FORM 213 5/2025

Medical Documentation

WIC-Eligible Nutritionals and Therapeutic Formula

WIC Clinic:

Fax #:

WIC ID #:

Idaho WIC's current standard contract formulas are Similac Advance and Similac Soy Isomil. Similac Sensitive and Similac Total Comfort are also allowed. Medicaid is the first payer for therapeutic formulas and nutritionals. **Per Medicaid, at this time they will only cover formula for life-threatening diagnoses**. **If WIC is covering the formula, please complete this form for WIC authorization and return the completed form to the patient's WIC clinic.**

SECTION I — TO BE COMPLETED FOR ALL ORDERS

PATIENT (First/MI/Last): **DOB:**

PARENT/CAREGIVER (First/MI/Last):

SECTION II — THERAPEUTIC FORMULA/NUTRITIONALS

This documentation is federally required to ensure the patient under your care has a medical condition/diagnosis that dictates the use of therapeutic formula/nutritionals or requires changes to the WIC supplemental food package.

Section A: Must be completed by a healthcare provider.

Section B: The health care provider can select a WIC Registered Dietitian (RD). If selected, the WIC RD will determine appropriate issuance, prescribed amount, and length of time needed for WIC foods based on the patient's qualifying condition(s).

☐ Supplemental foods, amount and length of need to be determined per WIC RD.

A) Therapeutic Formula/Nutritionals:

Product Name:_____

Dx: _____

Duration: _____ months (maximum 12 mos)

Amount: _____ oz/day

☐ Prematurity ☐ GERD or reflux

☐ Failure to thrive ☐ Food allergy: _____

☐ Dysphagia Other: _____

Special instructions/comments:

This prescription is: ☐ new ☐ refill

B) WIC FOOD RESTRICTIONS: The patient will receive WIC foods in addition to the formula prescribed. Please check all foods listed below that are NOT appropriate for the diagnosis.

	WIC Foods	Category	Restrictions / Comments
Infants (6-12 mos)	Baby cereal	☐	
	Baby fruit/vegetable	☐	
Children (1-5 yrs)	Cow's milk	☐	
	Cheese	☐	
	Eggs	☐	
	Peanut butter	☐	
	Whole grains	☐	
	Cereal	☐	
	Beans	☐	
	Vegetables / fruits	☐	
	Juice	☐	

Health Provider's Name (please print) | **Location** | **Phone:** / **Fax:**

Health Care Provider's Signature

× _____ ☐ MD ☐ DO ☐ PA ☐ NP/CNM **Date:** _____

WIC USE ONLY RD review: Date: