Magellan COMPLETE CARE®

Nutritional Authorization Form

PCP Information		
Name:	**Phone number:**	**Address:** **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:**