Please include chart notes.
Upload form to authorization or fax form to (916) 424-6200.

vivanthealth

Infant Nutrition Benefits Authorization Request Form – Therapeutic Formula

- Therapeutic formula is a conditional benefit of the Medi-Cal program.
- Members should not be referred to the 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.

Infant member name: ______________________

Infant date of birth: ______________________ Infant member ID: ______________________

Parent/guardian name: ______________________

Mother's member ID: ______________ Phone number: ______________ Alt. number: ______________

Address: ______________________

Requesting provider: ______________________ **Primary care provider:** ______________________

Telephone number: ______________________ Fax: ______________________

Signature: ______________________ **Date:** ______________________

Premature Infant Formula/Caloric Dense (for example: Neosure, Enfacare Profree, Lofenalac, Lacto Free, Criticare, Vivonex, Sim 60/40, Neocare, Neocate One, Peptamen Jr., Portagen, and Vivonex Pediatric)
Formula request: ______________________ Qty./month: ______________ Duration (mos.): ______________

Diagnosis (ICD-10 code required):
- ☐ P0730 Preterm newborn uns. weeks gest.
- ☐ P92.9 Feeding problem of newborn uns.
- ☐ P05.10 Newborn small gest. age uns. weight
- ☐ Other: ______________

Medical Justification:
- ☐ Gestational age ______________ ☐ Birth weight ______________
- ☐ Need for additional protein, calcium, and phosphorus for 1 year

Notes: ______________________

Hypoallergenic (Elemental) Formula (for milk protein intolerance; for example: Nutramigen, Alimentum, EleCare, and Peptamen)
Formula request: ______________________ Qty./month: ______________ Duration (mos.): ______________
*Extended formula requests, for longer than 3 months, require a milk/soy re-challenge for re-authorization

Diagnosis (ICD-10 code required):
- ☐ L5039 Urticaria unspecified
- ☐ T78.2XXA Anaphylactic shock uns. initial
- ☐ L30.9 Dermatitis unspecified
- ☐ L27.2 Dermatitis due to ingested food
- ☐ R19.7 Diarrhea, unspecified
- ☐ R11.10 Vomiting unspecified
- ☐ K52.2 Allergic and dietetic GE and colitis
- ☐ Other ______________

Labs: (include results if any of the following tests obtained):
- ☐ Positive RAST test
- ☐ Positive stool heme
- ☐ Positive skin testing
- ☐ Elevated serum eosinophils
- ☐ Positive stool for reducing substance
- ☐ Serum IGE
- ☐ Fecal leukocytes
- ☐ Gastric biopsy
- ☐ Other ______________

Formula/Supplements (for example: PediaSure, Ensure, Ensure Plus, Sustacal with fiber, Isocal, Jevity, Kindercal, Boost, and Boost Plus)
Formula request: ______________________ Qty./month: ______________ Duration (mos.): ______________
*Extended formula requests, for longer than 3 months, require a milk/soy re-challenge for re-authorization

Diagnosis (ICD-10 code required):
- ☐ P92.3 Failure to thrive in newborn
- ☐ R62.51 Failure to thrive child
- ☐ R13.0 Dysphagia unspecified
- ☐ Q38.3 Anomaly of tongue
- ☐ Q35.9 Cleft palate unspecified
- ☐ Q36.9 Cleft lip unilateral
- ☐ Q37.9 Uns. cleft palate with uni. cleft lip
- ☐ Other ______________

Medical Justification:
- ☐ Does child have problems eating, swallowing, or absorbing food? ______________
- ☐ Child is fed gastrostomy tube. If so, what percentage of calories? Calories: ______
- ☐ ______% of total daily calorie comes from formula

Notes: ______________________

Banked Human Milk Qty./month: ______________ Duration (mos.): ______________
*Extended formula requests, for longer than 3 months, require a milk/soy re-challenge for re-authorization

Diagnosis (ICD-10 code required):
Baby must be intolerant to all therapeutic formulas ***and*** mom has a condition preventing breastfeeding.
- ☐ ______________________
- ☐ ______________________

Medical Justification:
Notes: ______________________

CSS referral: ☐ Yes ☐ No If yes, status of referral ______________________

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