SecurityHealth Plan℠
Promises kept, plain and simple.

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 1.877.727.2232 | 715.221.9898

Parenteral Nutrition Home Infusion

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Ordering provider name (print)	Telephone number	Fax number
Place of service: ☐ Home ☐ Skilled nursing facility ☐ Other _____		
DME name		
Vendor contact name	Vendor telephone number	Vendor fax number
DME vendor address		
Procedure information		
Scheduled date of service or equipment to be received (month/day/year)	Requested service/procedure/DME	HCPC code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

What is the route of the parenteral feeding: ☐ Total parenteral nutrition (TPN) ☐ Peripheral parenteral nutrition (PPN)

Route of administration: ☐ Central line (including PICC) ☐ Hemodialysis access line ☐ Peritoneal catheter

☐ Other _____

Days per week administered or infused _____

Date of start of care (m/d/y) _____ /_____ /_____ End date (m/d/y) _____ /_____ /_____

Product HCPCS code(s): Code 1 _____ Code 2 _____ Code 3 _____ Code 4 _____

Calories per day for each corresponding HCPCS code: ☐ Yes ☐ No

Code 1 _____ Code 2 _____ Code 3 _____ Code 4 _____

Does the member have a permanent impairment: ☐ Yes ☐ No

Parenteral nutrition is covered in any of the following situations:

The member has undergone recent (within the past 3 months) massive small bowel resection leaving less than or equal to five feet of small bowel beyond the ligament of Treitz. . . . . ☐ Yes ☐ No

The member has a short bowel syndrome that is severe enough that the patient has net gastrointestinal fluid and electrolyte malabsorption such that on an oral intake of 2.5 – 3 liters/day the enteral losses exceed 50% of the oral/enteral intake and the urine output is less than 1 liter/day. . . . . ☐ Yes ☐ No

The member requires bowel rest for at least 3 months and is receiving intravenously 20 – 35 cal/kg/day for treatment of symptomatic pancreatitis with/without pancreatic pseudocyst, severe exacerbation of regional enteritis, or a proximal enterocutaneous fistula where tube feeding distal to the fistula isn't possible ☐ Yes ☐ No

The member has complete mechanical small bowel obstruction where surgery is not an option ☐ Yes ☐ No

The member is significantly malnourished (10% weight loss over 3 months or less and serum albumin less than or equal to 3.4 gm/dl) and has very severe fat malabsorption (fecal fat exceeds 50% of oral/enteral intake on a diet of at least 50 gm of fat/day as measured by a standard 72-hour fecal fat test). ☐ Yes ☐ No

The member is significantly malnourished (10% weight loss over 3 months or less and serum albumin less than or equal to 3.4 gm/dl) and has a severe motility disturbance of the small intestine and/or stomach which is unresponsive to prokinetic medication and is demonstrated either:

– scintigraphically (solid meal gastric emptying study demonstrates that the isotope fails to reach the right colon by 6 hours following ingestion) ☐ Yes ☐ No

OR

– radiographically (barium or radiopaque pellets fail to reach the right colon by 6 hours following administration). These studies must be performed when the beneficiary is not acutely ill and is not on any medication which would decrease bowel motility ☐ Yes ☐ No

Unresponsiveness to prokinetic medication is defined as the presence of daily symptoms of nausea and vomiting while taking maximal doses ☐ Yes ☐ No

A disease and clinical condition has been documented as being present and it has not responded to altering the manner of delivery of appropriate nutrients (e.g. slow infusion of nutrients through a tube with the tip located in the stomach or jejunum) ☐ Yes ☐ No

A failed trial of tube enteral nutrition before parenteral nutrition ☐ Yes ☐ No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to: Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715.221.9918	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Provider Assistance at 1.800.472.2363.

