Enteral Prescription Request/Letter of Medical Necessity

Coram® CVS specialty™ infusion services

Enteral Nutrition Center **Tel:** ______________ **Fax:** ______________

TO: ____

FAX: ______________________ Pages: ______________

PHONE: ______________________ Date: ______________

Patient:	DOB:	Zip code:	ID:
Reason for request:			
Date order to take effect:	Estimated length of need:	Height:	Weight:

Formula:	Quantity/ 30 days	Calories/day:	HCPC:	☐ Tube feeding provides majority of patient's nutrition
Reason High Calorie Protein Beverage Vanilla flavor			B4155	
Reason High Calorie Protein Beverage Chocolate flavor			B4155	
Reason High Calorie Protein Beverage Strawberry flavor			B4155	
☐ Substitution with formulary equivalent permitted	Total calories/day: ______________			

Route:

- ☐ Oral
- ☐ NG tube (B4081/B4082): Brand: ____________ Size:______ FR______ inch Qty: ____________
- ☐ NJ tube (B4081/B4082): Brand: ____________ Size: ______FR ______ inch Qty: ____________
- ☐ (B4088) Low Profile Tube type (G, J, or GJ, please specify): ____________ Brand: ____________ Size:_____FR _____cm Qty: ______ Ext set qty B9998:____________
- ☐ G tube (B4087): Brand: ____________ Size:________FR Qty: __________
- ☐ (B4087) Tube type (J or GJ, please specify): ____________ Brand: ____________ Size: _______ FR Qty: __________

Admin:

- ☐ Bolus via syringe (1 syringe/day – B4034/S9343/S9340)
- ☐ Gravity via bag (1 bag/day - B4036/S9341/S9340 and IV pole – E0776)
- ☐ Pump rate:______ ml/hr x ______hrs/day (1 set/day - B4035/S9342/S9340, pump - B9002, IV pole – E0776)

Diagnoses (ICD-10 codes):

Comments or additional orders:

Order Received From (if Verbal Order): ______________________________ Date: ____________

Supplier Name: ______________________________

Supplier Signature: ______________________________ Date: ____________

If you have questions, please contact the Enteral Nutrition Center.

Please sign, date and return if you agree with this prescription recommendation.

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering a tube feeding product for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my medical records support the medical need for the items prescribed.

Printed physician name: ______________________________ NPI: ______________

Physician signature: ______________________________ Date: ______________

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