



**MEDICAL DOCUMENTATION - HEALTH CARE PROVIDER AUTHORIZATION  
FOR SPECIAL FORMULAS AND WIC SUPPLEMENTAL FOOD**

Medical documentation is federally required to ensure that the patient under your care has a medical condition that requires the use of special formula and that conventional foods are precluded, restricted, and inadequate to meet their special nutritional needs.

**INSTRUCTIONS: COMPLETE SECTIONS A AND D FOR ALL PATIENTS.**

- To request a special formula and supplemental foods, also complete section B.
  - To request a soy beverage, tofu or additional cheese, also complete section C.
- The Missouri WIC Program will not authorize issuance for:**
- Non specific symptoms; such as intolerance, fussiness, gas, spitting up, constipation or colic.
  - Enhancing nutrient intake or managing body weight without any underlying medical condition.
- Fax form to WIC clinic or have WIC participant return form to clinic.**

LOCAL AGENCY

PHONE

FAX

**A. PATIENT INFORMATION (COMPLETED BY PHYSICIAN OFFICE STAFF)**

PATIENT'S NAME (LAST, FIRST, MI)			DOB	
PARENT/CAREGIVER'S NAME		HEIGHT	WEIGHT	HGB
<b>Medical Reason/Dx:</b> (Qualifying Condition) <i>*MO WIC Risk Factor eligibility in parenthesis.</i>	<input type="checkbox"/> Prematurity (*RF 142)	<input type="checkbox"/> Low Birth Weight (*RF 141)	<input type="checkbox"/> Failure to Thrive (*RF 134)	<input type="checkbox"/> Metabolic Disorders
	<input type="checkbox"/> Gastrointestinal Disorders (*RF 342)	<input type="checkbox"/> Malabsorption Syndromes (*RF 341)	<input type="checkbox"/> Immune System Disorder (*RF 360)	<input type="checkbox"/> Severe Food Allergy (*RF 353)
<input type="checkbox"/> Other-Describe (Life Threatening Disorders, Diseases and Medical Conditions that impair digestion, absorption, or utilization of nutrients that could adversely affect the participants nutrition status). (*RF 341-362)				

APPROVAL LENGTH  
 1 MONTH     2 MONTHS     3 MONTHS     4 MONTHS     5 MONTHS     6 MONTHS (MAX)

**B. SPECIALTY FORMULA AND WIC SUPPLEMENTAL FOODS (COMPLETED BY PHYSICIAN OFFICE STAFF)**

FORMULA REQUESTED (SEE LISTED ON BACK)

PRESCRIBED AMOUNT  
 MAXIMUM ALLOWABLE OR  \_\_\_\_\_ OZ/DAY

SPECIAL INSTRUCTIONS/MIXING FOR FORMULA REQUESTED

SUPPLEMENTAL FOOD (CHECK ONE) <input type="checkbox"/> Issue full provision of age appropriate supplemental foods. <input type="checkbox"/> No WIC supplemental foods; provide formula only. <input type="checkbox"/> Issue a modified food package omitting the supplemental foods checked below.		SPECIAL INSTRUCTIONS FOR SUPPLEMENTAL FOOD
<b>WIC PARTICIPANT CATEGORY</b>	<b>WIC SUPPLEMENTAL FOODS (CHECK FOOD TO OMIT)</b>	
<b>Infants (6-11 mos)</b>  <b>Children (1-4 yrs) &amp; Women</b>	<input type="checkbox"/> Infant Cereal <input type="checkbox"/> Infant Fruits/Vegetables  <input type="checkbox"/> Milk* <input type="checkbox"/> Cheese <input type="checkbox"/> Peanut Butter <input type="checkbox"/> Eggs <input type="checkbox"/> Legumes <input type="checkbox"/> Breakfast Cereals <input type="checkbox"/> Juice <input type="checkbox"/> Whole Grains <input type="checkbox"/> Fruits & Vegetables <input type="checkbox"/> Fish (fully breastfeeding women only)	

\*WIC provides low fat milk for women and children > 2 years of age. Whole milk may be issued only to patients receiving specialty formula whose medical condition qualifies them. Only whole milk will be issued to 1 year olds.

