

**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 <i>OR</i> Meets at Least Two Criteria in the Right Column	
<input type="checkbox"/> 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.	<p style="margin: 0;"><b>Use the space below, to indicate which <i>two</i> or more criteria have been met:</b></p> <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> Member has already demonstrated a medically significant decline in weight within the 3 month period prior to the assessment. <input type="checkbox"/> 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	
<ul style="list-style-type: none"> <li>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.), <b>AND</b></li> <li>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. <b>** Refer to AMPM, Policy 430.</b></li> </ul>	

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