INFANT NUTRITION BENEFITS AUTHORIZATION REQUEST FORM
Therapeutic Formula

- Therapeutic formula is a conditional benefit of the CalViva Health Medi-Cal program.
- Members should not be referred to the Women, Infants and Children (WIC) program to receive this benefit.
- Nutritional supplements/replacements are provided as a therapeutic regimen for patients with medically diagnosed conditions when that condition precludes the full use of regular foods. The medical necessity of the product should be differentiated from the use as a convenience item.

To expedite, include chart notes. This form is for directly contracting fee-for-service (FFS) Medi-Cal providers.
Fax form to 1-800-743-1655.

Parent/guardian name: (Last, first):_____ **Primary telephone #:**_____
Member name (infant) (Last, first):_____ **DOB:** _____ **Member ID #:**_____
Address (City, state, ZIP code): _____ **Alt. telephone #:**_____

Requesting provider: **PCP:** _____ **Medical group:** _____

Name:_____ Telephone #:_____ Fax #:_____

Address (City, state, ZIP code):_____

Premature Infant Formula/Caloric Dense (for example: Neosure,® Enfacare® Profree, Lofenalac,® Vivonex,® Similac® PM 60/40, Neocate® One, Peptamin Jr.,® Portagen®)	**Formula requested:** _____ **Qty/Mo:**_____ **Duration:** _____ (months)	**Diagnosis: (ICD-10 code required)** ☐ **P07.2** Prematurity/LBW ☐ **P92.9** Prematurity – feeding problem ☐ **P05.1** Small for gestational age ☐ Other:_____ ☐ Other:_____	**Medical justification** ☐ Gestational age_____ ☐ Birth weight _____ ☐ Need for additional protein, calcium and phosphorus for 1 yr **Notes:** _____ _____	**CCS referral:** ☐ Yes ☐ No **If "Yes," status of referral:** _____ _____ **Approved CCS-eligible condition:** _____
Hypoallergenic (Elemental) Formula *(for milk protein intolerance)* (for example: Nutramigen,® Alimentum,® Elecare,® and Peptamin®)	**Formula requested:** _____ **Qty/Mo:** _____ **Duration:** _____ (months)* *Extended formula requests, for longer than 3 months, require a milk/soy rechallenge for reauthorization.	**Diagnosis: (ICD-10 code required)** ☐ **L50.9** Urticaria ☐ **T78.2** Anaphylaxis ☐ **L25.9** Eczema ☐ **L27.2** Food allergy dermatitis ☐ **R19.7** Diarrhea ☐ **R11.1** Persistent vomiting ☐ **K52.9** Allergic gastroenteritis ☐ **K52.21** Milk protein enterocolitis ☐ Other: _____	**Labs** – Include results if any of the following tests obtained: ☐ Positive RAST test ☐ Serum IGE ☐ Positive stool heme ☐ Fecal leukocytes ☐ Positive skin testing ☐ Gastric biopsy ☐ Elevated serum eosinophils ☐ Positive stool for reducing substance ☐ Other:_____ _____	**CCS referral:** ☐ Yes ☐ No **If "Yes," status of referral:** _____ _____ **Approved CCS-eligible condition:** _____
Formulas/ Supplements (for example: Pediasure,® Ensure,® Ensure Plus,® Isocal,® Jevity,® Kindercal,® Boost,® and Boost Plus®)	**Formula requested:** _____ **Qty/Mo:**_____ **Duration:**_____ (months)* *Extended formula requests, for longer than 3 months, require documentation of nutritional requirements for reauthorization.	**Diagnosis: (ICD-10 code required)** ☐ **P92.9** Slow weight gain/FTT (newborn) ☐ **R62.51** Slow weight gain/FTT (older infant) ☐ **R13.1** Dysphagia – diff swallowing ☐ **Q38.3** Anomaly of tongue ☐ **Q35.9** Cleft palate ☐ **Q36.9** Cleft lip ☐ **Q37.9** Cleft palate w/cleft lip ☐ Other: _____	**Medical justification** ☐ Does child have problems eating, swallowing or absorbing food? _____ ☐ Child is fed by gastrostomy tube. If so, what percentage of calories? _____ ☐ _____% of total daily calories comes from formula. **Notes:** _____ _____	**CCS referral:** ☐ Yes ☐ No **If "Yes," status of referral:** _____ _____ **Approved CCS-eligible condition:** _____
Banked Human Milk	**Qty/Mo:**_____ **Duration:**_____ (months)* *Extended human milk requests, for longer than 3 months, require medical justification for reauthorization.	**Diagnosis: (ICD-10 code required)** Baby must be intolerant to all therapeutic formulas ***and*** mom has a condition preventing breastfeeding. ☐ _____ ☐ _____ ☐ _____	**Medical justification** **Notes:** _____ _____ _____	**CCS referral:** ☐ Yes ☐ No **If "Yes," status of referral:** _____ _____ **Approved CCS-eligible condition:** _____

Print physician name: _____ Physician signature: _____ Date: _____