

Neighborhood Health Plan of RI

Nutritional Supplement Request Form

NHPRI is secondary to WIC Benefits. WIC covers infant formula & nutritional supplements for **(1) infants and children under 5 years of age, (2) pregnant women, (3) and breastfeeding mothers.** WIC can be reached at 1-800-WIC-7434. WIC uses a preferred list of nutritional supplements that should clinically meet the member's medical needs. WIC's preferred products should be utilized, if clinically appropriate, before NHPRI reviews a prior authorization for a supplement not covered by WIC. **NHPRI** does not cover any infant formula because infant formula is classified as **food and not as a "supplement"**. **Food(s)** is excluded from coverage.

Instructions: This form is to be filled out completely and faxed back to 866-423-0945 NHPRI Customer Service (tel) 459-6020

<u>Patient Name (required):</u>	<u>Patient NHPRI # (required):</u>
<u>Patient DOB (required):</u>	<u>Diagnosis (required):</u>
<u>Physician Name/Specialty:</u>	<u>Physician Telephone Number and Fax (required):</u>
<u>Physician DEA #:</u>	<u>Name of contact person at Physician's office:</u>
<u>Name of nutritional supplement:</u>	<u>Caloric intake desired per day with supplements:</u>
<u>Quantity (per month in number of cans):</u>	<u>Expected Length of Treatment (please be specific):</u>

Date _____ Kg _____ cm

Current Weight/Percentile _____ lbs _____ % Height/Percentile _____ in _____ % BMI _____

Past Weight _____ Date _____ Past Weight _____ Date _____

Yes No Member is pregnant or breastfeeding. If yes, please refer member to WIC for nutritional supplement coverage.

Yes No Member is currently receiving nutritional supplement through WIC. If yes, how much is WIC supplying?

Yes No Member is > 5 years old and the nutritional formula is their sole source of nutrition, or

Yes No Member has diagnosis of HIV or AIDS or

Yes No Member is under 7 years old and has a diagnosis of "failure to thrive" (**growth charts must be submitted**) or

Yes No Member is age 7 or above who has a recent unplanned weight loss of at least 10%, and
(please circle one)

- a. Increased metabolic need resulting from severe trauma, or
- b. Malabsorption difficulties (e.g., short-gut syndrome, fistula, cystic fibrosis, renal dialysis), or
- c. Ongoing cancer treatment or pulmonary insufficiency, or
- d. Nutritional deficiency shown by recent low serum protein levels, or
licensed nutritionist/dietician assessment shows sufficient caloric/protein intake is not obtainable through regular, liquefied or pureed foods.
- e. Anorexia Nervosa (<15% IBW)

Others (please describe in details): _____

Approve indefinitely for HIV patients. Approve for 3 months for all other diagnoses. On re-authorizations, consider age of infant or child and most recent weight with nutritional supplement requirement vs. solid intake.

Provider's Signature _____ NPI _____ Date _____

Who is supplying the supplement? (Check box) contracted DME or Home Infusion vendors Retail Pharmacy