

# Oral Nutritional Supplement Request Form



CareOregon®

For assistance with the form, you may call CareOregon at 503-416-4100 or 800-224-4840, Monday through Friday from 8 am - 5 pm. CareOregon requests careful selection when checking urgent as it delays review of other requests that may seriously jeopardize the health of another member, please mark URGENT only as necessary.

\*\* Please complete all fields legibly. We recommend providing supporting medical records. \*\*

CareOregon reviews all requests within 24 hours. Fax form to: 503-416-8109

<input type="checkbox"/> <b>Urgent request:</b> By selecting the expedited review and signing this form below, I certify that applying the standard review will seriously jeopardize the life or health of the member. Both Standard and Urgent requests will be reviewed within 24 hours.	
<b>Patient Information</b>	
Patient name: _____ Member ID#: _____	
Patient DOB: _____ Pharmacy name: _____ Pharmacy phone: _____	
Supplement requested: _____ Primary diagnosis: _____	
<b>Prescriber Information</b>	
Prescriber name/ specialty: _____ NPI#: _____	
Prescriber office phone: _____ Prescriber office fax: _____	
Prescriber contact: _____ Quantity requested (per month): _____ Length of treatment: _____	
Is the patient currently on nutritional supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are oral nutritional supplements the sole source of nutrition for the patient (i.e., patient does not consume any food items or meals)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient reside in a long-term care or chronic care facility? If yes, provide facility name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have > 1 year history of malnutrition or cachexia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have a diagnosis of failure to thrive (FTT)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have an increased metabolic need from severe trauma (e.g., severe burn, major bone fracture)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have a malabsorption difficulty such as Crohn's Disease, cystic fibrosis, bowel resection/removal, short gut syndrome, gastric bypass, renal dialysis, dysphagia, achalasia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have a diagnosis that requires additional calories and/or protein intake (e.g., cancer, AIDS, pulmonary insufficiency, MS, ALS, Parkinson's, cerebral palsy, Alzheimer's)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have serum protein < 5.6g/dl or albumin < 3.4g/dl?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Please attach: 1) Member's serial weight and BMI history for past 6 months, and 2) Most recent PCP or dietician assessment of nutritional status indicating adequate nutrition is not attainable through dietary intervention with regular or pureed foods and 3) Related Labs and 4) Underlying diagnosis.</b>	
Prescribers signature: _____	Date: _____

**Confidentiality notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return FAX) immediately and arrange for the return or destruction of these documents.

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