

# Oral Nutritional Supplements

**Included Products:** Boost, Boost High Protein, Boost Plus, Ensure, Ensure Enlive, Ensure High Protein, Ensure Light, Ensure Plus, Ensure Plus HN, Jevity, Liquid Nutrition, Liquid Nutrition Plus, Nubasics, Nubasics Plus, Nutrition Plus, Osmolite, Pediasure, Pediasure with Fiber, Peptamen, Peptamen Junior, Promod, Resource, Resource Plus, Resource Diabetic

Created: 06/07/2010

Revised: 05/09/2024

Reviewed: 05/09/2024

Updated: 06/01/2024

## Age 6 years or Older

Initial Criteria		If yes	If no
1.	Is the nutritional supplement to be administered via enteral tube feeding (e.g. G-tube, NG-tube)?  Note: for tube feedings, please submit via a DME vendor thru the DME benefit.	Close request.	Continue to #2.
2.	Is the member currently on oral nutritional supplements?	Continue to #3.	Continue to #4.
3.	Has there been an annual assessment by the MD or RD for continued use and documentation indicates there is weight maintenance (no continued weight loss or low serum protein)?	Continue to #7.	Do not approve.
4.	Does the member have a nutritional deficiency identified by any ONE of the following? a. Total protein < 5.6g/dl or albumin < 3.4g/dl or b. Registered Dietician assessment in the past 3 months indicates sufficient caloric/protein intake is not obtainable through regular, liquefied or pureed foods (i.e., liquefied/pureed foods have been tried and failed)	Continue to #6.	Continue to #5.
5.	Does the member meet BOTH of the following criteria? a. Prolonged history (years) of malnutrition and diagnosis or symptoms of cachexia and member resides in a home, nursing facility, or chronic home care facility. b. Obtaining criteria from question #4 would be futile and invasive.	Continue to #6.	Do not approve.

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6.	<p>Does the member have an unplanned weight loss of <math>\geq 10\%</math>* and ONE of the following criteria?</p> <ul style="list-style-type: none"> <li>a. Severe trauma resulting in increased metabolic need (e.g., severe burn, major bone fracture), or</li> <li>b. Malabsorption difficulty (e.g., Crohn's disease, short-gut syndrome, bowel resection, fistula, gastric bypass, cystic fibrosis, renal dialysis, dysphagia, achalasia), or</li> <li>c. Diagnosis that requires additional calories (cancer, AIDS, Pulmonary insufficiency MS, ALS, Parkinson's, cerebral palsy, Alzheimer's)</li> </ul> <p>*Weight loss criteria may be waived if body weight is being maintained by supplements due to member's medical condition (e.g., renal failure, AIDS)</p>	Continue to #7.	Do not approve.
7.	Approve for life.		

## Age Younger than 6 Years

Initial Criteria	If yes	If no
<p>1. Is the nutritional supplement to be administered via enteral tube feeding (e.g. G-tube, NG-tube)?</p> <p>Note: for tube feedings, please submit via a DME vendor thru the DME benefit.</p>	Close request.	Continue to #2.
2. Is the request for a non-standard infant formula to meet a unique medical indication?	Refer for medical director review.	Continue to #3
3. Is the member currently on oral nutritional supplements?	Continue to #4.	Continue to #5.
4. Has there been an annual assessment by the MD or RD for continued use and documentation indicates there is weight maintenance?	Continue to #8.	Do not approve.
5. Does the member have a diagnosis of failure to thrive?	Continue to #6.	Do not approve.
<p>6. Does the member have a nutritional deficiency identified by any ONE of the following?</p> <ul style="list-style-type: none"> <li>a. Total protein &lt; 5.6g/dl or Albumin &lt; 3.4g/dl, or</li> <li>b. Registered dietician assessment in the past 3 months indicates sufficient caloric/protein intake is not attainable through regular, liquified or purified foods.</li> </ul>	Continue to #7.	Do not approve

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7.	<p>Does the member meet ONE of the following criteria?</p> <ul style="list-style-type: none"> <li>a. Severe trauma resulting in increased metabolic need (e.g., severe burn, major bone fracture), or</li> <li>b. Malabsorption difficulty (e.g., Crohn’s disease, short-gut syndrome, bowel resection, fistula, gastric bypass, cystic fibrosis, renal dialysis, dysphagia, achalasia), or</li> <li>c. Diagnosis that requires additional calories (cancer, AIDS, Pulmonary insufficiency MS, ALS, Parkinson’s, cerebral palsy, Alzheimer’s)</li> </ul>	Continue to #8	Do not approve
8.	Approve for 12 months.		

Is the request for a non-standard infant formula to meet a unique medical indication? Yes,

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