State of Vermont WIC Program

MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS

INFANTS AND CHILDREN

1. **Patient's name:** _____ **Date of Birth:** ___/____/____

2. **Parent or Guardian's name:** _____

3. **Qualifying Medical Condition(s)**

List the diagnosed medical condition(s) **and** the ICD-10 code(s) justifying the formula/medical food prescription.

Diagnosed medical condition(s):	**Applicable ICD-10 code(s):**

Note: WIC approval and provision of prescription formulas and medical foods are based on Vermont WIC program policies and procedures.

4. **Formula or medical food requested:** _____

Product form: ☐ Powder ☐ Concentrate ☐ Other _____

Prescribed ounces per day*:_____ ***OR*** ☐ ad lib

Length of formula use: **Infants:** ☐ 6 months or _____ months
Children: ☐ _____ months *OR* ☐ As tolerated until age 5

5. **WIC supplemental foods:**

Please indicate if **all foods are allowed** or any supplemental foods **contraindicated** by the patient's medical diagnosis. Maximum amounts allowed will be offered unless limitations are specified.

Infants:

☐ All Foods Allowed at age ≥ 6 months

OR

Foods contraindicated:

☐ Infant cereal
☐ Infant food vegetables/ fruits

Length of use: ☐ Up to age 1 year
☐ Other:

Children: (12 months of age and older)

☐ All Foods Allowed

OR

Foods contraindicated:

☐ Breakfast cereal
☐ Eggs
☐ Beans
☐ Peanut butter
☐ Dairy products
☐ Juice
☐ Vegetables and Fruits
☐ Whole grains
☐ Soy products

Length of use: ☐ As tolerated until age 5
☐ Other:

6. **Low-fat or skim milk requested for child age 12 – 24 months:** ☐ (check box to request)

Length of use: ☐ Until age 2 ☐ Other:

7. **WIC Authorization:**

☐ By checking this box, I authorize the WIC Nutrition Professional to determine any future appropriate supplemental foods and amounts, ***excluding*** formula/medical foods.

8.	**HEALTH CARE PROVIDER SIGNATURE** (MD, APRN or PA):	**Date:**
Printed Name or Stamp (Health Care Provider):		
Medical Office/Clinic/Hospital:		Phone:
Address:		Fax:

Prescription is subject to WIC approval. WIC is a supplemental nutrition program and can only provide the amount of formula or food allowed by Federal Program policy.

Instructions for Physicians or Physician Assistants or Nurse Practitioners

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

Item #1: Write patient's complete name and date of birth.
Item #2: Write patient's parent or guardian's name.

Item #3: Document one or more of the patient's qualifying medical condition(s) and ICD-10 code(s). **Nonspecific symptoms such as intolerance, fussiness, gas, spitting up, constipation and colic are not considered qualifying conditions.**

Item #4: The Vermont WIC Program endorses breastfeeding as the optimal method to feed most 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 Vermont WIC Program has a sole source contract with Abbott Nutrition® to provide the standard iron-fortified milk- and soy-based formulas Similac and Isomil, for healthy infants from birth to twelve months of age whose mothers choose not to breastfeed or who partially breastfeed. **We do not provide milk- or soy-based *standard* infant formulas that are not part of our contract.** The Program will provide medical infant and child formulas such as: protein hydrolysate (hypoallergenic), hypercaloric, elemental and metabolic formulas with an appropriate nutrition related ICD-10 diagnosis. Note: WIC is a supplemental program and may not provide the total amount of formula or medical food prescribed.

For infants: Indicate the medical formula, physical form, amount prescribed per day, and intended length of use. Powder or concentrate are the physical forms routinely provided by WIC. Ready-to-Feed (RTF) formula may be authorized when WIC nutrition staff determines and document 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. It is WIC's policy to re-evaluate the infant's continued need for medical formula every 6 months.

For children 12 months and older: Indicate the medical formula or medical food and intended length of use. Prescription renewal may be required periodically, based on medical condition.

Item #5 The patient will also receive supplemental foods from the WIC Program, appropriate to their participant category in addition to the formula indicated. For infants and children, please indicate if **all foods are allowed** or indicate the supplemental foods that are **contraindicated** by the patient's medical diagnosis. Infants will only receive infant foods from WIC after 6 months of age. Indicate intended length of use.

Item # 6 **Low-fat or skim milk request:** Medical provider may request low-fat or skim milk for a child age 12 to 24 months of age by checking the box indicated. (Whole milk is the standard issuance for children in this age group).

Item #7 Providing **WIC Authorization** allows the WIC Nutrition Professional to determine any future additions or subtractions to the supplemental foods provided by the WIC Program. This authorization does not include medical formulas or medical foods.

Item #8 A Health Care Provider's **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 or guardian to take to their local WIC program or fax/mail to the WIC clinic serving the patient.

For more information or additional copies of this form visit the Vermont Health Department website at http://www.healthvermont.gov/wic/providers.aspx

WIC Office Use: **WIC Staff 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.

WIC is an equal opportunity provider.