HUSKY Health Program Donor Breast Milk
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.

Member Information		
Member ID #:		Member Name (Last, First):
DOB:	Sex:	Primary Diagnosis Code:
Address:		City, State, Zip:
Milk Bank/Billing Provider Information		
Medicaid Billing #:		Billing Provider Name (Last, First):
Address:		City, State, Zip:
Contact Name:		Contact Fax #:
Contact Phone #:		
Ordering/Referring Provider Information		
Medicaid ID #:		Referring Provider Name (Last, First):
Phone #:	Fax #:	NPI #:
Address:		City, State, Zip:
Authorization Information		
HCPCS Code: T2101		# of 100 ml bottles in 30-day authorization period:
Start Date:		End Date:

Initial Authorization Requests:
Please fill out completely and attach a signed letter of medical necessity from prescribing practitioner in inpatient hospital setting, additional relevant clinical documentation, and pricing information.

1. Current age of infant: _____ months		
2. Is donor breast milk the best option to supplement the infant's medical/nutritional needs?	◯ Yes	◯ No
3. Does the infant have a congenital or acquired condition for which feeding with human milk is particularly advantageous to support treatment and recovery? If yes, please indicate condition: _____	◯ Yes	◯ No
4. Is the infant unable to receive maternal breast milk due to it being unsuitable for consumption secondary to infectious disease, medication, or other maternal condition, or is the infant's mother unable to produce enough breast milk to promote growth and development?	◯ Yes	◯ No

Reauthorization Requests:
Please fill out completely and attach relevant clinical documentation, a signed prescription, and pricing information**. For infants six months of age and older, please also attach a feeding trial and transition plan.**

1.Current age of infant: _____ months		
2. Is the infant currently on supplemental donor breast milk?	◯ Yes	◯ No
3. Does supplemental donor breast milk continue to be the best option for supplementing the medical/nutritional needs of the infant?	◯ Yes	◯ No
4. Does the infant have a congenital or acquired condition for which feeding with human milk is particularly advantageous to support treatment and recovery? If yes, please indicate condition:_____	◯ Yes	◯ No
5. Does the infant require the continuation of supplemental donor breast milk?	◯ Yes	◯ No

Certification Statement: This is to certify that the requested item is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.

Provider Signature:	Date: