



STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

Mississippi Division of Medicaid, Pharmacy Prior Authorization Unit, Gainwell Technologies, PO Box 2480, Ridgeland, MS 39158

Medicaid Fee for Service/MSCAN/MSCHIP Members
Gainwell Technologies

Fax to: 1-866-644-6147 Ph: 1-833-660-2402

[Pharmacy Prior Authorization - Mississippi Division of Medicaid \(ms.gov\)](http://Pharmacy Prior Authorization - Mississippi Division of Medicaid (ms.gov))

Submit your PA requests via the MESA (Medicaid Enterprise System Assistance) provider portal for the most efficient processing
[Mississippi Medical Assistance Portal for Providers > Home \(ms-medicaid-mesa.com\)](http://Mississippi Medical Assistance Portal for Providers > Home (ms-medicaid-mesa.com))

BENEFICIARY INFORMATION	
Beneficiary ID: _____ - _____ - _____	DOB: ____/____/____
Beneficiary Full Name: _____	
PRESCRIBER INFORMATION	
Prescriber's NPI: _____	
Prescriber's Full Name: _____	Phone: _____
Prescriber's Address: _____	FAX: _____
PHARMACY INFORMATION	
Pharmacy NPI: _____	
Pharmacy Name: _____	
Pharmacy Phone: _____	Pharmacy FAX: _____
CLINICAL INFORMATION	
Requested PA Start Date: _____ Requested PA End Date: _____	
Drug/Product Requested: _____ Strength: _____ Quantity: _____	
Days Supply: _____ RX Refills: _____ Diagnosis or ICD-10 Code(s): _____	
<input type="checkbox"/> Hospital Discharge	<input type="checkbox"/> Additional Medical Justification Attached
Medications received through coupons and/or samples are not acceptable as justification	
PLEASE COMPLETE AND FAX DRUG SPECIFIC CRITERIA/ADDITIONAL DOCUMENTATION FORM FOUND BELOW	
<i>Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)</i>	
I certify that all information provided is accurate and appropriately documented in the patient's medical chart.	
Signature required: _____	Date: _____
Printed name of prescribing provider: _____	

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PRIOR AUTHORIZATION DESCRIPTION



Enteral Nutrition

Enteral nutrition is used as a nutritional replacement for patients who are unable to get enough nutrients in their diet. These formulas are taken by mouth or through a feeding tube and are used by the body for energy and to form substances needed for normal body functions. Documentation to support coverage of enteral nutrition must be maintained in the beneficiary's medical record.

A copy of the original prescription or order must accompany this PA request.

- Enteral nutritional replacement products are included in the facilities' per diem rate for residents in a long-term care facility (defined as nursing home, intermediate care facility for individuals with intellectual disabilities [ICF/IID] or psychiatric residential treatment facility [PRTF]). Enteral products ARE NOT REIMBURSABLE separately as a pharmacy "point of sale" service.
- If the beneficiary is Medicare eligible, then Medicare Part B or Medicare Advantage must be billed first as primary coverage.

DOM covers enteral nutrition when one of the following criteria is met:

1. For beneficiaries with inborn errors of metabolism.

2. For beneficiaries aged 21 years or older (non-EPSTD eligible; see criteria #3 for EPSTD definition), the requested enteral nutritional product must be the sole source of nutrition or when there are special circumstances (such as chemotherapy and/or radiation therapy to the head and neck region, etc.) that justify the need for enteral nutrition.

3. The Division of Medicaid has established a program of Early and Periodic Screening, Diagnosis, and Treatment (EPSTD), which provides preventive and comprehensive health services for Medicaid-eligible children and youth up to age twenty-one (21). The service ends on the last day of the beneficiary's twenty-first (21st) birthday month. For EPSTD-eligible beneficiaries, specialized enteral feedings must constitute more than 50% of the nutritional needs. A qualifying diagnosis is required.

