

Revised: April 1997  
Approval: W.M.L.

## **Newborn Child Coverage**

### **Benefit Coverage**

Services will be covered for newborns for the month of birth and the following month under the mother's I.D. and capitation. For a child born in the month immediately preceding the mother's enrollment, the newborn will be covered during the mother's first month of enrollment.

### **Examples of Covered Benefits**

1. Medically necessary nursery care for the baby while the mother is hospitalized.
2. Medically necessary nursery care when the baby is ill (NICU) and needs to remain in the hospital for medical reasons after the mother is discharged.
3. Office visits during the first month and the month following birth.

Revised: December 1995

Approval: W.M.L.

**Nutritional/Dietetic Counseling**

**See: Health Education**

## **Nutritional Supplements and Special Formulas**

### **Benefit Coverage**

1. Outpatient Nutritional Supplements
  - a. For children under age 5, routine formulas can be obtained through the Women, Infants, and Children Program (WIC). By submitting a special request form (see attached samples) to WIC, a provider may request a non-contracted formula needed because of intolerance problems. Individuals not eligible for WIC must purchase routine formulas at their expense.
  - b. Special formulas for infants, such as Nutramigen and Pregestimil, will be provided through IEHP contracted pharmacies. Nutritional supplements can be obtained under the pharmacy benefit by submitting a Pharmacy Exception Request (PER) accompanied by the IEHP Nutritional Evaluation Form (attached).
  - c. Nutritional supplements, such as Ensure, Sustacal, etc., for any Member requires prior authorization and will be provided through IEHP contracted pharmacies. Nutritional supplements can be obtained under the pharmacy benefit by submitting a PER accompanied by the IEHP Nutritional Evaluation Form (see attached forms).
2. Inpatient Nutritional Supplements
  - a. Nutritional supplements for treatment during hospital acute care or inpatient extended care, including those provided at time of discharge, are covered by the formulary of the hospital and are the financial responsibility of the Member's assigned hospital.

### **Benefit Exclusion**

1. Routine formulas are not covered by IEHP.
2. Nutritional supplements are not covered on the IEHP Formulary unless medically necessary and not obtainable through WIC.
3. Nutritional supplements are not covered unless prior authorization is obtained through the PER process including the completion of a Nutritional Evaluation Form (attached).

## **Nutritional Supplements and Special Formulas** (continued)

### Benefit Exclusion (continued)

4. Non-FDA approved supplements are not a covered benefit.

### Examples of Covered Benefits

1. Nutritional supplements covered under the IEHP Formulary when prescribed by a licensed practitioner and meeting IEHP prior authorization requirements.

### Examples of Non-Covered Benefits

1. Outpatient nutritional supplements without prior authorization.
2. Nutritional supplements available through WIC.
3. Nutritional supplements requested by patient as patient preference.
4. Routine formulas for infants or children



INLAND EMPIRE HEALTH PLAN

## INFANT NUTRITIONAL EVALUATION FORM

**TO BE COMPLETED BY PRESCRIBING PHYSICIAN ONLY**  
**PLEASE FAX THIS FORM TO (909) 890-2058**

**Member Name:** \_\_\_\_\_ **IEHP ID #:** \_\_\_\_\_

**Member DOB:** \_\_\_\_\_ **Nutritional Supplement Requested:** \_\_\_\_\_

Normal Infant Formula are not covered (covered thru WIC, to find the nearest WIC local agency, please call California State WIC Branch at 1-888-942-9675; County of Riverside Health Services Agency, Department of Public Health: 800-455-4942; San Bernardino County Department of Public Health: 909-387-8301).

Please provide information below:

- If member needs Infant Formula due to medical conditions, please specify and provide documentation:  
\_\_\_\_\_
- ICD-9: \_\_\_\_\_
- Hypoallergenic **infant formula** (Alimentum, Nutramigen) will only be covered if soy-protein based formula has been tried, and with documented allergic symptoms:  
\_\_\_\_\_
- This baby has tried other infant formula \_\_\_\_\_ before and failed.

Please note that most infant formula requests are covered up to 1 year of age unless it is medically necessary (documentation required). Weight must be less than 25% of the median weight for age.

1. What is your estimate of the duration of need for the requested nutritional product by this patient?  
\_\_\_\_\_
2. How many cans/bottles/packets will this patient require per day/week/month? \_\_\_\_\_ per \_\_\_\_\_
3. What is the patient's current height and weight? **Height:** \_\_\_\_\_' \_\_\_\_\_" **Weight:** \_\_\_\_\_lbs.
  - a. Weight: \_\_\_\_\_% of median weight (weight must be less than 25% of the median weight for age)
  - b. Please document this patient's most recent weight loss.
  - c. How much weight lost: \_\_\_\_\_lbs. Over what period of time: \_\_\_\_\_
4. Other comments: \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**303 E. Vanderbilt Way, Suite 100, San Bernardino, CA 92408**  
**FAX (909) 890-2058**

Revised 7/08



INLAND EMPIRE HEALTH PLAN

### ADULT NUTRITIONAL EVALUATION FORM

**TO BE COMPLETED BY PRESCRIBING PHYSICIAN ONLY  
PLEASE FAX THIS FORM TO (909) 890-2058**

**Member Name:** \_\_\_\_\_ **IEHP ID #:** \_\_\_\_\_

**Member DOB:** \_\_\_\_\_ **Nutritional Supplement Requested:** \_\_\_\_\_

Please provide information below:

- If member needs ADULT NUTRITIONAL SUPPLEMENT due to medical conditions, please specify and provide documentation:

\_\_\_\_\_

\_\_\_\_\_

- ICD-9: \_\_\_\_\_

- Please explain why normal diet is not sufficient.

\_\_\_\_\_

\_\_\_\_\_

Please note that most adult nutritional supplement requests are covered only with medical conditions (documentation required) that may cause extensive weight loss. Weight must be less than 25% of the median weight for age, or BMI<18 kg/m<sup>2</sup>.

1. What is your estimate of the duration of need for the requested nutritional product by this patient?

\_\_\_\_\_

2. How many cans/bottles/packets will this patient require per day/week/month? \_\_\_\_\_ per \_\_\_\_\_

3. What is the patient's current height and weight? **Height:** \_\_\_\_\_' \_\_\_\_\_" **Weight:** \_\_\_\_\_lbs.

- a. Weight: \_\_\_\_\_% of median weight or BMI= \_\_\_\_\_ kg/m<sup>2</sup> (weight must be less than 75% of the median weight for age, or BMI<18 kg/m<sup>2</sup>)

- b. Please document this patient's most recent weight loss.

- c. How much weight lost: \_\_\_\_\_lbs. Over what period of time: \_\_\_\_\_

4. Other comments: \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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