



**POLICY 310 – GG – ATTACHMENT A - AHCCCS CERTIFICATE OF MEDICAL NECESSITY FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS, FOR MEMBERS 21 YEARS OF AGE AND OLDER – INITIAL OR ONGOING REQUESTS**

**NOTE:** A Prior Authorization is not required for the first 30 days with members who require oral supplemental nutritional feedings on a temporary basis due to an emergent condition, for e.g. post-hospitalization.

**MEMBER INFORMATION**

**MEMBER NAME:** \_\_\_\_\_ **AHCCCS ID NUMBER:** \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

**DATE OF BIRTH:** \_\_\_\_\_

**MEMBER ADDRESS:** \_\_\_\_\_

**CONTRACTED HEALTH PLAN:** \_\_\_\_\_

**ASSESSMENT PERFORMED BY:** \_\_\_\_\_ **AHCCCS PROVIDER ID:** \_\_\_\_\_

**PROVIDER SPECIALTY:** \_\_\_\_\_ **ASSESSMENT DATE:** \_\_\_\_\_

**TELEPHONE NUMBER:** \_\_\_\_\_

**TYPE OF REQUEST**

**TYPE OF NUTRITION**

- Initial
- Ongoing
- Weaning from Tube Feeding
- Oral Feeding – Supplemental
- Oral Feeding –Sole Source
- Emergency Supplemental Nutrition

**ORAL PREFERRED SUPPLEMENT** Type: \_\_\_\_\_

Substitution Permissible:  Yes  No

**ASSESSMENT:** (Supporting documentation dated within three months of this request must be submitted with the Certificate of medical necessity to support each of the criteria indicated below.)

**THE MEMBER SHALL MEET EACH OF THE FOLLOWING REQUIREMENTS:**

1. Currently underweight with a BMI of less than 18.5,
2. Nutritional status presents serious health consequences,
3. Demonstrated, medically significant decline in weight,
4. Is able to consume/eat no more than 25% of his/her nutritional requirements from typical food sources,
5. Has been assessed and treated for medical conditions that could cause undernourishment and/or,
6. Has had a documented trial of higher caloric foods, blended foods or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration.

**MEDICAL DOCUMENTATION/CERTIFICATE OF MEDICAL NECESSITY**

Initial and ~~o~~Ongoing ~~c~~Certificate of ~~m~~Medical ~~n~~Necessity is considered valid for a period of six months. Subsequent submissions must include a current physical assessment in the form of a clinical note or other supporting documentation that includes the members overall response to therapy and justification for continued therapy. This must include the member’s tolerance to therapy, recent hospitalizations, current height, weight, and BMI. Additionally, encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included within the documentation, when appropriate.

\_\_\_\_\_  
SUBMITTING PROVIDER SIGNATURE\_\_\_\_\_  
DATE\_\_\_\_\_  
PRINTED NAME\_\_\_\_\_  
PROVIDER TYPE\_\_\_\_\_  
CONTACT NUMBER