Family or Participant ID#____________________________

State of Connecticut WIC Program-Department of Public Health

MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS

INFANTS AND CHILDREN

1. Patient's Name: ____ **Date of Birth (DOB):** ___/____/____

2. Parent/Guardian: ____

Prescription is subject to WIC approval and provision is based on Program policy and procedure.

3. Please check qualifying medical condition(s)/ICD-9 code(s)

- ☐ 693.1 Allergy, Food
- ☐ 281.9 Anemia
- ☐ 279.4 Autoimmune Disorder
- ☐ 770.7 Chronic Respiratory Disease, perinatal
- ☐ 746.9 Congenital Heart Disease
- ☐ 748.9 Congenital Anomaly, Respiratory
- ☐ 751.9 Congenital Anomaly, GI
- ☐ 749.0 Cleft Palate
- ☐ 749.1 Cleft Lip
- ☐ 343.9 Cerebral Palsy
- ☐ 277.0 Cystic Fibrosis
- ☐ 783.4 Developmental Delay
- ☐ 250.01Diabetes Mellitus Type I
- ☐ 783.4 Failure to Thrive/Inadequate Growth
- ☐ 271.1 Galactosemia
- ☐ 580.81 Gastroesophageal Reflux
- ☐ 279.3 Immunodeficiency
- ☐ 271.3 Lactose Intolerance
- ☐ 579.9 Malabsorption
- ☐ 358.9 Neuromuscular Disorder
- ☐ 765.1 Prematurity
- ☐ 270.1 Phenylketonuria (PKU)
- ☐ _____ Other diagnosis with ICD-9 code
  Specify ______________________________

Patient must have a diagnosis and not symptoms.

4. Formula requested: ____

Prescribed ounces per day* (unless ad lib): ________ ☐ Powder ☐ Concentrate ☐ Other ________

***WIC is a supplemental nutrition program and may not provide the total amount of formula or food prescribed.**

Instructions for preparation: ____

Caloric density (e.g. 20cal/oz; 24 cal/oz; 30 cal/oz) _________ Length of use: ☐ 1 mo ☐ 3 mos ☐ 6 mos

5. WIC Supplemental Foods Available Check foods that are **contraindicated** based on medical diagnosis

Note: The patient will receive supplemental foods, appropriate to their age and participant category in addition to the formula indicated. Please check any supplemental foods **contraindicated** by the patient's medical diagnosis. If there are only restrictions to amounts of supplemental foods provided due to medical diagnosis, check box and explain in the space provided. Prescription renewal is required periodically, based on age and medical condition. **No prescription is valid for more than six months.**

INFANTS: (6-11 months of age)

CONTRAINDICATED FOODS

- ☐ Infant cereal
- ☐ Infant food vegetables/ fruits
- ☐ All foods contraindicated
- ☐ Restrictions in amounts- Explain:

CHILDREN: (12 months of age or older)

CONTRAINDICATED FOODS

- ☐ Milk or milk substitutes Specify type: ____________________
- ☐ Breakfast cereal
- ☐ Whole wheat bread or other allowed whole grains
- ☐ Vegetables and fruits ☐ Juice
- ☐ Peanut butter ☐ Eggs ☐ Legumes
- ☐ All foods contraindicated
- ☐ Restrictions in amounts- Explain:

Length of use: ☐ 1 mo ☐ 3 mos ☐ 6 mos

6. Milk substitutes: For children with qualifying conditions, soy-based beverage (soymilk), calcium-set tofu or cheese can be substituted for milk.

☐ Soy-based beverage (soymilk) ☐ Tofu ☐ Cheese

Prescribed amount per day (unless ad lib): __________ ☐ Restriction(s), explain________________________________

Length of use: ☐ 1 mo ☐ 3 mos ☐ 6 mos

7. HEALTH CARE PROVIDER SIGNATURE: **Date:**
(MD, APRN or PA)

Printed Name (Health Care Provider):

Medical Office/Clinic/Hospital: Phone:

Address: Fax:

Instructions for Physicians or Physician Assistants or Nurse Practitioners

(Only Healthcare Providers licensed to write a prescription in Connecticut can complete this form)

Item #1: Write patient's complete name and date of birth (DOB).
Item #2: Write patient's parent/guardian name.

