Pharmacy Medical Policy
Home Total Parenteral Nutrition (TPN)

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Policy Number: 296
BCBSA Reference Number: None

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Pharmacy Operations by completing the Prior Authorization Form on the last page of this document.

This medication is not covered by the pharmacy benefit. It is covered by the Medical Benefit or as a Home Infusion Therapy.

Prior Authorization Information

<table>
<thead>
<tr>
<th>☑ Prior Authorization</th>
<th>☐ Step Therapy</th>
<th>☐ Quality Care Dosing</th>
<th>☑ Rx</th>
<th>☑ MED</th>
</tr>
</thead>
</table>

Pharmacy Operations:
Tel: 1-800-366-7778
Fax: 1-800-583-6289
Policy last updated 7/1/2023

To request for coverage: Physicians may call, fax, or mail the attached form (Formulary Exception/Prior Authorization form) to the address below.

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043

Individual Consideration: Policy for requests that do not meet clinical criteria of this policy, see section labeled Individual Consideration.
We may cover medically necessary total parenteral nutrition (TPN) in the home\(^3\) for conditions resulting in impaired intestinal absorption and/or resulting in abnormal food intake, including, but not limited to, any of the following:\(^1,^9\)

- Crohn’s disease
- CNS disorder resulting in swallowing difficulties and high risk of aspiration
- Hyperemesis gravidarum\(^6\)
- Intestinal pseudo-obstruction
- Massive small bowel resection with inadequate remaining resorptive capacity (short gut syndrome)
- Single\(^6,^7,^8\) or multiple fistulae (enterocolic, enterovesical, or enterocutaneous)
- Newborn anomalies of the gastrointestinal tract which prevent or contraindicate oral feeding such as tracheo-esophageal fistula, gastrochisis, omphalocele, or massive intestinal atresia
- Infants and young children who fail to thrive due to cardiac or respiratory disease, short bowel syndrome, malabsorption, or chronic idiopathic diarrhea
- Prolonged paralytic ileus after major surgery or multiple injuries
- Malabsorption due to Whipple’s disease
- Malabsorption due to chronic infectious enteritis
- Severe forms of Protein-Energy Undernutrition (PEU) [i.e. ALB \(\leq 2.4\)]
- Radiation enteritis
- Chronic pancreatitis\(^4\)
- Severe acute pancreatitis\(^6,^7,^8\)
- Pancreatic pseudocysts\(^4\)
- Obstructing stricture\(^8\) or cancer of the mouth, esophagus, stomach\(^1\) or intestine\(^6\)
- Post stem cell transplant patients and specifically those with graft vs. host disease\(^6\)

Eligible patients must meet the following: In some circumstances such as anticipation of prolonged course of illness, all of these criteria need not be applied:

- Weight is significantly less than normal for age and height compared to pre-illness weight
- BUN less than 10 (not an accurate marker in renal failure patients)
- Patients are unable to receive more than 30% of caloric requirements enterally. NOTE: There are no kilocalories minimums in pediatric patients.

We may cover medically necessary intradialytic parenteral nutrition (IDPN) as an alternative to a regularly scheduled regimen of total parenteral nutrition (TPN) only in those patients who would be considered candidates for TPN (see TPN coverage above.)\(^10\)

We do not cover TPN in the home\(^9\)

- To increase protein or caloric intake in addition to the patient’s daily diet\(^9\)
- In patients with a stable nutritional status, in whom only short-term parenteral nutrition might be required for less than 2 weeks\(^9\)
- For routine pre and/or postoperative care.\(^9\)

We do not cover intradialytic parenteral nutrition (IDPN) in those patients who would be considered a candidate for TPN but for whom the intradialytic parenteral nutrition is not offered as an alternative to TPN, but in addition to regularly scheduled infusions to TPN.

We do not cover intradialytic parenteral nutrition in patients who would not otherwise be considered candidates for TPN.

Other Information

Home total parenteral nutrition (TPN) is payable to contracted home infusion therapy providers only.

