Exceptional Request Form: Infant Formula

	PROTECTED B WHEN COMPLETED

SECTION 1: PRESCRIBER/PATIENT INFORMATION

Prescriber Name: **Prescriber Address:** **Prescriber Phone:**	**Fax:**	**Prescriber #:** **Date (dd/mm/yyyy):**
Patient's Surname: **DOB (dd/mm/yyyy):**		**Given Name(s):** **Gender:**
Parent/Guardian	**Surname:** **Status #:**	**Given Name(s):** **DOB (dd/mm/yyyy):**
Pharmacy Name:		**Pharmacy Phone:**
Infant Formula Requested:		**DIN:**

SECTION 2: TO BE COMPLETED BY PRESCRIBER (PHYSICIAN OR REGISTERED DIETITIAN)

Infant Formula Coverage for Children < 1 Year Of Age (Corrected Gestational Age for Prematurity)

- Nutrition products **will not be approved for the following conditions:** colic, constipation, fussiness, gas, prevention of allergies, sleeping problems, spitting up, or a supplement to breastfeeding, or replacement of breastfeeding.
- If approved, coverage for nutrition products will be provided for an **initial period of six to twelve months** depending on the nature of the request. Reassessment is required for continued coverage.

Nutrition product requested :____

Percentage (%) of daily caloric intake that this nutrition product represents or will represent:________________%

Expected duration of therapy: ☐ 3 months ☐ 6 months ☐ 9 months ☐ until first birthday

Underlying medical condition that is causing difficulties with feeding: ____

Please specify route of administration: ☐ Oral (continue to **SECTION A**) ☐ Enteral (continue to **SECTION B**)

SECTION A: Please indicate the **primary** reason for infant formula

☐ Prematurity or ☐ Low birth weight Gestational age at birth: _______ weeks Growth chart percentile for corrected gestational age: _____ Birth weight: _______kgs Current weight: ___kgs Other information: _____________________________________	☐ Cow milk protein allergy: Nutrition products tried and the outcome: Formula: ____________ Outcome: ________________________ Formula: ____________ Outcome: ________________________ Formula: ____________ Outcome: ________________________
☐ Contraindication for breastfeeding[1] ☐ HIV ☐ Hepatitis C ☐ Active Tuberculosis ☐ Herpetic lesions on breast ☐ Other contraindication (specify): __________________ (1) https://www.canada.ca/en/health-canada/services/canada-food-guide/resources/infant-feeding/nutrition-healthy-term-infants-recommendations-birth-six-months.html#a10	☐ Failture to thrive/growth faltering: Growth chart percentiles: At Birth: __________ Current: __________Date:___________ (dd/mm/yyyy) Has there been a decrease in the percentile ranking of two growth parameters? ☐ Yes ☐ No If yes, please describe: _________________________________ ____ ____ ____ ____
☐ Other reason (not already listed; please specify) ____ Specific symptoms: ___________________________________ Rationale for the use of an Infant Formula: _______________ ____	

SECTION B:

If available, please provide any of the following documents to support the request:

☐ The consultation report(s) by other health care professionals relevant to the request, e.g. dietician.
☐ A copy of the discharge summary if the client has been recently hospitalized.

Prescriber Signature: _______________________	**Date (dd/mm/yyyy):** ________________

FAX TOLL FREE: 1-888-299-9222 or Mail To:

Health Benefits
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