THE OHIO STATE UNIVERSITY
HEALTH PLAN

Infant Formula Request Form (Up to age 1 year)

Submit completed form and supporting documentation to

UtilizationManagement.OSUHealthPlan@OSUMC.edu or fax to 614-292-2667

General Information		
Covered Person (Patient):	**ID Number:**	
DOB:	**Age:**	
Physician Information		
PCP:	**Phone:**	**Fax:**
Requesting MD:	**Phone:**	**Fax:**
Office Contact:	**Phone:**	**Fax:**
Vendor Information		
Vendor Name:	**Address:**	
TIN:	**Contact Name:**	
Phone:	**Fax:**	
Clinical Information		
Diagnosis:		
Birth weight:	**Current Weight:**	**Percentile:**
For premature infant, gestational age at birth:		
Formula trials:		

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

Exact formula name and dose as it appears on the prescription:		
Billing Information		
ICD-10 Code(s):	**HCPCS Code(s):**	**Units Requested (per month):**

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