We do not separately reimburse the following: B4220 (parenteral nutrition supply kit; pre mix, per day), B4222 (parenteral nutrition supply kit; home mix, per day), B4224 (parenteral nutrition administration kit, per day), B9004-B9006 (parenteral nutrition infusion pump), syringes, discard boxes, thermometers,
specimen cups, scissors, or hyperalimentation storage units. The listed supplies are included in the per diem rate and will reject leaving no patient balance.

TPN is considered primary therapy when multiple therapies are administered on the same date of service. The services would be paid as Y9598 (multiple therapies).

**CPT Codes / HCPCS Codes / ICD Codes**

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member. A draft of future ICD-10 Coding related to this document, as it might look today, is included below for your reference.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

**CPT Codes**

There is no specific CPT code for this service.

**HCPCS Codes**

<table>
<thead>
<tr>
<th>HCPCS codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4164</td>
<td>Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit), home mix</td>
</tr>
<tr>
<td>B4168</td>
<td>Parenteral nutrition solution: amino acid, 3.5%, (500 ml = 1 unit) - home mix</td>
</tr>
<tr>
<td>B4172</td>
<td>Parenteral nutrition solution: amino acid, 5.5% through 7%, (500 ml = 1 unit) - home mix</td>
</tr>
<tr>
<td>B4176</td>
<td>Parenteral nutrition solution: amino acid, 7% through 8.5%, (500 ml = 1 unit) - home mix</td>
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<tr>
<td>B4178</td>
<td>Parenteral nutrition solution: amino acid, greater than 8.5% (500 ml = 1 unit), home mix</td>
</tr>
<tr>
<td>B4180</td>
<td>Parenteral nutrition solution: carbohydrates (dextrose), greater than 50% (500 ml = 1 unit), home mix</td>
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<tr>
<td>B4185</td>
<td>Parenteral nutrition solution, per 10 grams lipids</td>
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<tr>
<td>B4189</td>
<td>Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 g of protein - premix</td>
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<tr>
<td>B4193</td>
<td>Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, 52 to 73 g of protein - premix</td>
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<td>B4197</td>
<td>Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, 74 to 100 grams of protein - premix</td>
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<tr>
<td>B4199</td>
<td>Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein - premix</td>
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<tr>
<td>B4216</td>
<td>Parenteral nutrition; additives (vitamins, trace elements, Heparin, electrolytes), home mix, per day</td>
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<tr>
<td>B4220</td>
<td>Parenteral nutrition supply kit; premix, per day</td>
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<tr>
<td>B4222</td>
<td>Parenteral nutrition supply kit; home mix, per day</td>
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<tr>
<td>B4224</td>
<td>Parenteral nutrition administration kit, per day</td>
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<tr>
<td>B5000</td>
<td>Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal - Amirosyn RF, NephrAmine, RenAmine - premix</td>
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</tbody>
</table>
Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic - FreAmine HBC, HepatAmine - premix

Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress - branch chain amino acids - premix

Parenteral nutrition infusion pump, portable

Parenteral nutrition infusion pump, stationary

Home infusion therapy, total parenteral nutrition (TPN); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem (do not use with home infusion codes S9365-S9368 using daily volume scales)

Home infusion therapy, total parenteral nutrition (TPN); 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem

Home infusion therapy, total parenteral nutrition (TPN); more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem

Home infusion therapy, total parenteral nutrition (TPN); more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem

