Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: _____________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

# Horizon NJ Health

## *Nutritional Supplements– Medical Necessity Request*

**For all members, please complete this section:**

Current Weight: _______lbs. Date Taken*: _______
_______kg

Weight 6 months ago: __________ lbs
__________kg

Current Height: ______________ Date Taken: _________

* Weight must be obtained within the past 30 days for initial requests and 60 days for subsequent (renewal) requests

- Will the member be eating or drinking any other food/pureed food besides the requested supplement)? **Yes or No**
    - If No, please provide clinical reason why member will not be eating or drinking any other food/pureed food besides the requested supplement _________________________
      ___________________________________
- Will this product be administered via a feeding tube (e.g., G-tube, NG-tube)? **Yes or No**

**For members less than 5 years of age, please complete this section:**

1. Does the member qualify for the WIC (Women, Infants, and Children) program*? **Yes or No**
    - **a.** Has the member tried to obtain the medication through WIC? **Yes or No**
2. Does the member have a WIC medical necessity denial letter? **Yes or No**
3. Does WIC offer a viable alternative to the product being requested? **Yes or No**
    - a. If yes, can the physician prescribe the WIC-covered alternative? **Yes or No**
        - i. If no, why not? ______________________________
4. Is the request in excess of the number of cans that WIC allows? **Yes or No**
    - a. If yes, how many additional cans are being requested per month? _____
    - b. Are the additional cans medically necessary? **Yes or No**

*** Please note that the member needs to try to obtain the medication through WIC first. If denied by WIC, a WIC medical necessity denial letter must be obtained and faxed to HNJH at 609-538-0847.**

**Diagnosis Information** (please select diagnosis and provide requested information):

□ General Nutritional Deficiency

□ Inability to swallow solid food. (Please indicate the specific reason member cannot swallow solid foods.)
- □ Broken Jaw
- □ Anatomical inability to swallow (i.e. head and neck cancer or tumor of the esophagus or stomach)
- □ Central Nervous system disease
- □ Receiving nutrition via feeding tube
- □ Other: _____________________________

□ Inherited/Congenital Metabolic Disease or Condition (i.e. Phenylketonuria, Cystic Fibrosis, etc.)
- Please list the specific disorder: ______________________________

□ Pregnancy
- Is the member currently pregnant? **Yes or No**
- Please provide the due date _______________

□ Dysphagia or Swallowing disorder (due to e.g stroke, brain injury, spinal cord injury, GERD, esophagitis)
- Please list specific disorder
  ____________________________

□ HIV/AIDS Wasting

□ Surgery

**Physician office's signature*_______________________________ Print Name______________________________**

***Form must be completed and signed by physician or licensed representative from the physician's office**.

Member Name: _____________________________ Member ID: _______________ Member DOB: _______________

Drug Name: ____________________________ Strength: _______________ Directions: _____________________________________

Physician Name: _________________________ Physician Phone #: ________________________ Specialty: ____________________

Physician Fax #: ____________________ Pharmacy Name: ___________________________Pharmacy Phone: _________________

□ Post-op
□ Upcoming surgery
- Is a liquid diet required? **Yes or No**

□ Ketogenic Diet
- Does the member have epilepsy? **Yes or No**

□ Failure to Thrive
□ Other: ______________________________

**Physician office's signature*______________________________ Print Name______________________________**
***Form must be completed and signed by physician or licensed representative from the physician's office**.