SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Amino Acid Formula

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Ordering provider name (print)	Telephone number	Fax number
Place of service: ☐ Home ☐ Skilled nursing facility ☐ Other _____		
DME name		
Vendor contact name	Vendor telephone number	Vendor fax number
DME vendor address		
Procedure information		
Scheduled date of service or equipment to be received (month/day/year)	Requested service/procedure/DME	HCPC code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

Does the member have:

eosinophilic esophagitis ..... ☐ Yes ☐ No

eosinophilic gastroenteritis ..... ☐ Yes ☐ No

eosinophilic colitis ..... ☐ Yes ☐ No

severe atopy or eczema with multiple food allergy syndrome (IgE mediated) confirmed by skin testing ..... ☐ Yes ☐ No

Coverage of amino acid-based infant formula will be considered for infants with demonstrated milk and soy food protein-induced enterocolitis syndrome.

Diagnosis confirmed by:

pediatric allergist ..... ☐ Yes ☐ No

If yes, provider name _____ Date (m/d/y) _____ /_____ /_____

pediatric gastroenterologist ..... ☐ Yes ☐ No

If yes, provider name _____ Date (m/d/y) _____ /_____ /_____

Has the member failure of an adequate trial of a protein hydrolysate formula (Alimentum® or Nutramigen®) ..... ☐ Yes ☐ No

How long was the trial of each product _____

Is the infant breast fed . . . . . ☐ Yes ☐ No

If yes, there must be documentation that the mother had eliminated milk and soy from her diet, and that the infant also failed a trial of protein hydrolysate formula

Expected course of treatment _____

_____

Duration of treatment with amino acid-based infant formula _____

_____

Is the primary source of formula supplied by WIC (Women, Infants, and Children). . . . . ☐ Yes ☐ No

What type of formula is being recommended _____

Does the formula contain 100% free amino acids as the protein source. . . . . ☐ Yes ☐ No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to: Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715-221-9918	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Provider Assistance at 1-800-548-1224.

