## REQUEST FOR NUTRITIONAL SUPPLEMENT

	Living	g 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 & Frequence	cy:		Related Diagnos	sis:	
D. CURRENT RELATED MEDICAL CONDITIONS (Please check all that apply and indicate date of onset.)				·	
- <u></u>	Condition		Condition		Date of Onset
Renal Dialysis			☐ Other		
Chemotherapy			☐ Other		
Frequency:					
Radiation			Wounds		Data of Open
Frequency:			woulius		Date of Onset
☐ Burns (within past 3 months)			Location:		_
Location/Degree:			Stage/Type:		
Sepsis (within past 3 months)			Location:		
Type:			Stage/Type:		
☐ Major Surgery (within past 3 months)			Location:		
Type/Location:			Stage/Type:		_
	within past 3 months)		Location:		
Type:			Stage/Type:		

E. HEIGHT/WEIGHT INFORMATION						
Participant's current height/weight:/						
BMI below 21:	orization guideline met)					
3. Previously documented weight: From: UCAT RN Eval Other						
4. Date of previous weight: Total pounds lost: % body weight lost:						
5. Documented weight loss:						
or became neighbors. If now less passes mentals I are less passes tally I have need						
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	s and by whom; and					
How, how often, and by whom progress toward outcome will be assessed.						
G. ADDITIONAL SUPPORTING DOCUMENTATION (O	ntional)_					
G. ADDITIONAL SUFFORTING DOCUMENTATION (O	ptionary					
Signature of Participant or Legal Agent Date (If Participant signs with a mark, two witnesses are required.)	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).