DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-11054 (04/2020)

STATE OF WISCONSIN
Wis. Admin. Code §§ DHS 107.10(2)(c), 152.06(3)(h), 153.06(3)(g), 154.06(3)(g)

FORWARDHEALTH

PRIOR AUTHORIZATION / ENTERAL NUTRITION FORMULA ATTACHMENT (PA/ENFA)

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Enteral Nutrition Formula Attachment (PA/ENFA) Instructions, F-11054A. Providers may refer to the Forms page of the ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions. All required fields must be completed for accurate processing.

SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)

2. Member ID Number

3. Date of Birth – Member

SECTION II – PRESCRIBER INFORMATION

4. Name – Prescriber

5. National Provider Identifier – Prescriber

6. Address – Prescriber (Street, City, State, Zip+4 Code)

7. Phone Number – Prescriber

SECTION III – PRESCRIPTION OR ORDER INFORMATION (Submit a copy of the prescription or order not greater than one year old with each PA request.)

8. Indicate the date the prescription or order was written. Prescriptions or orders should not be greater than one year old.

SECTION IV – DIETARY ASSESSMENT AND PLAN

9. Indicate the member's total daily caloric requirements. Total daily caloric requirements are the calculated caloric needs from all nutritional sources.

10. Indicate how the enteral nutrition formula(s) prescribed or ordered will be administered.

- ❑ Feeding tube only
- ❑ Mouth only
- ❑ Mouth and feeding tube

If the enteral nutrition formula will be administered using both mouth and feeding tube, indicate the following:

Calories per day administered orally _____

Calories per day administered via feeding tube _____

11. If the member receives less than 50 percent of daily nutrition orally from a nutritionally complete enteral nutrition formula, describe the plan to decrease dependence on the supplement, or provide rationale as to why decreasing dependence is not possible.

SECTION V – CLINICAL INFORMATION

12. Primary Diagnosis Code and Description as It Relates to Enteral Nutrition

13. Secondary Diagnosis Code and Description as It Relates to Enteral Nutrition (A secondary diagnosis is not required.)

14. Height and Weight Measurements

Current Height: _____ inches Date Measured _____

Current Weight: _____ pounds Date Measured _____

15. Indicate the member's medical condition. Check all that apply. If the member is tube-fed only, skip Elements 15 through 17 and proceed to Element 18.

- ❑ Inborn errors of metabolism (for example, histidinemia, homocystinuria, phenylketonuria, hyperlysinemia, maple syrup urine disease, tyrosinemia, or methylmalonic acidemia)
- ❑ More than 50 percent of the member's caloric need is required to be met orally by specialized nutrition due to a medical condition (for example, ketogenic diet, food protein-induced enterocolitis, severe allergy, eosinophilic esophagitis, or eosinophilic gastritis)
- ❑ Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, or motility of the gastrointestinal tract (for example, short-gut syndrome, fistula, cystic fibrosis, inflammatory bowel disease, ischemic bowel disease)
- ❑ Central nervous system disease leading to interference with neuromuscular mechanisms of ingestion of such severity that the member cannot be maintained with regular oral feeding
- ❑ Nutritional deficiency (for example, failure to thrive or malnutrition)
- ❑ Chronic disease (for example, advanced AIDS, end-stage renal disease with or without renal dialysis)
- ❑ Ongoing cancer treatment or specific cancers (for example, gastrointestinal or head/neck)
- ❑ Other. If other is checked, describe the reason in the space below.

16. For the member's medical condition checked in Element 15, regardless of the member's age, indicate in the space provided the specific details of the medical condition, including treatment recommendations, as it relates to enteral nutrition. If applicable, indicate any clinical changes that have occurred since previously approved PAs have been submitted.

17. For enteral nutrition formula administered orally, regardless of the member's age, describe why a diet of regular- or altered-consistency table foods and beverages is not nutritionally sufficient for the member, and why nutritional requirements necessitate the use of enteral nutrition formula.

18. For specially formulated enteral nutrition formula, regardless of the member's age, describe why general purpose enteral nutrition formula does not meet the member's nutritional needs, is not tolerated, or is not clinically appropriate for the member.

19. For diagnoses of failure to thrive or malnutrition, regardless of the member's age, describe the member's anthropometric measurements (for example, height-for-length, progression along a growth chart, percentiles, or body mass index). Include any lab values or other clinical information to substantiate the member's nutritional deficiency.

SECTION VI – ADDITIONAL INFORMATION

20. Include any additional information in the space below, including a description of the member's dietary assessment and dietary plan.

SECTION VII – PA REQUEST INFORMATION FOR CALORIES PER DAY

	21. Procedure Code*	22. Modifiers, if Applicable	23. Calories Per Day Requested	24. Number of Days Requested	25. Units Requested (Element 23 x Element 24 / 100)
Example	BXXXX		1,000	365	3,650
A.					
B.					
C.					

SECTION VIII – PA REQUEST INFORMATION FOR MILLILITERS PER DAY (For PA requests for procedure codes where units are defined as milliliters only.)

	26. Procedure Code*	27. Modifiers, if Applicable	28. Milliliters Per Day Requested	29. Number of Days Requested	30. Units Requested (Element 28 x Element 29 / 500)
Example	BXXXX		1,000	365	730
A.					
B.					

SECTION IX – AUTHORIZED SIGNATURE OF BILLING PROVIDER

By signing below, I agree to the truthfulness, accuracy, timeliness, and completeness of this PA request and that any clinical information (for example, medical records, other documentation) submitted with this request was obtained from the prescriber.

31. **SIGNATURE**

32. Printed Name

33. Position Title	34. Date Signed

FOR FORWARDHEALTH USE ONLY

* Providers may refer to the Healthcare Common Procedure Coding System code book for procedure code descriptions.

Reset Form