Pediatric/Adult Formula

Prior Authorization Request Form

For all ages

Clear Form

FAX: 508-756-1382

Member:		Member ID:
Member DOB:		Member Age:
PCP:		PCP TIN:
PCP Phone:		PCP Fax:
Requesting MD:		Requesting MD TIN:
Requesting MD Phone:		Requesting MD fax:
Contact Name:		Contact Number:
Diagnosis:		
Birth Weight:	Current Weight:	Percentile:
For premature infant, gestational age at birth:		
The following are **REQUIRED** before request will be processed: ☐Current clinical notes ☐Growth chart ☐Prescriptions for GERD – *with dates* ☐Documentation per Condition Specific Criteria		

FORMULA	TRIAL START/DURATION	WEIGHT	SYMPTOMS
Milk Based:			
Soy Based:			
Other Formula Tried:			

Formula Requested: _____

Please select one of the covered conditions:

CONDITION select one	INITIAL REVIEW	SUBSEQUENT REQUESTS
☐ **ATOPIC DERMATITIS**	☐ Allergist confirmation of formula induced atopic dermatitis ☐ Documentation confirming role of commercial formula in causing atopic dermatitis	If age > 1 year, must provide **ALL** of the following: ☐ Nutritionist consultation ☐ % calories from formula _____ ☐ Allergist re-evaluation ☐ Consideration of re-trial of commercial foods or formula (Reason for contraindication: _____
☐ **BLOODY STOOLS**	☐ Guaiac testing confirms blood ☐ Other etiologies (e.g. fissure, inflammatory/infectious colitis) excluded ☐ Bloody stools occurred on milk based formula or breastfeeding and dairy elimination diet resolved issue	If age>1 year, must provide **ALL** of the following: ☐ Nutritionist consultation ☐ % calories from formula _____ ☐ Gastroenterologist evaluation ☐ Retrial of commercial formula unless contraindicated (Reason for contraindication: _____
☐ **EOSINOPHILIC ESOPHAGITIS/ GASTROENTERITIS**	☐ Endoscopy/biopsy ☐ Gastroenterology consultation (Allergist if indicated) ☐ Elimination diet or supportive IgE specific antibody testing confirmation that symptoms are caused by milk and soy	If age> 1 year, must provide the following: ☐ Nutritionist consultation ☐ % calories from formula _____ ☐ Follow-up endoscopy
☐ **FAILURE TO THRIVE**	**Any** of the following (0-24 months): ☐ Decrease of 2 or more major weight for age percentile lines ☐ Weight less than 5th percentile for age (corrected for prematurity) ☐ Weight for length less than 10th percentile ☐ Age 2-18: BMI < 5th percentile For adults **Any** of the following: ☐ Involuntary loss of >10% of usual body weight over 3-6 months; **or** ☐ BMI less than the 5th percentile, or 18.5 kg/m2**.** ☐ If on dialysis: BMI<22 or serum albumin <4 g/dl ☐ If cystic fibrosis: weight for length or BMI <25th percentile	If age>1 year, must provide **ALL** of the following: ☐ Nutrition consult ☐ % calories from formula _____ ☐ Appropriate specialist evaluation ☐ Clinical reassessment ☐ Evidence of attempts or inability to tolerate supplementation with commercially available foods and nutritional supplements if appropriate ☐ Written plan of care for regular monitoring

☐ **GERD**	History and PE confirms high probability of GERD characterized by **ALL** of the following: ☐ Regurgitation with complication (e.g. blood in regurgitated food) ☐ Nutritional compromise (i.e. severe vomiting, weight loss, lack of weight gain) due to insufficient caloric intake or formula refusal If transitioning from breast milk: ☐ Appropriate maternal elimination diet For formula fed infants, trials of following have not resolved symptoms: ☐ Milk based ☐ Soy based ☐ Thickened feeds	Subsequent requests up to age 1 must include: ☐ Symptoms significantly improved with special medical formula ☐ Retrial of commercially available food or formula were unsuccessful (unless contraindicated Reason for contraindication:_____ ☐ Gastroenterologist confirms ongoing need for requested special formula Subsequent request age>1 year must include **ALL:** ☐ Nutritionist consultation ☐ % calories from formula _____ ☐ Gastroenterologist evaluation ☐ Retrial of commercially available food or formula were unsuccessful (unless contraindicated Reason for contraindication:_____
☐ **GI IRRITABILITY**	☐ Documentation confirms infant up to 6 months has severe and persistent symptoms ☐ Documentation of nutritional compromise If 6-12 months: Documentation must confirm: ☐ Trial of commercial formula was unsuccessful ☐ Gastroenterologist evaluation confirms ongoing use of special formula is medically necessary	☐ Documentation confirms infant up to 6 months has severe and persistent symptoms ☐ Documentation of nutritional compromise If 6-12 months: Documentation must confirm: ☐ Trial of commercial formula was unsuccessful ☐ Gastroenterologist evaluation confirms ongoing use of special formula is medically necessary If age>1 year, must provide **ALL** of the following: ☐ Nutritionist consultation ☐ % calories from formula _____ ☐ Gastroenterologist evaluation ☐ Retrial of commercial formula unless contraindicated (Reason for contraindication:

☐ **IgE MEDIATED FOOD ALLERGY**	**ANY** of the following confirmed by documentation: ☐ Severe vomiting and abdominal pain within minutes to hours of food ingestion ☐ Severe diarrhea within 6 hours of food ingestion ☐ Pruritus ☐ Angioedema and urticarial ☐ Stridor, wheezing, or anaphylaxis If non-urticarial rash or rash and negative IgE to soy: ☐ Documentation of failed commercial formula trial	If age>1 year, must provide **ALL** of the following: ☐ Nutritionist consultation ☐ % calories from formula _____ ☐ Allergist evaluation ☐ Retrial of commercial formula unless contraindicated (Reason for contraindication: _____
☐ **INBORN ERROR OF METABOLISM**	☐ Letter of medical necessity documenting clinical history, supportive evaluation and testing	☐ Letter of medical necessity documenting clinical history, supportive evaluation and testing
☐ **KETOGENIC FORMULA FOR UNCONTROLLED SEIZURES**	☐ Seizures refractory to standard medications	**ALL** of the following: ☐ Nutritionist consultation ☐ % calories from formula _____
☐ **MALABSORPTION**	**ALL** of the following confirmed by documentation: ☐ Diagnosis of food protein-induced enteropathy or enterocolitis confirmed by pediatric gastroenterologist ☐ Symptoms occurred while being fed mild-based formula or breast milk and symptoms resolved with dairy elimination diet Diagnosis of **ANY** of the following: ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Gastrointestinal Motility Disorders ☐ Chronic Intestinal Pseudo-Obstruction ☐ Cystic Fibrosis	If age>1 year, must provide **ALL** of the following: ☐ Nutritionist consultation ☐ % calories from formula _____ ☐ Gastroenterologist evaluation ☐ Clinical reassessment ☐ Retrial of commercial formula unless contraindicated (Reason for contraindication: _____
☐ **PREMATURITY**	Authorized up to 3 months of life if documentation confirms **EITHER:** ☐ Birth weight 1500g or less and hospital discharge weight less than 10th percentile for age corrected for prematurity ☐ Intolerance to cow mild-based formula due to ANY covered condition	☐ All requests related to premature infants >3 months of life are re-evaluated against relevant Covered Condition Criteria.

MD SIGNATURE:_____ Date:_____