OKLAHOMA
Health Care Authority | Serving Oklahomans through SoonerCare

DONOR HUMAN MILK REQUEST FORM

(Must be reordered every 90 days)

This form must be substantiated and accompanied by written documentation from the member's clinical record of why the particular infant cannot survive and gain weight on any appropriate formula, such as an elemental formula or enteral nutritional product other than donor human breast milk, and that a clinical feeding trial of an appropriate, nutritional product has been considered with each authorization.

<table>
<tr><th colspan="4">Part A</th></tr>
<tr><td colspan="2">Member's Name:</td><td colspan="2">Member's Medicaid Number:</td></tr>
<tr><td>Date of Birth:</td><td>Weight:</td><td colspan="2">Diagnosis:</td></tr>
<tr><td colspan="4">Date of last feeding trial and what was tried:</td></tr>
<tr><td colspan="4">The infant has one or more of the following conditions:
a) _____ Infant born at Very Low Birth Weight (VLBW) (less than 1.500 grams or lower); or
b) _____ Gastrointestinal anomaly, metabolic/digestive disorder or recovery from intestinal surgery where digestive needs require additional support; or
c) _____ Diagnosed failure to thrive; or
d) _____ Formula intolerance with either 1) documented feeding difficulty or 2) weight loss; or
e) _____ Infant hypoglycemia; or
f) _____ Congenital heart disease; or
g) _____ Pre- or post organ transplant; or
h) _____ Other serious health conditions where the use of donor breast milk is medically necessary and will support the treatment and recovery of the infant, please explain:</td></tr>
<tr><td colspan="4">Infant's biological mother's milk is:
a) _____ Contraindicated
b) _____ Unavailable due to medical or psychosocial condition
c) _____ Available but is insufficient to meet infant's dietary needs</td></tr>
<tr><td colspan="4">The parent/guardian has signed and dated an informed consent that the risks and benefits of using banked donor human milk have been discussed with them. ____Yes ____ No</td></tr>
<tr><td>Dates of service requested:</td><td colspan="2">From:</td><td>To:</td></tr>
<tr><td colspan="3">Ounces of donor human milk per day being ordered:</td><td>Total Ounces Requested:</td></tr>
</table>

ADDRESS
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

WEBSITES
oklahoma.gov/ohca
mysoonercare.org

PHONE
Admin: 405-522-7300
Helpline: 800-987-7767

Ordering Provider's Signature:	Date:
Ordering Provider's Name:	Provider's Phone#:
SoonerCare Provider ID:	

Part B		
The particular donor human milk bank adheres to quality guidelines consistent with the Human Milk Banking Association of North America Yes _____ No _____		
Milk Bank Name:	Milk Bank Phone #:	
Milk Bank Street Address:		
City:	State:	ZIP+4:
SoonerCare Provider ID or NPI:		
Part C		
Dispensing Provider Name:		
Dispensing Provider Address:		
City:	State:	ZIP+4:
SoonerCare Provider ID:		

ADDRESS
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

WEBSITES
oklahoma.gov/ohca
mysoonercare.org

PHONE
Admin: 405-522-7300
Helpline: 800-987-7767