



Washington State WIC Nutrition Program
MEDICAL FOODS AND MEDICAL FORMULAS

April 2011

If your client needs a medical food and/or medical formula follow the steps below:

1. Review whether the prescribed medical food and/or medical formula is on the Washington State WIC Approved Formulas list at: <http://www.doh.wa.gov/cfh/wic>.
2. If the prescribed medical food and/or medical formula is not on the Washington State WIC Approved Formula list, refer your client to Medicaid, TRICARE, or the client's health insurance provider to receive it from them.
3. If your client is **NOT** eligible to receive the prescribed medical food and/or medical formula from Medicaid, TRICARE, or the client's health insurance provider:
 - a. The client must get written documentation from Medicaid, TRICARE, or the client's health insurance provider explaining the reason(s) why it will not be provided.
 - b. The medical provider must complete this form.
4. Inform your client to take the completed form and the written documentation from Medicaid, TRICARE or the client's health insurance provider to the local WIC clinic.
5. Local WIC clinic staff will consult with Washington State WIC Nutrition Program staff to determine whether your client is eligible to receive the prescribed medical food and/or medical formula from WIC.

Client's Name: _____ Date of Birth: _____

Caregiver's Name (if applicable): _____

1. **Check Qualifying Medical Diagnosis** (The qualifying medical diagnosis must correspond with the medical need of the prescribed medical food and/or medical formula. A symptom description such as "colic", "constipation", "rash", "spitting up", "vomiting", or fussiness" is not an acceptable medical diagnosis for WIC):

- Premature birth: ≤ 37 weeks gestation (only if child is less than 2 years old)
- Low birth weight: ≤ 5 lbs 8 oz (only if child is less than 2 years old)
- Failure-to-thrive
- Gastrointestinal Disorders/malabsorption syndromes
- Immune system disorders
- Severe food allergies
- Milk protein allergy
- Metabolic disorders/inborn errors of metabolism
- Life-threatening medical condition that impairs the client's nutritional status (Explain in Notes): _____
- Other medical diagnosis (Describe): _____

Notes: _____

2. **Specify Brand Name, Amount Needed in Ounces Per Day, Physical Form** (Identify for each medical food and/or medical formula prescribed whether it is powder, liquid concentrate, ready-to-feed, solid bar, pudding, etc., and any other descriptive information as appropriate and necessary.):

Brand Name (and manufacturer if known) of each Medical Food and/or Medical Formula	Amount Needed Ounces Per Day	Physical Form (and other descriptive information)

3. **Enter Number of Months** (Specify how long the prescribed medical food and/or medical formula is medically necessary):
 _____ Months (Not to exceed 12 months)

4. **Medical Provider Information:**

Name: _____ Phone: _____ Fax #: _____
 (Required) Print or Stamp (Required) (Recommended)

Signature: _____ Date: _____ Email: _____
 (Required) (Required) (Recommended)

Return completed form to your client or to the local WIC clinic

WIC Clinic Name: _____ Phone #: _____ Fax #: _____

Questions? Call your local WIC clinic or the Washington State WIC Nutrition Program at 1-800-841-1410



Instruction to complete the Medical Foods and Medical Formulas Form

Use this form for all WIC Clients – Women, Infants and Children

Client Information: Complete the top portion of the form with the client's name, date of birth, and caregiver's name (if client is an infant or child).

1. **Check Qualifying Medical Diagnosis:** This box must be completed in order to provide prescribed medical food and/or medical formula. The qualifying medical diagnoses are specified by federal regulations and must correspond with the medical need of each medical food and/or medical formula prescribed. A symptom description such as "colic", "constipation", "rash", "spitting up", "vomiting", or "fussiness" is not an acceptable qualifying medical diagnosis for WIC.

If **Other medical diagnosis** is marked, describe the medical diagnosis. The space next to **Notes** is for any additional information that WIC staff should know related to the medical diagnosis and the need for the medical food and/or medical formula.

2. **Specify Brand Name, Amount Needed in Ounces Per Day, Physical Form:**

- **Brand Name:** For each medical food and/or medical formula, enter in the brand name and the name of the manufacturer if known.
- **Amount Needed in Ounces Per Day:** Enter the amount prescribed per day to be consumed. Example: A formula is packaged in powder form. Enter the number of reconstituted ounces the client should consume per day.
- **Physical Form (and other descriptive information):** Identify for each medical food and/or medical formula prescribed whether it is powder, liquid concentrate, ready-to-feed (RTF), solid bar, pudding, etc., and any other descriptive information as appropriate and necessary.

The maximum amounts of the medical foods and medical formulas allowed are defined by federal regulation.

3. **Enter Number of Months:** The prescription cannot exceed 12 months. The number of months the prescription is effective will apply to all medical foods and/or medical formula prescribed. A new form is required when: 1) the prescription for medical foods and/or medical formula expires or changes; and 2) the day the infant turns one year of age.

Due to the additional documentation and special ordering procedures for medical foods and/or medical formula, there may be a delay between when the product is ordered and when the client receives the product.

4. **Medical Provider Information:** The name of the medical provider (licensed health care professional who can write medical prescriptions under State law), telephone, signature and date is required. A Fax number and Email address are optional but recommended.

Questions should be directed to the client's local WIC clinic or to Washington State WIC staff at:
1-800-841-1410.

Return completed form to your client or to the local WIC clinic. The information on the completed form is confidential. Please assure confidentiality when mailing or faxing this form to the client or to the client's WIC clinic. Do not mail or fax this form to the Washington State WIC Nutrition Program.

WIC Clinic Name, Phone # and Fax #: (Completing this section is optional for local WIC clinic staff)
WIC staff complete this section when the form is given to the WIC client to take to their medical provider.

For an electronic copy of this form, visit: <http://www.doh.wa.gov/cfh/wic>.



This institution is an equal opportunity provider. **Washington WIC does not discriminate.**
For persons with disabilities this document is available on request in other formats. To submit a request, please call: 1-800-841-1410 (TDD/TTY 1-800-833-6388).