Benefit Renewal Checklist

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Oral Nutrition Formula Users: What to Review Before Coverage Renews

Every year, health plans reset—and coverage for oral nutrition formula (drinkable medical formula) is often affected. Oral formula coverage is less consistent than other DME categories, so it's worth a close look before renewal.

Here are the top 3 things to check.

1 Medical Necessity Documentation, Diagnosis Requirements & Prior Authorization

Oral formula is treated differently than most medical supplies—many plans only cover it for specific diagnoses, so documentation matters more here than for other benefits.

- **Confirm what diagnosis or documentation qualifies you for coverage**—e.g., dysphagia, malabsorption, or an inherited metabolic disorder—since many plans require formula to be your sole or primary source of nutrition.
- **Check if a new swallow study, updated Letter of Medical Necessity, or physician prescription** is required for the new plan year, and who submits it.
- **Confirm whether a new Prior Authorization or updated Letter of Medical Necessity is needed.** A new plan year may require an update and who is responsible for submitting the Prior Authorization (you, your DME/formula supplier, or your physician).
- **Check the approval window.** Some plans only approve 3–6 months at a time, which can leave gaps if renewal isn't timed correctly.

2 Benefit Category & Formulary Coverage

Oral formula can be covered under the pharmacy benefit, the medical (DME) benefit, or a separate nutritional/medical-food benefit—and that category can shift at renewal.

- **Confirm which benefit category your formula falls under this year**—pharmacy, medical (DME), or nutrition category, since it can affect your cost-share and where you're allowed to order it.
- **Verify your specific brand, product, and flavor are still covered** and check monthly case or can quantity limits, which can reset or shrink at renewal.
- **Check for a new step-therapy or generic/store-brand substitution requirement,** which may require trying a lower-cost formula before your current one is approved.

3 Where to Fill Your Order & Your Costs

Where you're allowed to purchase oral formula and what you'll pay can change when a new plan year begins.

- **Confirm which pharmacy or supplier (DME) is in-network**—retail pharmacy, mail order, and specialty suppliers each may have different rules, and networks change annually.
- **Confirm your deductible, copay, coinsurance, and any annual dollar cap on formula,** since these usually reset on renewal and directly affect your monthly cost.
- **Know your appeal process and timeline** in case formula is denied as "not medically necessary" or a "convenience item"—most plans give a limited window (often 60–180 days) to appeal.

Quick Tip

Call your insurer's member services line 4–6 weeks before renewal and ask directly: **"Is my oral nutrition formula covered under my pharmacy or medical (DME) benefit, what diagnosis or documentation is required, and will my specific product still be covered next plan year?"** Write down the date, representative name, and reference number for your records.

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