Oral Enteral Nutrition (Nutritional Supplement) Order Form – Age 21+

Patient Name: ________________ DOB: ____/__ /_____Member ID Number:___________________________

Member Mailing Address:_____________________Member Phone Number:______________________

Physician Name: ____NPI:__________________

Office Phone Number:_______________________ Office Fax Number: ____________________________

*__ORDER: (check one)__ *NAME OF SUPPLEMENT: _____________________ ☐ Allow substitutions

*__FORMULA__ ☐ B4150: Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber.

☐ B4152: Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber.

☐ B4154: Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins, and/or minerals, may include fiber.

*QUANTITY / FREQUENCY (cans per day / ML per hour): __________*ROUTE ☐ oral ☐ via PEG ☐ via J-tube

*# of REFILLS requested: _____ Unless specified a **ONE MONTH** supply will be dispensed. If medically necessary, we will approve up to 3 refills (oral administration) or 6 refills (feeding tube administered).

*DIAGNOSIS: _______________

SUPPORTING INFORMATION (Select all that apply – if not complete request may be denied for lack of information):

If unable to weigh, and providing an anthropomorphic measurement, please specify which measurement is being used.

*Current Weight: _________ Date Weighed: ___________ If cannot weigh, other measurement: ____________

*Previous Weight:_________ Date Weighed:___________ If cannot weigh, other measurement: ____________

*Current BMI (Body Mass Index): ______________________________Height:_______________________

↓ ***Select One:**	
☐	Patient is unable to perform oral feedings (NPO) AND patient requires enteral feedings.
☐	Patient is able to swallow some things (NOT NPO) BUT patient requires enteral feedings.
☐	Patient is able to take this supplement orally and patient HAS a feeding tube.
☐	No feeding tube present

Patient can eat: ☐ Regular Foods ☐ Pureed Food ☐ Food spoon thick (pudding) ☐ Nectar thick liquids

☐ Regular Liquids

What is patient taking orally? (meds, liquids, solids, etc.): ____________________________________

Does patient have malabsorption? ☐ No ☐ Yes – why? _____________________________________

*What is patient's DAILY CALORIC REQUIREMENT? ☐ 1800 kcal ☐ 2000 kcal ☐ Other ______________

***Please include ordering provider's most recent *signed* progress note. If no progress notes available, include a statement from the ordering provider that details WHY the progress note is not available.**

***Physician's Signature: ____ Date: ____________**

*** Indicates mandatory field**

Revised 9.20.23