



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 Soy Isomil. Similac Sensitive, Similac for Spit Up and Similac Total Comfort are also allowed. 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 — 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>Prematurity GERD or reflux</p> <p>Failure to thrive Food allergy: _____</p> <p>Dysphagia Other: _____</p> <p>Special instructions/comments:</p> <p>This prescription is: new 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>			
		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				

<p>Health Provider's Name (please print)</p>	<p>Location</p>	<p>Phone:</p>
		<p>Fax:</p>

Health Care Provider's Signature

× _____ MD DO PA NP **Date:** _____

WIC USE ONLY RD review: _____ Date: _____

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