



INLAND EMPIRE HEALTH PLAN

This policy has been developed through review of medical literature, consideration of medical necessity, generally accepted medical practice standards, and approved by the IEHP Pharmacy and Therapeutics Subcommittee.

Drug: Adult Nutritional Supplement

Class: Nutritional Supplement

Formulary medication: N/A

Effective Date: January 2005, revised November 2006, August 2008, August 2009

Policy/Criteria:

1. Conditions meeting criteria for authorizations include:
 - Inflammatory bowel disease ● Carcinoma of the GI Tract ● Short-bowel syndrome
 - Fistulas of the GI tract ● Pancreatitis and pancreatic insufficiency ● Malabsorption
 - Vascular disease of the small bowel ● Radiation and chemotherapeutic enteropathy
 - Enteral (tube) feeding ● Inborn errors of metabolism ● Food allergies and intolerances
 - AIDS/HIV with weight loss
2. Member's weight must be less than normal BMI (<18.5)
3. Member cannot maintain adequate nutrition with ordinary diet. Alternative nutritional program must be tried or considered (such as pureed or blenderized foods, dietary management, etc).
4. Physician must submit Nutritional Evaluation Form to IEHP for approval.



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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 75% of the median weight for age, or BMI<18 kg/m².

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/m² (weight must be less than 75% of the median weight for age, or BMI<18 kg/m²)
- 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: _____