

RYAN WHITE PROGRAM NUTRITIONAL SUPPLEMENTS

Letter of Medical Necessity for Supplementation in ADULTS

Date: _____

As the primary medical caretaker for _____, who has a diagnosis of HIV/AIDS, it is my considered opinion that he/she requires enteric nutritional supplements.

I believe that nutritional supplements are medically indicated in this case and I have referred this patient for a professional Nutritional Assessment by a Registered Dietitian/Nutritionist.

I understand enteral nutrition must be evaluated by a Dietitian/Nutritionist every _____. (Please indicate period of time for nutritional re-evaluation. Number of refills authorized cannot exceed this period of time.)

Sincerely,

_____, M. D./ D.O./ ARNP/ PA-C

SIGNATURE

(Physician, Nurse Practitioner or Physician Assistant)

PRINT NAME

(Physician, Nurse Practitioner or Physician Assistant)

Florida Medical License #

PRINT NAME

(Registered Dietitian/Nutritionist)

SIGNATURE

(Registered Dietitian/Nutritionist)

Dietitian/Nutritionist Florida License #

Nutrition Products Available Through the Ryan White Program

Physician/ Nurse Practitioner/ Physician Assistant/ Dietitian/Nutritionist, please indicate preferred product, flavor, number of servings recommended and number of refills authorized. (Dietitian/Nutritionist, please refer to the Criteria for Dispensing Nutritional Supplements FORM for patient's nutritional assessment on back page.)

Please document patient's: Height: _____ Weight: _____ Lbs Kgs IBW/UBW: _____ Lbs Kgs

NOTE: 1 Serving = 2 Scoops

Progain Powder - ___ No. of **SERVINGS per DAY** Vanilla Chocolate
(HIGH calorie product)

Number of Refills Authorized _____

(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/dietitian as indicated above)

IgG Pure - ___ No. of **SERVINGS per DAY** (Only natural flavor available)
(LOW calorie product)

Number of Refills Authorized _____

(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/ dietitian as indicated above)

Please note: If the patient is on MEDICAID, please refer to the MEDICAID Medical Necessity Request Letter.

Patient's 10 digit MEDICAID Number: _____

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

**RYAN WHITE PROGRAM
CRITERIA FOR DISPENSING NUTRITIONAL SUPPLEMENTS**

The following are potential situations where commercial nutritional supplements could be considered medically indicated.

Patient must meet at least two (2) criteria listed below.

(Consultation with a Registered Dietitian/Nutritionist for nutritional assessment and a Letter of Medical Necessity are required.)

Please check all that apply:

- Current body weight < 10% IBW/UBW
- Weight loss of:
 - 5% of the initial/baseline weight over the past month -OR-
 - 7.5% over the past 3 months -OR-
 - 10% weight loss within the last 6 months
- Body Cell Mass (BCM) < 40% (MALES) or BCM < 35% (FEMALE) of IBW
- Body Mass Index (BMI) < 20
- Recent illness/hospitalization that will interfere with patient's ability to consume or tolerate adequate non-supplemental nutrition
- Diarrhea/malabsorption with > 3 large, liquid stools/day
- Dysphagia and/or odonyphagia where commercial supplements are the only source of nutrition tolerated
- Serum albumin < 3.5 g/dl
- Failure to gain/maintain weight in the past when following a dietary regimen to promote weight gain
- Inadequate living conditions or inability to buy/prepare meals
- Inability to understand and or follow nutritional recommendations

NUTRITIONAL PLAN FOR SUPPLEMENTS

I. INITIAL Consultation: Date: _____ Weight: _____

Patient assessed/instructed by Registered Dietitian/Nutritionist: **(Please check the appropriate box)**

- Nutritional supplements **recommended** Nutritional supplements **NOT** recommended

II. FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

- Nutritional supplements **continued** Nutritional supplements **discontinued**

III. ADDT'L FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

- Nutritional supplements **continued** Nutritional supplements **discontinued**

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

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