- EPSTD beneficiaries up to age 5 years must be registered with the federal program for women, infants, and children (WIC) in order to receive WIC monthly nutritionals. If WIC eligible, DOM *may* allow up to a 30 day transition period for NEW starts on WIC covered products.
- Provide an estimate of initial coverage needs until WIC benefits start or if there is a gap in coverage of WIC benefits (up to, but not more than, a 30-day supply).
- Please attach and FAX to 1-866-644-6147 a copy of the WIC program formula request form when submitting this PA form. Include the WIC Monthly Quantity Limit and the average amount needed after WIC benefits are exhausted.

4. The unique composition of the formula must contain nutrients the beneficiary is unable to obtain from food. The composition of the formula must represent an integral part of the treatment of the specified diagnosis and/or condition.

It must be documented that the beneficiary is either unable to take oral nutrition or unable to sufficiently maintain life without an enteral nutritional replacement product.

Approval may be granted for up to 12 months. A prior authorization for enteral nutrition is for the nutritional product only and *does not* include supplies necessary to administer the nutrient.

SUBMISSION AND/OR APPROVAL OF A DRUG PRIOR AUTHORIZATION REQUEST DOES NOT GUARANTEE MEDICAID PAYMENT FOR PHARMACY PRODUCTS OR THE AMOUNT OF PAYMENT. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.

Confidentiality Notice: This communication, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply telephone (1-833-660-2402) or fax (1-866-644-6147) and destroy all copies of the original message.

CRITERIA/ADDITIONAL DOCUMENTATION

ENTERAL NUTRITION



BENEFICIARY INFORMATION	
Beneficiary ID: _____ - _____ - _____	DOB: ____/____/____
Beneficiary Full Name: _____	

Enteral Nutrition Criteria

A copy of the original prescription or order must accompany this PA request.

- Enteral nutritional replacement products are included in the facilities' per diem rate for residents in a long-term care facility (defined as nursing home, intermediate care facility for individuals with intellectual disabilities [ICF/IID] or psychiatric residential treatment facility [PRTF]). Enteral products **ARE NOT REIMBURSABLE** separately as a pharmacy "point of sale" service.
- If the beneficiary is Medicare eligible, then Medicare Part B or Medicare Advantage must be billed first as primary coverage.

Enteral Nutrition may be approved for beneficiaries meeting specified criteria:

- Does the beneficiary have an inborn error of metabolism? YES NO
- If non-EPSTD eligible (beneficiary is 21 years of age or older), is enteral product requested the sole source of nutrition? YES NO
- If EPSTD eligible (beneficiary is less than 21 years of age), is enteral product requested sole source or primary (>50%) source of nutritional needs? YES NO
- Is beneficiary eligible and registered with WIC? YES NO

EPSTD eligible beneficiaries up to age 5 years must be registered with the federal program for women, infants, and children (WIC) in order to receive WIC monthly enteral products.

Enteral/Clinical Information:

Enteral Product Name and Strength: _____ NDC Number*: _____

**Note: NDC Numbers are needed for processing and can be obtained by contacting enteral product pharmacy providers.*

Quantity: _____ per Month OR Day

- Age <5 years, and WIC eligible, please indicate:
 - If WIC eligible, DOM **MAY** allow up to a 30 day transition period for NEW starts on WIC covered products.
 - Initial Coverage until WIC Benefits start or a GAP in coverage of WIC benefits (up to, but not more than, a 30-day supply):** _____ -day supply
 - Please attach and FAX a copy of the WIC program formula request form when submitting this PA form.
 - WIC Monthly Quantity Limit: _____
 - Average monthly amount needed after WIC benefits are exhausted: _____

OR

- Inborn Errors of Metabolism: Yes Diagnosis/ICD-10 code(s): _____ No

OR

- Sole Source of Nutrition (solid food not an option-tube feeding) OR special circumstances such as chemotherapy and/or radiation therapy to the head and neck region, etc.): Yes Diagnosis/ICD-10 code(s): _____ No

OR

- Primary (>50%) or sole source of nutritional needs if EPSTD eligible (beneficiary is less than 21 years of age):
Yes Diagnosis/ICD-10 code(s): _____ No

Medical Justification:

Printed Name of Prescribing Provider: _____ Date: _____

Approval may be granted for up to 12 months. A prior authorization for enteral nutrition is for the nutritional product only and does not include supplies necessary to administer the nutrient.

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