



Medical Documentation
WIC-Eligible Nutritionals and Therapeutic Formula

WIC Clinic:
Fax #:
WIC ID #:

Idaho WIC's current standard contract formulas are Similac Advance and Similac Isomil Soy. Medicaid is the first payer for therapeutic formulas and nutritionals. **Per Medicaid, at this time they will only cover formula for life-threatening diagnoses. If WIC is covering the formula, please complete this form for WIC authorization and return the completed form to the patient's WIC clinic.**

SECTION I —TO BE COMPLETED FOR ALL ORDERS

PATIENT (First/MI/Last):	DOB:
PARENT/CAREGIVER (First/MI/Last):	

SECTION II ALTERNATIVE 19 CALORIE PER OUNCE INFANT FORMULAS

PROVIDE: Similac Total Comfort Similac Spit Up Similac Sensitive

REASON: Formula intolerance as evidenced by:

DURATION: _____ month(s) (max 12 months) **AMOUNT:** _____ oz/day Max allowed WIC staff to decide amount

SECTION III THERAPEUTIC FORMULA/NUTRITIONALS

This documentation is federally required to ensure the patient under your care has a medical condition/diagnosis that dictates the use of therapeutic formula/nutritionals or requires changes to the WIC supplemental food package.

Section A: Must be completed by a healthcare provider.

Section B: The health care provider can select a WIC Registered Dietitian (RD). If selected, the WIC RD will determine appropriate issuance, prescribed amount, and length of time needed for WIC foods based on the patient's qualifying condition(s).

Supplemental foods, amount and length of need to be determined per WIC RD.

<p>A) Therapeutic Formula/Nutritionals:</p> <p>Product Name: _____</p> <p>Dx: _____</p> <p>Duration: _____ months (maximum 12 mos)</p> <p>Amount: _____ oz/day</p> <p><input type="checkbox"/> Prematurity <input type="checkbox"/> GERD or reflux</p> <p><input type="checkbox"/> Failure to thrive <input type="checkbox"/> Food allergy: _____</p> <p><input type="checkbox"/> Dysphagia <input type="checkbox"/> Other: _____</p> <p>Special instructions/comments:</p> <p>This prescription is: <input type="checkbox"/> new <input type="checkbox"/> refill</p>	<p>B) WIC FOOD RESTRICTIONS: The patient will receive WIC foods in addition to the formula prescribed. Please check all foods listed below that are NOT appropriate for the diagnosis.</p> <table border="1" style="width:100%"> <thead> <tr> <th></th> <th>WIC Foods</th> <th>Category</th> <th>Restrictions / Comments</th> </tr> </thead> <tbody> <tr> <td rowspan="2">Infants (6-12 mos)</td> <td>Baby cereal</td> <td></td> <td></td> </tr> <tr> <td>Baby fruit/vegetable</td> <td></td> <td></td> </tr> <tr> <td rowspan="9">Children (1-5 yrs)</td> <td>Cow's milk</td> <td></td> <td></td> </tr> <tr> <td>Cheese</td> <td></td> <td></td> </tr> <tr> <td>Eggs</td> <td></td> <td></td> </tr> <tr> <td>Peanut butter</td> <td></td> <td></td> </tr> <tr> <td>Whole grains</td> <td></td> <td></td> </tr> <tr> <td>Cereal</td> <td></td> <td></td> </tr> <tr> <td>Beans</td> <td></td> <td></td> </tr> <tr> <td>Vegetables / fruits</td> <td></td> <td></td> </tr> <tr> <td>Juice</td> <td></td> <td></td> </tr> </tbody> </table>		WIC Foods	Category	Restrictions / Comments	Infants (6-12 mos)	Baby cereal			Baby fruit/vegetable			Children (1-5 yrs)	Cow's milk			Cheese			Eggs			Peanut butter			Whole grains			Cereal			Beans			Vegetables / fruits			Juice		
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Health Provider's Name (please print)	Location	Phone:
		Fax:

Health Care Provider's Signature

× _____ MD DO PA NP **Date:** _____

WIC USE ONLY RD review: _____ Date: _____

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