# REQUEST FOR NUTRITIONAL SUPPLEMENT

☐ Living Choice ☐ Medically Fragile

| Participant Name | | | | |
|---|---|---|---|---|
| | *Last* | *First* | *M.I.* | *SoonerCare ID* |

## A. DESCRIPTION

Oral Nutritional Supplements provide medically necessary nutrient intake for individuals with special nutritional needs related to a specific medical condition for which the use of oral nutritional supplements is an accepted treatment. The participant must either have a medical condition requiring special nutrients or preventing him/her from obtaining sufficient nutrients with food alone, have a Body Mass Index below 21, or have experienced a significant weight loss.

## B. TYPE OF REQUEST

☐ New Request ☐ Request for extension ☐ Request for change in authorized product and/or quantity

## C. PRESCRIPTION

Physician's prescription must include specific product name, amount, frequency and related diagnosis.

☐ **Physician's prescription attached (required)** Product Name: ______________________

Amount & Frequency: ________________________________ Related Diagnosis: ______________________

## D. CURRENT RELATED MEDICAL CONDITIONS (Please check all that apply and indicate date of onset.)

| Condition | Date of Onset | Condition | Date of Onset |
|---|---|---|---|
| ☐ Renal Dialysis | | ☐ Other | |
| ☐ Chemotherapy<br>Frequency: ______________ | | ☐ Other | |
| ☐ Radiation<br>Frequency: ______________ | | **Wounds** | **Date of Onset** |
| ☐ Burns (within past 3 months)<br>Location/Degree: ____________ | | ☐ Location: ______________<br>Stage/Type: ____________ | |
| ☐ Sepsis (within past 3 months)<br>Type: ____________________ | | ☐ Location: ______________<br>Stage/Type: ____________ | |
| ☐ Major Surgery (within past 3 months)<br>Type/Location: ____________ | | ☐ Location: ______________<br>Stage/Type: ____________ | |
| ☐ Major Trauma (within past 3 months)<br>Type: ____________________ | | ☐ Location: ______________<br>Stage/Type: ____________ | |

## E. HEIGHT/WEIGHT INFORMATION

1. Participant's current height/weight: ________ / ________ Date weighed: ____________________________
2. Participant's Body Mass Index (BMI): ________________

   BMI below 21: ☐ Yes (skip to Section F – authorization guideline met) ☐ No (continue to #3 below)
3. Previously documented weight: ___________ From: ☐ UCAT ☐ RN Eval ☐ Other _______________
4. Date of previous weight: _________________ Total pounds lost: __________ % body weight lost: ________
5. Documented weight loss: ☐ 10% loss past 6 months ☐ 5% loss past 30 days ☐ Neither

## F. CORRESPONDING GOALS

☐ **Corresponding goals attached (required)**

Corresponding goals must include the following information:

1) The nutritional outcome of the request (wound healing, increased weight, etc.);
2) What steps are to be taken to meet nutritional goals and by whom; and
3) How, how often, and by whom progress toward outcome will be assessed.

## G. ADDITIONAL SUPPORTING DOCUMENTATION (Optional)

| | | | |
|---|---|---|---|
| **Signature of Participant or Legal Agent**<br>*(If Participant signs with a mark, two witnesses are required.)* | **Date** | **Signature of TCCM** | **Date** |
| | | | |
| **Signature of Witness** | **Date** | **Signature of Witness** | **Date** |

## AUTHORIZATION GUIDELINES

Authorization for payment of oral nutritional supplement products requires documentation of medical necessity by the TC/CM. An Orally Administered Nutritional Supplement – Documentation of Need must be completed and signed by the Participant and the TC/CM. The TC/CM must document the medical need for which oral nutritional supplement is an accepted treatment, the nutritional outcome, action steps and monitoring plan. The TC/CM must submit:

1. a completed and signed Request for Nutritional Supplement form
2. a copy of physician's prescription The prescription must include specific product, amount, frequency, and related diagnosis for which the nutritional supplement is being prescribed)
3. the Plan or Plan Addendum for authorization (please indicate amount requested in monthly quantity).