

Prescriber Criteria Form

Parenteral Nutrition 2024 PA Fax BD-18 v1 010124.docx
 Parenteral Nutrition
 Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
 Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
 Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
 When conditions are met, we will authorize the coverage of Parenteral Nutrition.

Drug Name: _____

Patient Name:		
Patient ID:		
Patient DOB:	Patient Phone:	
Prescriber Name:		
Prescriber Address:		
City:	State:	Zip:
Prescriber Phone:	Prescriber Fax:	
Diagnosis:	ICD Code(s):	

Please circle the appropriate answer for each question.			
1	Is the parenteral nutrition request for intradialytic parenteral nutrition (IDPN) or total parenteral nutrition (TPN)? [Note: Intraperitoneal nutrition (IPN) is covered under the End-Stage Renal Disease Prospective Payment System (ESRD PPS) (case-mix adjusted bundled PPS for Medicare outpatient ESRD facilities). Therefore, IPN is not eligible for coverage under Part D.] [If no, then no further questions.]	Yes	No
2	Does the patient have or is the patient expected to have permanent dysfunction of the digestive tract (duration greater than 90 days)?	Yes	No

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:** _____