

WIC FORMULA and MEDICAL NUTRITIONAL PRESCRIPTIONS

All components of this form are required and must be completed by a medical provider to receive Medically Prescribed Formulas through the WIC program. Personally identifiable information is used to determine WIC services (e.g., certification/enrollment and food package issuance) and may be disclosed to others only as allowed by state and federal laws.

Patient

Last Name

First Name

Birthdate

Parent/Caregiver

Last Name

First Name

PRESCRIPTION

1. Formula or Medical Nutritional Prescribed:

<u>Casein Hydrolysate</u>	<u>Premature & Transitional</u>	<u>Children</u> <small>(over 1 year still requiring formula)</small>	<u>Nutrient Dense Feedings</u> <small>(for women and children)</small>
<input type="checkbox"/> Nutramigen LIPIL (Powder)	<input type="checkbox"/> Enfamil EnfaCare LIPIL	<input type="checkbox"/> Enfamil AR LIPIL	<input type="checkbox"/> Boost Plus
<input type="checkbox"/> Pregestimil LIPIL (Powder)	<input type="checkbox"/> Powder	<input type="checkbox"/> Enfamil Gentlease LIPIL	<input type="checkbox"/> Boost w/fiber
<input type="checkbox"/> Alimentum	<input type="checkbox"/> RTF	<input type="checkbox"/> Enfamil LIPIL	<input type="checkbox"/> Ensure
<input type="checkbox"/> Powder	<input type="checkbox"/> Similac NeoSure (Powder)	<input type="checkbox"/> Enfamil ProSobee LIPIL	<input type="checkbox"/> Ensure Plus
<input type="checkbox"/> RTF (Corn Allergy Only)			<input type="checkbox"/> Nutren Junior
<u>Amino Acid Based</u>	<u>Other Specialized Products</u>		<input type="checkbox"/> Nutren Junior w/fiber
<input type="checkbox"/> EleCare (powder)	<input type="checkbox"/> MSUD Analog (Powder)		<input type="checkbox"/> PediaSure
<input type="checkbox"/> EO28 Splash (Drink box)	<input type="checkbox"/> Similac PM 60/40 (Powder)		<input type="checkbox"/> PediaSure w/fiber
<input type="checkbox"/> Neocate Infant DHA & ARA (Powder)	<input type="checkbox"/> Acerflex (Powder)		
<input type="checkbox"/> Neocate Junior (Powder)	<input type="checkbox"/> Peptamen Junior (RTF)		
<input type="checkbox"/> Neocate One+ (Packets)	<input type="checkbox"/> Peptamen Junior w/fiber (RTF)		
<input type="checkbox"/> Nutramigen AA LIPIL (Powder)			

2. Prescribed amount: _____ Ounces per day **OR** _____ Cans per day **OR** Maximum amount provided by WIC

3. Medical documentation valid for: 1 month 2 months 3 months *a new prescription is required every 3 months

4. Medical diagnosis and ICD-9 code justifying the above formula or medical nutritional prescription:

<input type="checkbox"/> Autoimmune Disorder (279.4)	<input type="checkbox"/> Cerebral Palsy (343.9)	<input type="checkbox"/> Intestinal Malabsorption (579.9)
<input type="checkbox"/> Congenital Heart Disease (746.9)	<input type="checkbox"/> Cystic Fibrosis (277.0)	<input type="checkbox"/> Neuromuscular Disorder (358.9)
<input type="checkbox"/> Congenital Anomaly, Respiratory (748.9)	<input type="checkbox"/> Developmental Sensory/Motor Delays (783.4)	<input type="checkbox"/> Prematurity (765.1)
<input type="checkbox"/> Cleft Palate (749.0)	<input type="checkbox"/> Gastroesophageal Reflux (580.81)	<input type="checkbox"/> Hyperemesis Gravidarum (643)
<input type="checkbox"/> Cleft Lip (749.1)	<input type="checkbox"/> Immunodeficiency (279.3)	<input type="checkbox"/> Other Diagnosis with ICD-9 code (required)

Not Allowed: Federal regulations do not allow WIC to provide medical formulas based solely on the following conditions: lactose intolerance, unconfirmed allergies, managing body weight, intolerance symptoms, or growth concerns.

5. Food Prescription

- No solid foods: offering solids is contraindicated at this time. Please omit all supplemental foods and provide medical formula only.
- Allow age appropriate WIC Foods. Exceptions (specify): _____

Special Instructions:

SIGNATURE

Health Care Provider's Signature _____ Date Signed: _____
(Physician, Physician Assistant or Advanced Practice Nurse Practitioner signature is required for prescriptions of the above formulas or medical foods.)

Printed Name of Health Care Provider _____

Medical Office/Clinic _____

Address _____ Telephone _____

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