Item #3: From the list of most common nutrition related ICD-9 medical diagnoses determine and document one or more of the patient's serious qualifying medical condition(s) for which WIC prescriptions may be written. Other medical diagnosis that may require special/exempt infant formulas and approved WIC foods must have an ICD-9 code and will be considered on a case by case basis. **Non-specific symptoms such as intolerance, fussiness, gas, spitting up, constipation and colic are not considered qualifying conditions.**

Item #4: The Connecticut WIC Program endorses breastfeeding as the optimal method to feed infants. If infants do consume infant formula, WIC supports the American Academy of Pediatrics recommendation that all formula fed infants receive iron-fortified formula for the first year. The Connecticut WIC Program has a sole source contract with Nestlé® to provide standard iron-fortified milk- and soy-based formulas Good Start Gentle Plus® and Good Start Soy Plus®, for healthy infants from birth to twelve months of age whose mothers choose not to breastfeed or who partially breastfeed. **We will no longer provide milk- or soy-based standard infant formulas that are not part of our contract.** The Program will continue to provide special/exempt infant formulas such as: protein hydrolysate (hypoallergenic), hypercaloric, elemental and metabolic infant formulas with an appropriate nutrition related ICD-9 code. Note: WIC is a supplemental program and may not provide the total amount of formula or food prescribed. If an infant or child needs additional amounts of formula, contact Medicaid to see if the additional amounts can be covered based on medical diagnosis.
For infants: Indicate the special/exempt formula, physical form, instructions for preparation, and intended length of use. Powder or concentrate are the physical forms routinely provided by WIC. Ready-to-Feed (RTF) formula or medical foods may be authorized when WIC nutrition staff determines and documents that there is an unsanitary or restricted water supply or poor refrigeration, the person caring for the infant may have difficulty in correctly diluting the concentrated liquid or powdered formula or the product is only available in ready-to-feed.
For children 12 months and older: Indicate the special/exempt formula, instructions for preparation and intended length of use. It is WIC's policy to re-evaluate the participant's continued need for the formula on a periodic basis. If a supplemental (vs. complete) soy formula is prescribed for children ages 12-24 months, the Connecticut WIC Program provides Good Start 2 Soy Plus 2®. No other supplemental toddler soy product will be authorized when a supplemental toddler soy product is ordered.

Item #5 The patient will receive supplemental foods from the WIC Program, appropriate to their age and participant category in addition to the formula indicated. For infants 6 months of age or older and children, please check the supplemental foods that are contraindicated by the patient's medical diagnosis. If there are only restrictions to amounts of supplemental foods provided due to a medical diagnosis, check and explain in the space provided. For children over 2 years of age with inadequate growth or other specific medical diagnosis, whole milk can be provided on an individual basis. Please specify % milk fat in section indicated.

Item #6 **For children 12 months of age or older with qualifying conditions** such as milk allergy, severe lactose maldigestion or vegan diet, soy-based beverage (soymilk), calcium-set (calcium fortified) tofu or cheese can be substituted for milk. If a milk substitute is required, check one or more appropriate food item(s), indicate the amount prescribed per day and check the length of use. If there are only restrictions to amounts of supplemental foods provided due to a medical diagnosis, check and explain in the space provided. Provision of cheese in amounts **over 1 pound** requires a qualifying condition such as lactose intolerance or other medical diagnosis. Cheese can be substituted up to the maximum allowance of fluid milk. Medical documentation is not needed for cheese substitutions of 1 pound or less.

Item #7 A Health Care Provider's **original signature** is required. Print or stamp your name, medical office, phone number and address. By signing this form, you are verifying you have seen and evaluated the patient's nutrition and feeding problem(s) and symptoms determining, he/she has a serious medical condition. Give the completed form to the parent/guardian to take to their local WIC program or fax to the clinic serving the patient.

For more information or additional copies of this form please visit our website: www.ct.gov/dph/wic, then click on "For Medical Providers" tab in the left navigation bar.

WIC Office Use:

CPA Signature: ______________________________ **Date:** ______________

WIC Staff instructions: Review form for completeness. If there are questions, before approving the prescription, contact the participant's health care provider to resolve. Sign and date form. If formula is not available retail, complete formula request form as outlined in the State Plan/policies and fax to the State WIC Office.

WIC is an equal opportunity provider.