

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
 250.01 Diabetes 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 mos5. 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.**

Instructions for Physicians or Physician Assistants or Nurse Practitioners

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

INFANTS: (6-11 months of age)	CHILDREN: (12 months of age or older)		
CONTRAINDIQUATED FOODS			
<input type="checkbox"/> Infant cereal			
<input type="checkbox"/> Infant food vegetables/ fruits			
<input type="checkbox"/> All foods contraindicated			
<input type="checkbox"/> Restrictions in amounts- Explain: _____			
CONTRAINDIQUATED FOODS			
<input type="checkbox"/> Milk or milk substitutes Specify type: _____			
<input type="checkbox"/> Breakfast cereal			
<input type="checkbox"/> Whole wheat bread or other allowed whole grains			
<input type="checkbox"/> Vegetables and fruits		<input type="checkbox"/> Juice	
<input type="checkbox"/> Peanut butter		<input type="checkbox"/> Eggs	
<input type="checkbox"/> All foods contraindicated		<input type="checkbox"/> Legumes	
<input type="checkbox"/> 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: _____

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 Mead Johnson® to provide

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standard iron-fortified milk- and soy-based formulas **Enfamil PREMIUM Infant®** and **Enfamil Prosobee®**, 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, any approved WIC toddler soy formula can be issued as the State no longer has a rebate for that type of product.

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

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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.