Home infusion therapy, total parenteral nutrition (TPN); more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>A09</td>
<td>Infectious gastroenteritis and colitis, unspecified</td>
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<tr>
<td>B25.2</td>
<td>Cytomegaloviral pancreatitis</td>
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<tr>
<td>C04.0</td>
<td>Malignant neoplasm of anterior floor of mouth</td>
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<tr>
<td>C04.1</td>
<td>Malignant neoplasm of lateral floor of mouth</td>
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<tr>
<td>C04.8</td>
<td>Malignant neoplasm of overlapping sites of floor of mouth</td>
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<tr>
<td>C04.9</td>
<td>Malignant neoplasm of floor of mouth, unspecified</td>
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<tr>
<td>C05.0</td>
<td>Malignant neoplasm of hard palate</td>
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<tr>
<td>C05.1</td>
<td>Malignant neoplasm of soft palate</td>
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<tr>
<td>C05.2</td>
<td>Malignant neoplasm of uvula</td>
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<td>C05.8</td>
<td>Malignant neoplasm of overlapping sites of palate</td>
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<td>C05.9</td>
<td>Malignant neoplasm of palate, unspecified</td>
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<tr>
<td>C06.0</td>
<td>Malignant neoplasm of cheek mucosa</td>
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<td>Malignant neoplasm of vestibule of mouth</td>
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<td>Code</td>
<td>Description</td>
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<td>Malignant neoplasm of body of stomach</td>
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<td>C16.3</td>
<td>Malignant neoplasm of pyloric antrum</td>
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<td>C16.4</td>
<td>Malignant neoplasm of pylorus</td>
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<td>C16.5</td>
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<td>C16.6</td>
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<tr>
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<td>D00.01</td>
<td>Carcinoma in situ of labial mucosa and vermilion border</td>
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<td>D00.02</td>
<td>Carcinoma in situ of buccal mucosa</td>
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<td>D00.03</td>
<td>Carcinoma in situ of gingiva and edentulous alveolar ridge</td>
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<td>Carcinoma in situ of soft palate</td>
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<td>J86.0</td>
<td>Pyothorax with fistula</td>
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<td>Esophageal obstruction</td>
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<tr>
<td>K31.89</td>
<td>Other diseases of stomach and duodenum</td>
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<td>Code</td>
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<td>K31.9</td>
<td>Disease of stomach and duodenum, unspecified</td>
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<td>Left sided colitis with fistula</td>
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<td>K63.2</td>
<td>Fistula of intestine</td>
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<td>K90.81</td>
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<td>Late vomiting of pregnancy</td>
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<td>O21.8</td>
<td>Other vomiting complicating pregnancy</td>
</tr>
<tr>
<td>O21.9</td>
<td>Vomiting of pregnancy, unspecified</td>
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<tr>
<td>Q41.0</td>
<td>Congenital absence, atresia and stenosis of duodenum</td>
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<td>Q41.1</td>
<td>Congenital absence, atresia and stenosis of jejunum</td>
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<td>Q41.2</td>
<td>Congenital absence, atresia and stenosis of ileum</td>
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<tr>
<td>Q41.8</td>
<td>Congenital absence, atresia and stenosis of other specified parts of small intestine</td>
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<tr>
<td>Q41.9</td>
<td>Congenital absence, atresia and stenosis of small intestine, part unspecified</td>
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<tr>
<td>Q42.0</td>
<td>Congenital absence, atresia and stenosis of rectum with fistula</td>
</tr>
<tr>
<td>Q42.1</td>
<td>Congenital absence, atresia and stenosis of rectum without fistula</td>
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<tr>
<td>Q42.2</td>
<td>Congenital absence, atresia and stenosis of anus with fistula</td>
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<td>Q42.3</td>
<td>Congenital absence, atresia and stenosis of anus without fistula</td>
</tr>
<tr>
<td>Q42.8</td>
<td>Congenital absence, atresia and stenosis of other parts of large intestine</td>
</tr>
<tr>
<td>Q42.9</td>
<td>Congenital absence, atresia and stenosis of large intestine, part unspecified</td>
</tr>
<tr>
<td>Q79.2</td>
<td>Exomphalos</td>
</tr>
<tr>
<td>Q79.3</td>
<td>Gastrochisis</td>
</tr>
<tr>
<td>R19.7</td>
<td>Diarrhea, unspecified</td>
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<tr>
<td>R62.51</td>
<td>Failure to thrive (child)</td>
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<tr>
<td>Z94.84</td>
<td>Stem cells transplant status</td>
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**ICD-10 Procedure Codes**

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<th>ICD-10-PCS procedure codes:</th>
<th>Code Description</th>
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<tbody>
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<td>3E0336Z</td>
<td>Introduction of Nutritional Substance into Peripheral Vein, Percutaneous Approach</td>
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<tr>
<td>3E0436Z</td>
<td>Introduction of Nutritional Substance into Central Vein, Percutaneous Approach</td>
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</table>

