A Public Entity
Inland Empire Health Plan

Drug Class Prior Authorization Criteria
Pediatric Enteral Nutritional Supplement

Line of Business: Medicaid
P & T Approval Date: November 20, 2019 **Effective Date:** January 1, 2020

This criteria has been developed through review of medical literature, consideration of medical necessity, generally accepted medical practice standards, and approved by the IEHP Pharmacy and Therapeutics Subcommittee.

Background:

Physicians must provide medical justification for nutritional supplementation on the IEHP Prescription Drug Prior Authorization Request Form (RX PA). For information that may be necessary for nutritional supplementation justification, please review our IEHP Nutritional Evaluation Form (NEF).

Nutritional supplements are a Medicaid covered benefit when they are used in a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food. IEHP provides coverage for all medically necessary Medi-Cal covered enteral nutrition products, and to ensure that these services are provided in an amount no less than what is offered to beneficiaries under Medi-Cal fee-for-service.

Please see the following link for the complete list of products that are offered by Medi-Cal fee-for-service: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral_a04p00.doc

BOOST KID ESSENTIALS, COMPLEAT PEDIATRIC, NUTREN JUNIOR, PEDIASURE

Covered Uses:	All FDA-approved indications
Exclusion Criteria:	N/A
Required Medical Information:	Must meet "1" of the following requirements: a. Enteral Feeding administered through a feeding tube (e.g. gastric, nasogastric, jejunostomy tubes) b. Have a chronic medical diagnosis and unable to meet nutritional needs with dietary adjustment of regular or soft or pureed foods c. Documented clinical signs and symptoms that the member is nutritionally at risk (e.g. stunting, wasting, underweight, involuntary weight loss), as supported by weight-for-age, weight-for-length, or growth chart

d. Severe swallowing or chewing difficulty due to one of the following requirements:
   i. Cancer in the mouth, throat or esophagus
   ii. Injury, trauma, surgery or radiation therapy involving the head or neck
   iii. Chronic neurological disorders
   iv. Severe craniofacial anomalies
e. Transitioning from parenteral or enteral tube feeding to an oral diet

Emergency request: A one-time emergency one-month supply of enteral pediatric supplement is available in order to avoid disruption of regimen continuity, while IEHP conducts a medical necessity review

Age Restrictions: Must be between the ages of 1 and 13 years old

Prescriber Restriction: N/A

ALFAMINO JUNIOR, ELECARE JUNIOR, PEDIASURE PEPTIDE, PEPTAMEN JUNIOR, PEPTIDE JUNIOR, NEOCATE JUNIOR

Covered Uses: All FDA-approved indications

Exclusion Criteria: N/A

Required Medical Information:

Must meet "1" of the following requirements:
a. Intestinal malabsorption diagnosis (ICD-10-CM codes K90.0-K90.9 and K91.2); lactose intolerance alone is excluded
b. Must meet ALL of the following requirements:
   i. Have a chronic medical diagnosis with clinical signs and symptoms of inability to absorb nutrients or to tolerate intact food protein
   ii. Must have a history of use with a standard or specialized disease-specific enteral nutrition product that failed to provide adequate nutrition unless such products are medically contraindicated

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Age Restrictions:	Must be between the ages of 1 and 13 years old
Prescriber Restriction:	N/A
Other Criteria:	Emergency request: A one-time emergency one-month supply of enteral pediatric supplement is available in order to avoid disruption of regimen continuity, while IEHP conducts a medical necessity review

METABOLIC ENTERAL NUTRITION PRODUCTS (E.G. **GLUTAREX, KETONEX**)

Covered Use:	Inborn errors of metabolism
Exclusion Criteria:	CCS Eligible
Required Medical Information:	Consult IEPH pharmacist if not already covered by CCS.
Age Restrictions:	N/A
Prescriber Restriction:	N/A

References:

1. DHCS Medi-Cal Provider Manual Part 2 – Pharmacy: Enteral Nutrition Products. Available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral_a04p00.doc. Accessed April 2, 2019.

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Change Control		
Date	**Change**	**RPH**
11/20/2019	• Updated criteria to align with DHCS guidelines	CN
05/15/2019	• Renew with format changes only	ND
02/20/2019	• Added Criteria blurb "IEHP provides coverage for all medically necessary Medi-Cal covered enteral nutrition products, and to ensure that these services are provided in an amount no less than what is offered to beneficiaries under Medi-Cal fee-for-service" to specify coverage for products not on the criteria.	ND
05/16/2018	• Reformatted document	HC
04/26/2019	• Renew with no changes	JM