EXHIBIT 430-2
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
(EPSDT AGED MEMBERS - INITIAL OR ONGOING REQUESTS)

MEMBER INFORMATION Member's AHCCCS ID Number: _____ Contracted Health Plan: _____

Member's Name: _____ Date of Birth: _____
Last *First* *Initial*

Members' Address: _____

Assessment performed by: _____ AHCCCS Provider ID: _____

Provider Specialty: _____ Telephone Number: _____ Assessment Date: _____

TYPE OF REQUEST ☐ Initial ☐ Ongoing **PREFERRED SUPPLEMENT** Type: _____

Substitution Permissible: ☐ Yes ☐ No

TYPE OF NUTRITION FEEDING ☐ Weaning from Tube Feeding

☐ Oral Feeding –Sole Source ☐ Oral Feeding – Supplemental ☐ Emergency Supplemental Nutrition

ASSESSMENT FINDINGS: Indicate which of the following criteria have been met to support that oral supplemental nutritional feedings are medically necessary. (Supporting documentation dated no earlier than 3 months prior to the date of this request must be submitted with the Certificate of Medical Necessity to support each of the criteria selected below.)

Member Meets the Criteria in the Left Column *OR* Meets at Least Two Criteria in the Right Column	
☐ Member has been diagnosed with a chronic disease or condition, is below the recommended BMI percentile (or weight-for-length percentile for members less than two years of age) for the diagnosis per evidence-based guidance as issued by the American Academy of Pediatrics, and there are no alternatives for adequate nutrition.	**Use the space below, to indicate which *two* or more criteria have been met:** ☐ Member is at or below the 10th percentile for weight-for-length/BMI, on the appropriate growth chart for their age and gender, for 3 months or more. ☐ Member has reached a plateau in growth and/or nutritional status for more than 6 months, or more than 3 months if member is an infant less than 1 year of age. ☐ Member has already demonstrated a medically significant decline in weight within the 3 month period prior to the assessment. ☐ Member is able to consume/eat no more than 25% of nutritional requirements from age-appropriate food sources.
Additionally, Both of the Following Requirements Must be Met	
• The member has been evaluated and treated for medical conditions that may cause problems with growth (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems, etc.), **AND**	
• The member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration. ** Refer to AMPM, Policy 430.	

Initial and Ongoing Certificate of Medical Necessity is valid for a period of 6 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 supplemental therapy and justification for continued supplement use. This must include the member's tolerance to formula, recent hospitalizations, current height/weight percentiles, and BMI percentile for members two years of age or older. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

_____ _____
Submitting Provider Signature Date

_____ _____ _____
Printed Name Provider Type Contact Number