**Individual Consideration**

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual’s unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289
Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>7/2023</td>
<td>Reformatted Policy.</td>
</tr>
<tr>
<td>1/2018</td>
<td>Updated to include severe PEU as part of the criteria.</td>
</tr>
<tr>
<td>6/2017</td>
<td>Updated address for Pharmacy Operations.</td>
</tr>
<tr>
<td>10/2016</td>
<td>Clarified coding information.</td>
</tr>
<tr>
<td>7/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.</td>
</tr>
<tr>
<td>1/2014</td>
<td>Updated ExpressPAth Language and removed Blue Value.</td>
</tr>
<tr>
<td>2/2012</td>
<td>Updated to correct employee fax number on Home Infusion Therapy Authorization Form.</td>
</tr>
<tr>
<td>2/2012</td>
<td>BCBSA National medical policy review. No changes to policy statements.</td>
</tr>
<tr>
<td>2/2012</td>
<td>BCBSA National medical policy review. No changes to policy statements.</td>
</tr>
<tr>
<td>1/2010</td>
<td>BCBSA National medical policy review. Changes to policy statements.</td>
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<tr>
<td>7/2009</td>
<td>Updated format, definitions removed.</td>
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<td>9/2008</td>
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<tr>
<td>8/2007</td>
<td>BCBSA National medical policy review. No changes to policy statements.</td>
</tr>
</tbody>
</table>

References


**Endnotes**

2. Based upon a 10/1996 national Blue Cross Blue Shield Association policy.
3. Based upon a 7/1995 AMA DATTA (Diagnostic and Therapeutic Technology Assessment) entitled Peripheral Parenteral Nutrition, Glade MJ.
5. Recommendations were the 5/2001 GI Medical Policy Group meeting. For additional information see also Medicare's website at: http://www.umd.nypmc.com/ch18_parenteral.html.
6. Recommendations from Bruce Bistrian, MD, Chief of Clinical Nutrition from Beth Israel Hospital; June 2003
7. Recommendations from Douglas Wilmore, MD, Metabolic Support, Brigham and Women's Hospital; June 2003.
8. Recommendations from David Burns, MD, Nutrition Support, Lahey Clinic Medical Center; June 2003
9. Based upon the 2003 National Policy Based Blue Cross Blue Shield Association national policy 1.02.01, Total Parenteral Nutrition and enteral Nutrition in the Home.

**To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:**
Home Infusion Therapy - Total Parenteral Nutrition (TPN)
Prior Authorization Form

Please complete and fax with the physician's prescription to: (888) 641-5355. If the patient is a BCBSMA employee, please fax the form to: (617)246-4013.

<table>
<thead>
<tr>
<th>Company name:</th>
<th>Contact Name:</th>
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<tbody>
<tr>
<td>Phone #:</td>
<td>Provider #:</td>
</tr>
<tr>
<td>Fax#</td>
<td>Address:</td>
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<tr>
<td>Patient name:</td>
<td>Address:</td>
</tr>
<tr>
<td>Patient ID#:</td>
<td>DOB:<strong><strong>/</strong></strong>/_____</td>
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<table>
<thead>
<tr>
<th>Prescribing Physician/addr:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP name/address:</td>
<td>Telephone:</td>
</tr>
</tbody>
</table>

Is this fax number ‘secure’ for PHI receipt/transmission per HIPAA requirements? (circle one)  Yes  No

Type of Therapy

☐ TPN:  ___ Grams Amino Acids/Day  ___ Days/Weeks  ___ Grams Lipids/Day  ___ Days/Week

Primary Therapy

Primary drug name:  Approximate duration:  ___/___/___ to  ___/___/___

Dose: ____________________________
Frequency: _________________________
Route of administration: ____________________________

Other Therapy

Other drug name:  Approximate duration:  ___/___/___ to  ___/___/___

Dose: ____________________________
Frequency: _________________________
Route of administration: ____________________________

☐ Initial Certification  ☐ Recertification

☐ If this is a “drug only” authorization request, indicate other services the nursing agency is providing:

__________________________________________________________________________________

Nursing provided by: ____________________________
Contact: ____________________________ Fax: ____________________________

Request for 7 Day Coverage:  Date of occurrence:_______________ Request dates:_______________
Occurrence type:  ☐ Hospitalization  ☐ Death  ☐ Change of Therapy

Physician signature: ____________________________  Date:_______________

OR

☐ Copy of physician signed prescription is REQUIRED with this request