PLEASE SIGN AND FAX THIS FORM TO 1-877-433-8066. FOR QUESTIONS, PLEASE CALL 1-800-558-7677.

PATHWAY SERVICES REQUEST FORM FOR **SIMILAC EXPERT CARE® ALIMENTUM®***

1 SERVICE REQUESTED

Please select which service you are requesting:

○ Benefit Verification ○ Prior Authorization Support ○ Appeals Assistance ○ Claims Support

2 PATIENT INFORMATION

Patient Name ______________________ Date of Birth ______________________

Parent/Guardian Name ______________________ Relationship to Patient ______________________

Street Address ______________________ City/State/ZIP ______________________

Home Phone # ______________ Work/Cell Phone # ______________ Social Security # ______________

Allergies ______________________ Patient/Caregiver Primary Language ______________________

Gender ○ Male ○ Female

3 INSURANCE INFORMATION

(ATTACH A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD)

Primary Insurance Company ______________________ Secondary Insurance Company ______________________

Primary Insurance Company Phone # ______________________ Secondary Insurance Company Phone # ______________________

Subscriber Name ______________________ Subscriber Name ______________________

Subscriber ID # ______________________ Subscriber ID # ______________________

Policy/Employer/Group # ______________________ Policy/Employer/Group # ______________________

4 DIAGNOSIS

REQUIRED: *Please indicate ICD-9 or ICD-10 code(s) here* ______________

Similac Alimentum is a nutritionally complete, hypoallergenic formula for infants with colic symptoms due to protein sensitivity or a supplemental beverage for children with severe food allergies, sensitivity to intact protein, protein maldigestion or fat malabsorption.

○ Corn Allergy (Alimentum Ready to Feed Only)
○ Food Allergy
○ Eczema
○ Other ______________________
○ Sensitivity to Intact Protein, Allergic Colitis
○ Fat Malabsorption, Protein Maldigestion

5 RECOMMENDED PRODUCT

Powder Formula: ○ 1-lb Cans Ready to Feed Formula: ○ 1-qt Reclosable Bottles

6 DOSAGE INFORMATION

Based on my patient's current medical condition, I am prescribing __________ CALORIES and __________ OUNCES/mL per day with refills **for** ○ oral or ○ tube feeding.

7 PRESCRIBER INFORMATION

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I also acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe ***Similac Alimentum*** was based solely on my determination of medical necessity set forth herein.

Prescriber Name ______________________ Physician Provider/NPI # ______________________

Phone # ______________________ Physician Provider/Tax ID # ______________________

Name of Contact Person ______________________ Contact Phone # ______________ Fax # ______________

Street Address ______________________ City/State/ZIP ______________________

Prescriber Signature (Required) ______________________ Date ______________________

8 SPECIAL INSTRUCTIONS

Preferred Supplier ______________________ Other ______________________

*The list of diagnoses contained in this form is not all-inclusive. It is ultimately the responsibility of the healthcare professional/persons associated with the patient's care to determine and document the appropriate diagnosis(es) and code(s) for the patient's condition. Abbott Nutrition does not guarantee that the use of any information provided in this form will result in coverage or payment by any third-party payer.

AUTHORIZATION TO SHARE MEDICAL INFORMATION

Prescriber OR patient may sign this certification

Prescriber Certification Statement

By signing below, I hereby attest that I am the prescribing provider and I agree to submit this request to Abbott Nutrition's PATHWAY Reimbursement Support Program. I have determined that the Abbott Nutrition product I have recommended is medically appropriate and I have explained such to my patient. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996) to PATHWAY for the purpose of providing general reimbursement support, assisting in initiating or continuing therapy, and/or the evaluation of the patient's eligibility for the Abbott Nutrition Patient Assistance Program.

If applying for the Abbott Nutrition Patient Assistance Program, I certify that this patient has no insurance and is not eligible for other public health insurance programs. I agree to notify the Abbott Nutrition Patient Assistance Program if I become aware at any time in the future of changes in my patient's circumstances that would affect his or her eligibility, including but not limited to changes in health insurance status or coverage, financial status, United States residency status or the indication for which the product has been recommended for this patient. I understand that Abbott Nutrition reserves the right to change or terminate PATHWAY or the Patient Assistance Program any time, or to refuse to provide Abbott Nutrition product under the Abbott Nutrition Patient Assistance Program to any patient.

If my patient obtains an Abbott Nutrition product from the Abbott Nutrition Patient Assistance Program I understand that (a) no third party or patient can be charged for the Abbott Nutrition product provided under such program and (b) that no free product should be sold, traded, or distributed for sale. I also understand that provision of free product as part of the Abbott Nutrition Patient Assistance Program is not contingent upon future purchase or prescribing of Abbott Nutrition products.

My signature below indicates that I understand the information provided above and I certify that the patient has provided my office with written consent and authorization to proceed with this research. I understand that if I have not secured consent from my patient to pursue insurance research, PATHWAY will be unable to proceed with this request. I confirm I have the patient's consent prior to submitting the insurance research requests.

(Provider's signature required if provider initiates PATHWAY services)

Patient's Name (print) ____________________ DOB ____________

Provider's Name (print) ____________________

Provider's Signature ____________________ Date ____________

Provider's original signature (no stamped signatures)

Patient Certification Statement (required only if the patient is requesting PATHWAY services)

By signing below, you authorize PATHWAY to access your personal medical and insurance coverage information in order to perform PATHWAY services. The information that you provide will be held in strict confidence and only be used to conduct this verification and explore potential reimbursement or patient assistance options. We also want to inform you that you can refuse to provide this consent and/or withdraw it at any time but doing so would disable our program from being able to provide these services to you. Do you authorize our program to access your personal medical and insurance coverage information?

Patient's Name (print) ____________________

Patient's Signature ____________________ Date ____________

Signature of Patient or Patient Representative
(If signed by Representative, explain authority to act for the Patient)

Patient's Representative's Name (print) ____________________

Authority: ○ Parent/Legal Guardian ○ Power of Attorney ○ Limited Power of Attorney

○ Other (please specify) ____________________

Each healthcare provider is ultimately responsible for verifying codes, coverage, and payment policies used to ensure that they are accurate for the services and items provided.

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