

ORAL NUTRITIONAL SUPPLEMENT Request Form



CareOregon

315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
800-735-2900 (TTY/TDD)
www.careoregon.org

FAX to 503-416-8109

* For assistance with urgent requests Monday-Friday 8 a.m.-5 p.m., call CareOregon at 800-224-4840 or 503-416-4100. For assistance after hours, call Express Scripts at 877-526-2313. *

**** Please complete all fields and provide supporting medical records ****

<input type="checkbox"/> URGENT REQUEST: By selecting the expedited review and signing this form below, I certify that applying the standard review time frame will seriously jeopardize the life or health of the member or the member's ability to regain maximum function.	
Patient Information	Prescriber Information
Patient Name:	Prescriber Name/Specialty:
Patient DOB:	Prescriber DEA#:
Member ID#:	Prescriber Office Phone:
Pharmacy used by Patient:	Prescriber Office Fax:
Pharmacy Phone:	Prescriber Contact:
Name of Supplement Requested:	Quantity Requested (per month):
Primary Diagnosis re: Request:	Anticipated Length of Treatment (please be specific):
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 <u>any</u> 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
<p>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.</p>	
Provider 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.