

REQUEST FOR ENTERAL NUTRITION PRODUCT(S) and EQUIPMENT for CCS/GHPP PROGRAMS

Health Care Provider: Please complete this form for all initial and subsequent requests for enteral nutrition products and supplies. FAX this form with required documents to the pharmacy vendor. The following 4 documents (dated within 6 months of the request date) must accompany this form:

- SCC/CCS-paneled physician's signed prescription or signature on page 2 of this form
- SCC/CCS-paneled physician's medical reports/records for patient
- SCC/CCS-paneled registered dietitian's MNT plan with required documentation per N.L. ____
- Appropriate growth chart for age plotted with dates of heights/lengths and weights listed

Pharmacy Vendor: _____ **Phone:** _____ **FAX:** _____

Note: Authorization for enteral nutrition products will be limited to six months. The first date of service may commence the date the physician signs this form. Enteral nutrition requests may not be backdated.

Patient Name: _____ **CCS/GHPP #:** _____

DOB: _____ Age: _____

CCS/GHPP eligible medical condition: _____ ICD Code: _____

Authorized CCS SCC Center: _____

Authorized CCS/GHPP Physician: _____

Nutrition Products:

Full Product Name <i>Including caloric concentration and fiber (when applicable)</i>	11 Digit Product Code*	Delivery Route** (Circle)	Amount		Duration (Max = 6 mo.)
			Liquid (ml)	Powder (g)	
		OR TF	24 hr: 1 mo:	24 hr: 1 mo:	
		OR TF	24 hr: 1 mo:	24 hr: 1 mo:	
		OR TF	24 hr: 1 mo:	24 hr: 1 mo:	

* 11 Digit Product Code: use current Medi-Cal Provider Manual

**Delivery Route: OR = Oral, TF = Tube Feeding

Equipment and Supplies: (Pumps, IV Pole, Feeding Kits, etc.)

Full Product Name	Code	Quantity

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Justification (must be completed):

- Malabsorption or intolerance to standard formulas requiring elemental or semi-elemental product
- Metabolic condition requiring metabolic product
- Specialized enteral nutrition product required for disease state or _____
- Specialty infant product required for: _____
- Modular product or nutrition additive required for: _____
- Severe swallowing or chewing disorder and/or risk of aspiration
- Inadequate growth/malnutrition as evidenced by: _____

- Other: _____

RD name (print): _____ Phone: _____ Email: _____

Physician name (print): _____ License #: _____

Phone: _____ FAX: _____

Physician Signature: _____ Date: _____

CCS/GHPP County/Regional Office: _____ FAX: _____

Pharmacy vendor: Please forward this form, TAR/SAR, and all required documentation to the CCS authorizing office listed above.