State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712
Telephone 1-800-356-1561

Name: _____ Date: _____

STATE APPROVED CLINICAL CRITERIA FOR ENTERAL NUTRITION REQUIRE THAT WE HAVE THE FOLLOWING INFORMATION:

Enteral Product Prescribed: _____

Sig. (be specific as to # of cans per month): _____

Diagnosis: (give specific etiology for malnutrition) _____

1. _____ 2. _____

Current Height: _____ Age/Date of Birth: _____

Current Weight: _____ Previous Weight: _____ Date: _____

Serum Albumin: _____ Date Drawn: _____ No Albumin Done ☐

☐ Age less than 12 ☐ Age 79 or older

Additional information is required for the following:

HIV Patient: CD4 _____ Date _____ Viral Load _____ Date _____

Renal Patient: Post Dialysis Albumin _____ Date _____

Cancer Patient: Type of Cancer _____

Date of Diagnosis: _____

Presently on Chemo/Radiation: Yes ☐ No ☐
Is there evidence of metastasis: Yes ☐ No ☐

Gastrostomy Patient: Yes ☐ No ☐

Pregnancy: Estimated Due Date _____

☐ DISCONTINUE PRESENT THERAPY ☐ CONTINUE PRESENT THERAPY

Please confirm the medical necessity of the prescribed enteral therapy. Complete and sign this form within 10 days of the above date and mail to the above address. Please note that failure to respond to this request will result in future denial of enteral therapy.

Physician Signature: _____ Date: _____