THE OHIO STATE UNIVERSITY
HEALTH PLAN

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

Pediatric and Adult Formula
Prior Authorization Request Form

Member:	Member ID Number:	
Member DOB:	Member Age:	
PCP:	Phone:	Fax:
Requesting MD:	Phone:	Fax:
Office Contact:	Phone:	Fax:
Diagnosis:		
Height:	Current Weight:	Percentile:
Current diet:		
Percent of nutrition from formula:		
Exact formula and dose as it appears on prescription:		

The following are **Required** before request will be processed:
☐ Current clinical notes
☐ Documented clinical notes of retrial of milk and/or soy
☐ Growth chart
☐ Pediatric Gastroenterologist or allergist consultation
☐ Current nutritionist's report, including nutritional and caloric intake, and caloric goals

MD Signature: _____ Date: _____

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