THE OHIO STATE UNIVERSITY
HEALTH PLAN

Infant Formula
Prior Authorization Request Form

700 Ackerman Road, Suite 1007
Columbus, OH 43202
Phone 614-292-4700 or 800-678-6269

Up to age 1 year

Member:	Member ID Number:	
Member DOB:	Member Age:	
PCP:	Phone:	Fax:
Requesting MD:	Phone:	Fax:
Office Contact:	Phone:	Fax:
Diagnosis:		
Birth weight:	Current Weight:	Percentile:
For premature infant, gestational age at birth:		

The following are **Required** before request will be processed:
☐ Current clinical notes
☐ Growth chart
☐ Prescriptions for GERD (with dates)

FORMULA	TRIAL START DATE/ DURATION	WEIGHT	SIGNS, SYMPTOMS
Milk based:			
Soy based:			
Other formulas tried:			

Exact formula name and dose as it appears on the prescription:

_____

MD Signature: _____ Date: _____

Email completed form with supportive documentation
to: UtilizationManagement.OSUHealthPlan@osumc.edu
or fax to: 614-292-2667