

**Infant Formula Request Form (Up to age 1 year)**

Submit completed form and supporting documentation to

[UtilizationManagement.OSUHealthPlan@OSUMC.edu](mailto:UtilizationManagement.OSUHealthPlan@OSUMC.edu) or fax to 614-292-2667

<b>General Information</b>			
<b>Covered Person (Patient):</b>		<b>ID Number:</b>	
<b>DOB:</b>		<b>Age:</b>	
<b>Physician Information</b>			
<b>PCP:</b>		<b>Phone:</b>	<b>Fax:</b>
<b>Requesting MD:</b>		<b>Phone:</b>	<b>Fax:</b>
<b>Office Contact:</b>		<b>Phone:</b>	<b>Fax:</b>
<b>Vendor Information</b>			
<b>Vendor Name:</b>		<b>Address:</b>	
<b>TIN:</b>		<b>Contact Name:</b>	
<b>Phone:</b>		<b>Fax:</b>	
<b>Clinical Information</b>			
<b>Diagnosis:</b>			
<b>Birth weight:</b>		<b>Current Weight:</b>	<b>Percentile:</b>
<b>For premature infant, gestational age at birth:</b>			
<b>Formula trials:</b>			
<b>FORMULA</b>	<b>TRIAL START DATE/</b>	<b>WEIGHT</b>	<b>SIGNS, SYMPTOMS</b>
<b>Milk based:</b>			
<b>Soy based:</b>			
<b>Other formulas tried:</b>			
<b>Exact formula name and dose as it appears on the prescription:</b>			
<b>Billing Information</b>			
<b>ICD-10 Code(s):</b>		<b>HCPCS Code(s):</b>	<b>Units Requested (per month):</b>

<b>The following are Required before request will be processed:</b>
<input type="checkbox"/> <b>Current clinical notes</b>
<input type="checkbox"/> <b>Growth charts</b>
<input type="checkbox"/> <b>Prescriptions for GERD (with dates)</b>

**NOTICE:** This message is intended for the use of the individual(s) to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you have received this message in error, please notify the sender immediately and delete the related message.