:** | **Gender:** | **Member ID number:** |

A request for Oral Nutritional Supplements has been received by Magellan Complete Care of Arizona (HMO SNP). MCC of AZ (HMO SNP) requires (1) **prior authorization** for all oral nutrition supplements in order to determine medical necessity, and (2) a **signed prescription** from the member's provider.

A member is considered to be at nutritional risk if he or she has actual or potential for developing malnutrition, as evidenced by clinical indicators; the presence of chronic disease; or increased metabolic requirements due to impaired ability to ingest or absorb food adequately.

***Please complete and FAX the information below along with a prescription to 1-888-656-2390.***

| I. Service Information | | |
|---|---|---|
| Primary diagnosis for nutritional risk: | | ICD code: |
| Estimated length of treatment: | | Frequency: |
| **II. Patient Questionnaire** | | |
| Has the patient had >=10% weight loss in the last 3-6 months? | | ☐ Yes ☐ No |
| Is the patient's Body Mass Index (BMI) below 18.5kb/m2? | | ☐ Yes ☐ No |
| Does the patient have anatomic structures of GI tract that impair digestion? | | ☐ Yes ☐ No |
| Does the patient have prolonged nutrient losses due to malabsorption or short-bowel syndromes, celiac, chronic pancreatitis, Crohn's ESRD/dialysis, diabetes? | | ☐ Yes ☐ No |
| Does the patient have neurological disorders that impair swallowing/chewing? | | ☐ Yes ☐ No |
| Does the patient have increased metabolic and/or caloric needs due to prolonged fever, excessive burns, infection, trauma, draining abscess or wounds, hyperthyroidism, or illnesses that impair caloric intake or retention? | | ☐ Yes ☐ No |
| Does the patient have a diagnosis of failure to thrive or weight loss? | | ☐ Yes ☐ No |
| Is the patient receiving chemotherapy, immunosuppressant, or radiation? | | ☐ Yes ☐ No |
| Date of last exam: ____/____/____ | Weight 6 months ago: | BMI at last exam: |
| | Weight at last exam: | Albumin level: |
| | Height at last exam: | Serum protein level: |
| Comments: | | |
| **Provider signature:** | | **Date:** |