

Step-by-Step Instructions for Obtaining NY Medicaid Coverage

K-PAX Protein Blend requires a prior authorization initiated by an authorized prescriber (or their assistant) to be covered by the NY Medicaid program.

A Medicaid patient must have one of the following conditions to qualify:

- a. a documented diagnostic condition where caloric and dietary nutrients from food cannot be properly absorbed or metabolized (i.e. HIV/AIDS, Chronic Hepatitis, Cancer, Diabetes, Surgery)
- b. an adult patient with an unintentional weight loss of > 5% over the past two months (or a pediatric patient with no weight gain during the past six months).
- c. a patient whose condition prevents him/her from consuming normal table and/or softened food.
- d. the presence of abnormally low serum protein levels, serum albumin, or other evidence of malnutrition.

If your patient does not have weight loss, they may still qualify, if the answer to #15 is yes.

To Obtain a Prior Authorization Number Call NY Medicaid at 1-866-211-1736

Prescriber Medicaid Identifier # _____

- 1. Recipient Client ID number: _____
- 2. Recipient Date of Birth: _____
- 3. Prescriber telephone number: _____
- 4. Mode of administration: _____
- 5. If less than one year of age, does the patient require an added rice formula not provided by WIC?
- 6. Are you prescribing more than one enteral formula? _____
- 7. Number of enteral formula calories prescribed per day? _____

K-PAX Protein Blend = **If > 120 lbs. -> 420 C/day**
If < 120 lbs. -> 210 C/day

- 8. Number of Refills: _____
- 9. Is the enteral formula prescribed for an inborn metabolic disease or an infant formula for lactose intolerance, severe allergy or gastro esophageal reflux disease not responding to added rice formula?
- 10. Patient's Height: _____
- 11. Patient's Weight: _____
- 12. Does this patient have a medical condition that prevents them from consuming normal table or softened foods?
- 13. Have alternative dietary changes been tried but were unsuccessful?
- 14. Has the adult patient had an unintentional weight loss of > 5% over the past two months or the pediatric patient had no weight gain in six months? _____
- 15. Is there an abnormally low serum protein level, serum albumin, or other physiologic evidence of malnutrition?

Record the prior authorization number here (for your medical records)_____. Also provide patient with prior authorization# & prescription to take to their pharmacy.*