Harvard Pilgrim Health Care

Pedi/Adult Formula
Prior Authorization Request Form
For all ages

Fax completed form with supportive documentation to:
800-232-0816

Clear Form

Member:	Member ID#:	
Member DOB:	Member age:	
PCP:	PCP NPI:	
PCP phone:	PCP fax:	
Requesting MD:	Requesting MD NPI:	
Requesting MD phone:	Requesting MD fax:	
Contact's name:	Contact phone:	
Diagnosis (Required information):		
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 Date/Duration	Weight	Symptoms
Milk based:			
Soy based:			
Other formulas 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 ***all*** of 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

Condition — select one	Initial Review	Subsequent Requests
☐ 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 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: _____)

Condition — select one	Initial Review	Subsequent Requests
☐ 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 commercially available food or formula were unsuccessful 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: _____