



# Clinical Documentation Checklist

To help avoid delays in RELiZORB® (immobilized lipase) cartridge approval, it may be helpful to include documentation (examples below) with the RELiZORB Enrollment Form and Letter of Medical Necessity (LOMN), available at [relizorbhcorp.com](http://relizorbhcorp.com).

## Clinical documentation to accompany RELiZORB Enrollment Form

- Copy of front and back of insurance card
- MD office visit notes including initial evaluation/H&P, referrals
- RD office notes
- Medication list
- Weight history
- Letter of medical necessity, if needed

## Clinical documentation to accompany Letter of Medical Necessity (LOMN)

- Clinic visits in the last 6 months
- RD Nutrition notes from the last 6 months
- Growth charts, including height, weight, BMI, and weight for length (if applicable)

**RELiZORB Patient Enrollment**

RELiZORB should only be used in conjunction with enteral feeding supplies. RELiZORB should not be used with blended formulas. For more information regarding RELiZORB see visit [www.relizorb.com](http://www.relizorb.com) or call 1-844-632-9271. Please complete this form and email to [info@relizorbhcorp.com](mailto:info@relizorbhcorp.com) or fax to 1-844-233-3146. Please note—ALL INFORMATION IS REQUIRED to expedite processing of referral.

**1. Patient Information**

Name (Print) \_\_\_\_\_, Last \_\_\_\_\_  
 Street Address \_\_\_\_\_, City \_\_\_\_\_, State \_\_\_\_\_, ZIP \_\_\_\_\_  
 Date of Birth \_\_\_\_\_, Age \_\_\_\_\_, Gender  Male  Female

**2. Current Insurance Information**

**Primary Insurance Plan:**  Private/Commercial  Medicare  Medicaid  Medicare Advantage  Patient has no insurance

Primary Insurance Name \_\_\_\_\_ Member ID # \_\_\_\_\_  
 Insurance Plan # \_\_\_\_\_ Policy Holder \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Secondary Insurance Plan:**  Private/Commercial  Medicare  Medicaid  Medicare Advantage  Patient has no insurance

Secondary Insurance Name \_\_\_\_\_ Member ID # \_\_\_\_\_  
 Insurance Plan # \_\_\_\_\_ Policy Holder \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**3. Prescriber Information**

Prescriber Name (Print) \_\_\_\_\_, MD \_\_\_\_\_, PhD \_\_\_\_\_, DNP \_\_\_\_\_  
 Title \_\_\_\_\_, D.O. \_\_\_\_\_  
 Prescriber Specialty \_\_\_\_\_  
 Complete/Partial Name \_\_\_\_\_  
 Street Address \_\_\_\_\_, City \_\_\_\_\_, State \_\_\_\_\_, ZIP \_\_\_\_\_  
 Prescriber Direct Contact # \_\_\_\_\_  
 Prescriber Office Contact # \_\_\_\_\_, Phone \_\_\_\_\_, Fax \_\_\_\_\_, Email \_\_\_\_\_

RELiZORB Patient Enrollment Form available at [relizorbhcorp.com](http://relizorbhcorp.com)

**Letter of Medical Necessity Checklist & Sample**

In the following document, you will find a checklist and sample Letter of Medical Necessity (LOMN). You may use this checklist as a guide while completing your patient's individualized LOMN. You will need to customize and fill this out appropriately for each patient. Please note that all fields that require customizations are **red** and will need to be modified as the prescriber deems appropriate.

Please ensure the following are present on/with every LOMN:

- Patient First and Last Name
- Date of Birth
- Patient's Clinical History
  - All pertinent diagnoses that convey the need for RELiZORB
  - Include the diagnosis of "malabsorption", "malnutrition", and "exocrine pancreatic insufficiency (EPI)", **if applicable**
  - Note the therapies tried, how they were administered (orally or added to formula), the amount of pancreatic enzyme replacement therapy (PERT) use, if any, and the evidence to treatment failure
  - If RELiZORB has been trialed with patient, please note symptom improvements and weight or BMI changes, **if applicable**
- Treatment Plan
  - Reference any additional guidelines or clinical studies tied to the patient's clinical presentation
  - Note number of RELiZORB cartridge(s) required
- Summary
  - Medical necessity criteria and hazards to health if patient continues a failed therapy or continues without RELiZORB
- Attachments
  - Clinic visits in the last 6 months
  - Registered Dietitian (RD) notes from the last 6 months
  - Growth charts (height, weight, BMI, weight for length, **if applicable**)

For any questions, please contact RELiZORB Support Services at 1-844-632-9271. Sample LOMN continued on next page.

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Letter of Medical Necessity (LOMN) Template available at [relizorbhcorp.com](http://relizorbhcorp.com)

RELiZORB® (IMMOBILIZED LIPASE) CARTRIDGE is indicated for use in pediatric patients (ages 2 years and above) and adult patients to hydrolyze fats in enteral formula. RELiZORB is for use with enteral feeding only; do not connect to intravenous or other medical tubing. Medications should not be administered through RELiZORB. Please see Instructions for Use for full safety information at [www.relizorbhcorp.com](http://www.relizorbhcorp.com).