MARYLAND MEDICAID PHARMACY PROGRAM
1-800-932-3918
FAX 1-866-440-9345

PRESCRIBER STATEMENT OF MEDICAL NECESSITY
NUTRITIONAL SUPPLEMENT PRE-AUTHORIZATION FORM

BILLING INSTRUCTIONS FOR PHARMACY PROVIDER
NUTRITIONAL SUPPLEMENT PROGRAM

Upon notification of approval of payment for the nutritional supplement by the Program, pharmacy providers are to submit claims on-line as follows:

1. Bill the actual NDC of the nutritional product dispensed.
   a. Bill the **exact units as quantity dispensed. Units must be accurate, expressed in"ml" for liquids, ready-to-use formulas or liquid concentrates requiring further dilution,** "**gram" for powders before reconstitution, and "each" for powder in packets.** Note: 1 lb canister may contain from 423g to 480 grams of powder; an 8 oz can may =237 or 240ml of ready-to-use liquid depending on the specific product. **Do not round-up or estimate quantities.** Bill multiples of the exact unit package size.

   b. **Exceptions to the use of the ready-to-use form:** This dosage form may be dispensed only if there is an unsanitary or unsafe water supply or poor refrigeration, if the caregiver has difficulty in correctly diluting concentrated liquid or powdered formula, or if the formula is available only in ready-to-use form. Such information must be documented on the Statement of Medical Necessity form by the prescriber.

   c. Maximum 34 days supply per Rx. Max # of refills per Rx is 11. Although nutritional supplements are considered over-the-counter products, the Program still requires a valid prescription for the products to be dispensed. Such prescriptions should be retained and ready for audit as would a legend prescription.

2. Claim will initially deny with any of the following NCPDP exception codes: "70 = NDC Not Covered", "75= PA required", "76 = Max Quantity Exceeded", "78 = Cost Exceeds Max", or "88 = Overuse/Early Refill", etc. Providers must call the Program at 1-800-492-5231, Option 3 for pre-authorization. Pre-authorization may be issued for an extended period once the nutritional supplement need has been established via review of Form 3495 (Prescriber Statement of Medical Necessity-Nutritional Supplement Pre-Authorization Form).

3. For refill requests, fax **Form 3495 C**- Nutritional Supplement Service Pre-Authorization (PA) Request to the Program at 410-333-5398. After the service PA has been entered on-line by the Program, provider will be notified by facsimile to resubmit claim. If the claim should deny for additional exception codes, provider should fax another 3495 C service PA request to the Program. In case of urgency, provider may call the Program for further assistance.

4. Nutritional supplement orders are ideally and initially verified or recommended by a licensed nutritionist-dietician. For continuation of nutritional therapy, a new Nutritional Supplement Pre-Auth Form (3495) must be completed and resubmitted to the Program when it expires. Any change in the prescription requires completion of a new 3495.

5. For requests for payment of oral nutritional supplements for REM recipients who are not tube-fed, nor have a metabolic disorder, providers must submit to the Program: 1) a comprehensive metabolic panel with Mg and Phosphorus levels; 2) dated measurements of weight, height, with BMI; 3) percentile placement on the BMI-for-age chart and growth chart if under 18; and 4) serum pre-albumin level.

6. Continued use of nutritional supplements for REM recipients will be reviewed by the Program every 6 months to a year depending on the case. For recipients without evidence of medical need or proper documentation, **a one-time 30-day emergency supply** of the requested nutritional supplement will be pre-authorized until the proper documentation is received by the Program for determination of nutritional need.

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Incomplete forms will be returned for reprocessing

1. Patient's Name:_____ Phone: _____
   Patient's Address:_____
   Patient's Medicaid ID #:_____ DOB:_____
   Patient Location: ____ Residence ____Nursing Home ____ Hospital Date Last Doctor's Visit:_____
   Body Weight: _____kg or _____lb Height: _____ft. ____in. Date Measured:_____
2. **Justification for nutritional supplement need**
   a) Diagnosis _____ Date of onset _____
   b) Does recipient have an inborn error of metabolism? Yes No
   c) Is patient **currently tube-fed**? Yes No
      If partially tube-fed, only amount that is actually tube-fed will be approved. Please check % of tube-feeding:
      ____ 100% ____ 75% ____ 50% ____ 25% ____ <25%
      Anticipated duration of tube feeding _____(# days) _____(# months) _____indefinitely
      Place G-tube inserted:_____ Date G-tube inserted_____
   d) For REM recipients not tube-fed and without a metabolic disorder, the following documentation must be submitted to the Program for a determination of medical necessity for the nutritional supplement:
      ____ a comprehensive metabolic panel including prealbumin and serum magnesium & phosphorus levels
      ____ a BMI-for-age chart besides the standard or clinical growth chart. All plotted values on the chart must be legible
      ____ a recent medical history documenting nutritional status and any weight loss over the prior 6 months
      ____ with height/weight measurements and corresponding dates.
   e) Calories prescribed initially verified by _____ Ph.:_____ Fax: _____
      The cost saving powder or concentrate form must be used. List valid reasons why these forms are not used:
      _____
3. **Rx Nutritional Supplement Order. Must prescribe in calories to be converted to billable units (gm/ml/pkt, etc.)**

Product & Dosage Form:_____ Package Size:_____ #cans/case:_____
Dose & Dosage Frequency: _____
Must specify the following:
a. Total calories required per day:_____ % daily requirement:_____%
b. Total calories derived from regular diet (if patient can eat):_____ % daily requirement:_____%
c. Total calories derived from nutritional supplements: _____ % daily requirement:_____%
a minus b must equal c. Explain reason for exceeding the average caloric daily requirement:
_____
d. # calories per each unit dispensed: _____ calories per _____ *(specify unit below)*
____ gram ____ ml (concentrate) ____ ml (ready-to-use) ____ packet ____ Other_____
Specify: _____gram/ per can (ie., 423g-480g) or _____ ml /per can; or_____gram/packet
e. # units per day (e =c:d)_____ x 30 days=_____(Total quantity billed on-line/month)
f. _____ cans/day Specify: _____ ml/can #_____gm/day _____#packet/day
g. Calories prescribed: _____cal/Kg/day Body Weight:_____Kg Date measured:_____

4. Prescriber's Signature:_____ NPI # _____
   Prescriber's Name:_____ Degree: _____
   Address: _____
   Phone: _____ Fax: _____ Date:_____
5. Name of Pharmacy verifying calorie conversion into proper units billed _____
   Pharmacy Address_____ Ph._____ Fax_____ Date_____

FOR INTERNAL USE ONLY
APPROVED (*enter dates*) from:_____ **to** _____ **REJECTED Date:**_____ **Initials:** _____