Oral Nutritional Supplement Request Form

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**

☐ **Urgent request: 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.**

Patient Information

Patient name: _____ Member ID#: _____

Patient DOB: _____ Pharmacy name: _____ Pharmacy phone: _____

Supplement requested: _____ Primary diagnosis: _____

Prescriber Information

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?	◯ Yes ◯ No
Are oral nutritional supplements the sole source of nutrition for the patient (i.e., patient does not consume any food items or meals)?	◯ Yes ◯ No
Does the patient reside in a long-term care or chronic care facility? If yes, provide facility name: _____	◯ Yes ◯ No
Does the patient have > 1 year history of malnutrition or cachexia?	◯ Yes ◯ No
Does the patient have a diagnosis of failure to thrive (FTT)?	◯ Yes ◯ No
Does the patient have an increased metabolic need from severe trauma (e.g., severe burn, major bone fracture)?	◯ Yes ◯ 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)?	◯ Yes ◯ 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)?	◯ Yes ◯ No
Does the patient have serum protein < 5.6g/dl or albumin < 3.4g/dl?	◯ Yes ◯ No

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.

Prescribers signature: _____ **Date:** _____