Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

Oral Enteral Nutrition Worksheet
Prior Authorization Request

TO BE SUBMITTED BY MEDICAL VENDOR OR PHARMACY
Fax: 1-866-668-1214

☐ New Request ☐ Extension Request (Prior Authorization Number or EPA Number)

CLIENT INFORMATION

CLIENT NAME	CLIENT ID

CLIENT'S RESIDENCE
☐ Adult Family Home ☐ Skilled Nursing Facility ☐ Private Residence ☐ Boarding Home
☐ Assisted Living Facility ☐ Other (Specify):

Is client WIC (Women, Infants, and Children) program eligible? (Children less than 5 years) ☐ Yes ☐ No
(Attach WIC statement of denial)

PROVIDER INFORMATION

VENDOR NAME	VENDOR NPI
VENDOR TELEPHONE NUMBER	FAX NUMBER

SERVICE REQUEST INFORMATION

NUTRITION PRODUCT REQUESTED	QUANTITY IN HCPCS UNITS PER DAY	LENGTH OF NEED	HCPCS CODE
NUTRITION PRODUCT REQUESTED	QUANTITY IN HCPCS UNITS PER DAY	LENGTH OF NEED	HCPCS CODE

Provide all applicable diagnoses (ICD-9-CM Codes and description)	MEDICAL DIAGNOSIS
	NUTRITIONAL DIAGNOSIS

CLIENT

0-36 months – Weight/length for age percentile on CDC growth chart _____

3-17 years – Weight/height for age percentile on CDC growth chart _____ or BMI _____

18 or older BMI

All oral enteral nutrition products or formulas require expedited or prior authorization. Request for prior authorization must be accompanied by clinical documentation that supports appropriate medical use of the product.

Please explain the nutritional history as it relates to their medical diagnosis and why this client is at risk for developing malnutrition. Include results of laboratory tests already done.

What is the client's weight loss history (or growth history for children)?