Family or Participant ID#_____

State of Connecticut WIC Program-Department of Public Health

WIC Medical Documentation for Approved Special Formula and Approved Foods

Infants and Children

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

Parent/Guardian Name: _____ **Weeks Gestation (premature infants):** _____

REQUIRED: Select qualifying medical condition(s)/ICD-10 code(s) that require the use of special formula or medical foods. *Non-specific symptoms such as intolerance, fussiness, gas, spitting up, constipation, and colic are not considered qualifying conditions.*

☐ Allergy, Food (L27.2	☐ Cystic Fibrosis (E84.9)	☐ Lactose Intolerance (E74.39)
☐ Anemia (D53.9)	☐ Developmental Delay (R62.50)	☐ Malabsorption (K90.9)
☐ Autoimmune Disorder (M35.9)	☐ Diabetes Mellitus Type I (E10.9)	☐ Neuromuscular Disorder (G70.9)
☐ Congenital Heart Disease (Q24.9)	☐ Failure to Thrive/Inadequate Growth (R62.51)	☐ Prematurity (P07.30)
☐ Congenital Anomaly, Respiratory (Q34.9)	☐ Galactosemia (E74.21)	☐ Phenylketonuria (PKU) (E70.0)
☐ Congenital Anomaly, GI (Q45.9)	☐ Gastroesophageal Reflux (K21.9)	☐ Other diagnosis with ICD-10 code
☐ Cleft Palate (Q35.9)	☐ Immunodeficiency (D84.9)	Specify _____
☐ Cerebral Palsy (G80.9)		

The Connecticut WIC Program strongly endorses breastfeeding as the optimal method to feed most infants. For infants that do consume formula, Connecticut WIC standard formulas are Similac® Advance® 20cal/oz., Similac® Isomil® Soy 20cal/oz., Similac® Sensitive® 20cal/oz. and Similac® Total Comfort® 20cal/oz.

☐ Check here if patient is dually enrolled in HUSKY/Medicaid and the WIC Program. I acknowledge I MUST send a separate prescription with allowable ICD-10 code to the pharmacy for the patient to receive the product. Note: For dually enrolled patients, WIC also requires this form to be completed to ensure continuity of care.

☐ Check here for WIC participants without HUSKY/Medicaid.

Formula requested or prescribed via HUSKY/Medicaid: _____

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

☐ Check here to request ***Similac® For Spit-Up®* (20 cal/oz.) - must have** documented Gastroesophageal Reflux or Other ICD-10 code.

Instructions for preparation: _____

Caloric Density: ☐ 20cal/oz ☐ 22cal/oz ☐ 24cal/oz ☐ 26cal/oz ☐ 30cal/oz ☐ Other:_____

Length of Use: ☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months

No prescription is valid for more than 12 months. *Provision of prescribed formula is based on WIC Program policy and procedure. WIC is a supplemental nutrition program and may not provide the total amount of formula or food prescribed.*

Medical Documentation for Whole Milk for Children 2-5 Years of Age:

If child is over 2 years of age, does he/she require whole milk based on a qualifying condition? ☐ **Yes** ☐ **No**

Children aged 2 or older who are receiving formula for a qualifying medical condition and also receive milk are provided fat reduced milk. Whole milk can be provided if based on a documented qualifying medical condition that warrants the use of a high calorie special formula or supplement.

Medical Documentation for Fat-Reduced Milks for Children 12-23 Months of Age:

If the child is 12-23 months of age does he/she require fat reduced milk based on overweight or obesity? ☐ **Yes** ☐ **No** **Specify:** _____

Please specify 2%, 1% or skim. Whole milk is the standard milk given to children 12-23 months of age. Fat-reduced milk (2%, 1% or skim) can be provided for children 12-23 months when overweight or obesity is a concern.

WIC Supplemental Foods: Please check foods that are **not allowed** based on medical diagnosis

☐ Milk, Specify type: _____	☐ Whole wheat bread /whole grains	☐ Peanut butter	☐ All foods contraindicated
☐ Soy Milk/ Tofu	☐ Breakfast cereal	☐ Vegetables and fruits	☐ Restrictions in amounts:
☐ Cheese	☐ Whole grain pasta	☐ Infant cereal	Explain: _____
☐ Yogurt	☐ Legumes (beans/peas)	☐ Infant food-vegetables/ fruits	_____
☐ Juice	☐ Eggs		

REQUIRED: **Refer to WIC Nutrition Professional to identify appropriate types and amounts of WIC supplemental foods*.** ☐ Yes ☐ No

***By checking yes, you authorize the WIC Nutrition Professional to make future decisions about WIC supplemental foods.**

HEALTH CARE PROVIDER SIGNATURE: _____ **Date:** ___/___/____

(MD, APRN or PA)

Printed Name (Health Care Provider): _____ Phone: _____

Provider Stamp or Address: Fax:

WIC Use Only: Date received ___/___/____ **Contacted HCP?** **Yes** ☐ **No** ☐

CPA Signature: _____ **Date:** ___/___/____