Office of Pharmacy Services
1-800-932-3918
FAX 1-866-440-9345

REVISED PRESCRIBER STATEMENT OF MEDICAL NECESSITY
ORAL SUPPLEMENTS AND VITAMIN PRE-AUTHORIZATION FORM

BILLING INSTRUCTIONS FOR PHARMACY PROVIDER
ORAL SUPPLEMENTS AND VITAMIN NUTRITIONAL SUPPLEMENT PROGRAM

To Providers:

Form 3495 C- Nutritional Supplement Service Pre-Authorization (PA) is no longer used for ALL Prior Authorization requests.

For Parenteral and Enteral Nutrition coverage, please complete the Parenteral and Enteral Nutrition Authorization Form (PEN) and submit to the Office of Long Term Service and Supports.

Upon notification of approval of Prior Authorization, pharmacy providers are to submit claims on-line as follows:

1. Bill the actual NDC of the dispensed product.
    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. Bill multiples of the exact unit package size. Exceptions to the use of the ready-to-use product: The Department may conduct utilization review regarding the appropriate use of ready to use dosage form.[1]
        i. Provide clinical/medical information with the Statement of Medical Necessity form by the prescriber.
    c. Prescription is required and Program will only allow up to maximum 34 days' supply per fill.

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.
    i. Pre-authorization may be issued for an extended period once the oral supplement need has been established via review of Form 3495 (Prescriber Statement of Medical Necessity-Nutritional Supplement Pre-Authorization Form).

3. For continuation of nutritional therapy, a new Nutritional Supplement Pre-Authorization Form (3495) must be completed and resubmitted to the Program when it expires. Any change in the prescription requires a new prior-authorization via completion of a new 3495 form.

4. Continued use of approved products for REM participants will be reviewed by the Program every 6 months to a year, depending on the case.

[1] These ready to use products 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 product.

Maryland
DEPARTMENT OF HEALTH

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Incomplete forms will be returned

1. Patient's Name: _____ Phone: _____
   Patient's Address: _____
   Patient's Medicaid ID #: _____ DOB: _____

2. Justification for oral supplements and vitamins/minerals supplement need

   a) Diagnosis _____ Date of onset _____
   b) Does recipient have an inborn error of metabolism? ☐Yes ☐No
   Vitamin D Levels (if applicable): _____

3. Product Name & Dosage Form: _____ Package Size (mL/gm):_____

National Drug Code (NDC): _____ Billing units (gm/mL/pkt):_____
Package form _____
Dose & Dosage Frequency: _____
Dose per day: _____
Duration of therapy: _____
Route of administration: ☐ PO ☐ Tube-feed ☐ Other_____

4. Prescriber's Name: _____ NPI: _____
   Address (City/State/Zip): _____
   Phone: _____ Fax: _____ Date: _____

5. Name of Pharmacy _____

Pharmacy Address _____ Ph._____ Fax _____ Date _____

For electronic signatures: *MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.*

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber's Signature: _____ Date: _____