COLORADO
Department of Health Care Policy & Financing

Acentra HEALTH

Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219	**ColoradoPAR Program** Medical Review Department	Phone: 1-720-689-6340 Fax: 1-800-922-3508

QUESTIONNAIRE #10
Oral and Enteral Nutritional Formula
Optional Submission on All PARs

Member Name			Health First Colorado ID #		
Length of Need		Height		Weight	
BMI		Start Date			

(For all members, attaching growth chart is optional.)

The information requested below is required to determine medical necessity. Complete this form and attach 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. Last 2 years' weight history	☐ Stable ☐ Increase ☐ Decrease ☐ Unknown **Amount Change:**
3. If the member has received supplement feeding in the past two years, what was the weight and BMI when product previously started?	**Weight:** **BMI:**
4. Does the member have difficulty chewing/swallowing? a. If yes, describe.	☐ Yes ☐ No
5.Has a swallow study been completed? Including results is optional.	☐ 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? b. Date of lab value? ***Note:** Excludes wound care clients.	☐ Yes ☐ No Serum Albumin Level:_____ Date of lab value:_____
7. Brand formula(s) requested: a. Route of administration:	Name: ____ Cal/day: ____ Name: ____ Cal/day: ____ ☐ Oral ☐ Enteral
8. Is the formula:	☐ Supplement ☐ Total Nutrition

9. What was the date of the last nutrition consult at the MD or RD appointment?	_____
10. Please check which applies to this request.	☐ Initial ☐ Ongoing ☐ Change in formula
11. Please supply any additional information that will assist in determining **medical necessity** for this request:	

Print Prescriber Name _____

Prescriber NPI _____

Prescriber Signature _____

Date_____