



County

ORALLY ADMINISTERED NUTRITIONAL SUPPLEMENT DOCUMENTATION OF NEED

Member Name			
	<i>Last</i>	<i>First</i>	<i>Middle</i>
Address			
	<i>Street</i>	<i>City</i>	<i>State</i> <i>Zip</i>
Medicaid #			

A. PRESCRIPTION FROM MEMBER'S PHYSICIAN (Attach copy of physician's prescription)

B. RELATED DIAGNOSES (please check the appropriate box(es))

<input type="checkbox"/> Anorexia	<input type="checkbox"/> Pancreatic Insufficiency
<input type="checkbox"/> Acquired Immunodeficiency Syndrome (AIDS)	<input type="checkbox"/> Pncreatitis
<input type="checkbox"/> Burns	<input type="checkbox"/> Pulmonary Dysfunction
<input type="checkbox"/> Cancer	<input type="checkbox"/> Renal Dysfunction
<input type="checkbox"/> Dehydration	<input type="checkbox"/> Sepsis, Prolonged
<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Surgery, Major
<input type="checkbox"/> Gastrointestinal Disorders	<input type="checkbox"/> Trauma, Major
<input type="checkbox"/> Hepatic Dysfunction	<input type="checkbox"/> Wounds
<input type="checkbox"/> Malnutrition	<input type="checkbox"/> Other _____

C. HEIGHT/WEIGHT

Has the Member experienced a 10% or greater unintentional weight loss in the past 6 months? YES NO

D. TREATMENT GOAL

(i.e., wound healing; weight goal)

E. TREATMENT PLAN

Product Name _____ Amount and Frequency _____

F. PLAN FOR MONITORING PROGRESS TOWARD TREATMENT GOAL

(How, how often and by whom progress toward treatment goal will be assessed)

Signature of Member or Legal Agent <i>(If Consumer signs with mark, two witnesses are required)</i>			Date
Signature of Witness	Date	Signature of Witness	Date
Signature of Case Manager			Date

AUTHORIZATION GUIDELINE

Authorization for payment for oral nutritional supplement products requires documentation of medical necessity by the Case Manager. An Oral Nutritional Supplement Documentation of Need must be completed and signed by the Member's and the Case Manager to document clinical need, a treatment goal, a treatment plan and monitoring of clinical outcomes. The ADvantage Case Manager will submit the completed form and a copy of the Physician's prescription with the ADvantage Service Plan or Service Plan Addendum for authorization. This form will replace the outcome related to nutritional supplements on the service plan goals.

AUTHORIZATION CRITERIA

Any Related Diagnosis listed in **Section B**

AND From **Section C** – Height/Weight - 10% or more unintentional weight loss within the last 6 months

OR The Related Diagnosis in **Section B** is burns, wounds, sepsis, major surgery or major trauma

AND

Nutritional Outcome and Action Steps that at a *minimum* include:
Section D – a treatment goal (i.e. weight goal, wound healing),
Section E – product name, the amount and frequency,
Section F – and a monitoring strategy that specifies how, how often, and by whom progress toward the expected outcome will be assessed.