

**MARYLAND MEDICAID PHARMACY PROGRAM**

PH 1-800-932-3910

FAX 1-866-440-9345

**NUTRITIONAL SUPPLEMENT PROGRAM  
NUTRITIONAL SERVICE PRIOR-AUTHORIZATION REQUEST**

(To be faxed along with Form 3495)

Date of Request: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ MA#: \_\_\_\_\_ Phone: \_\_\_\_\_

Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**\*Note:** Although nutritional supplements are over-the-counter items, they require a valid prescription. These orders are subject to the same rules as legend drug prescriptions.

**Dispensing Pharmacist Signature Required**

I certify that the information presented on this form is correct and that the products were dispensed in the quantity and at the dosage as stated on the nutritional prescription and Form 3495. All paid claims are subject to post-payment review by the State. Providers are mandated to reverse any claim that is found to be improperly submitted. All services must be pre-approved by the State.

Prescriber's Name: \_\_\_\_\_ Degree: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ NPI # \_\_\_\_\_

**Requested Service PA:**

Date of Service: \_\_\_\_\_ Rx# \_\_\_\_\_ Qty: \_\_\_\_\_ Day Supply: \_\_\_\_\_

Nutritional Product: \_\_\_\_\_ NDC #: \_\_\_\_\_

**For Internal Use:**

Approved from: \_\_\_\_\_ to \_\_\_\_\_ Initials: \_\_\_\_\_ Qty: \_\_\_\_\_ Days Supply: \_\_\_\_\_ Max daily dose: \_\_\_\_\_

**Requested Service PA:**

Date of Service: \_\_\_\_\_ Rx# \_\_\_\_\_ Qty: \_\_\_\_\_ Day Supply: \_\_\_\_\_

Nutritional Product: \_\_\_\_\_ NDC #: \_\_\_\_\_

**For Internal Use:**

Approved from: \_\_\_\_\_ to \_\_\_\_\_ Initials: \_\_\_\_\_ Qty: \_\_\_\_\_ Days Supply: \_\_\_\_\_ Max daily dose: \_\_\_\_\_

**Requested Service PA:**

Date of Service: \_\_\_\_\_ Rx# \_\_\_\_\_ Qty: \_\_\_\_\_ Day Supply: \_\_\_\_\_

Nutritional Product: \_\_\_\_\_ NDC #: \_\_\_\_\_

**For Internal Use:**

Approved from: \_\_\_\_\_ to \_\_\_\_\_ Initials: \_\_\_\_\_ Qty: \_\_\_\_\_ Days Supply: \_\_\_\_\_ Max daily dose: \_\_\_\_\_

**Requested Service PA:**

Date of Service: \_\_\_\_\_ Rx# \_\_\_\_\_ Qty: \_\_\_\_\_ Day Supply: \_\_\_\_\_

Nutritional Product: \_\_\_\_\_ NDC #: \_\_\_\_\_

**For Internal Use:**

Approved from: \_\_\_\_\_ to \_\_\_\_\_ Initials: \_\_\_\_\_ Qty: \_\_\_\_\_ Days Supply: \_\_\_\_\_ Max daily dose: \_\_\_\_\_

Approved - Please resubmit claim on-line- Service PA has been issued.

Rejected - Missing 3495; please refax request with missing document.

Pending - Please call 1-800-932-3918 for follow-up questions.

Date Processed: \_\_\_\_\_ Initials: \_\_\_\_\_