**C. SOY BEVERAGE, TOFU OR ADDITIONAL CHEESE (COMPLETED BY PHYSICIAN OFFICE STAFF)**

CHECK THE BOXES BELOW TO PRESCRIBE SOY BEVERAGE, TOFU OR ADDITIONAL CHEESE. NOTE: CHEESE, TOFU AND SOY BEVERAGE AMOUNTS WILL BE DEDUCTED FROM THE MAXIMUM MONTHLY ALLOWANCE FOR REDUCED/LOW-FAT MILK, BASED ON PARTICIPANT CATEGORY.

Soy Beverage or Tofu for Children     >1 lb Cheese for Women or Children  
 >4 lbs Tofu for Women (Prenatal and Partially or Non-Breastfeeding)     >6 lbs Tofu (for fully Breastfeeding Women)

DIAGNOSIS (REQUIRED). PERSONAL PREFERENCE IS NOT AN ALLOWED REASON.

Milk Allergy     Severe Lactose Maldigestion     Vegan Diet

**D. HEALTH CARE PROVIDER INFORMATION (COMPLETED BY PRESCRIPTIVE AUTHORITY LICENSED BY THE STATE)**

SIGNATURE OF HEALTH CARE PROVIDER	DATE
PROVIDER'S NAME (PLEASE PRINT)	PHONE NUMBER
<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> NP	

**MISSOURI WIC PROGRAM**  
**APPROVED FORMULAS LISTING**

**STANDARD CONTRACT INFANT FORMULAS**

These formulas will be given unless a physician diagnoses a medical condition that warrants a specialty formula.

- No prescription is needed for infants to receive: **\*Enfamil Premium, Enfamil LIPIL with Iron, Enfamil Prosoabee Lipil/Enfamil Soy, or Gentlease LIPIL.**
- A prescription is needed for adults and children over one year of age and is valid for up to six (6) months.

**SPECIALTY FORMULAS FOR INFANTS**

Medical documentation is required for issuance of these formulas.

Reasons such as "colic," "spitting up," or "constipation" will NOT be accepted as a substitute for a medical diagnosis.

Elecare*	Enfamil Premature LIPIL with Iron (20 cal) (Nursette)	Pregestimil LIPIL*
Elecare DHA/ARA*	Enfamil Premature LIPIL with Iron (24 cal) (Nursette)	Pregestimil LIPIL (20 cal) *(Nursette)
EnfaCare LIPIL (22 cal)*	Enfaport LIPIL	Pregestimil LIPIL (24 cal) *(Nursette)
Enfamil A.R. LIPIL*	NeoCate Infant Formula*	Similac Alimentum*
Enfamil Human Milk Fortifier	NeoCate Infant Formula DHA/ARA*	Similac NeoSure (22 cal)*
Enfamil LIPIL w/Iron (20 cal) non-premature (Nursette)	Nutramigen AA*	Similac PM 60/40*
Enfamil LIPIL w/Iron (24 cal) non-premature (Nursette)	Nutramigen LIPIL with Enflora LGG*	Similac Special Care w/Iron (20 cal) (Nursette)
		Similac Special Care w/Iron (24 cal) (Nursette)

The \* indicates that the formula can also be issued to children whose medical condition qualifies them.

**SPECIALTY FORMULAS FOR WOMEN AND CHILDREN**

Women	Children
AI Soy	Boost Kid Essentials-All Flavors
Boost-All Flavors	Boost Kid Essentials 1.5 cal-All Flavors
Ensure-All Flavors	Boost Kid Essentials with Fiber 1.5 cal Vanilla
Ensure-Vanilla	Bright Beginnings Soy Pediatric Drink
Peptamen-All Flavors	Enfagrow Gentlease
Peptamen with Prebio	Enfagrow Premium (Enfamil Next Step LIPIL)
Peptamen 1.5-All Flavors	Enfagrow Soy (Enfamil Next Step Soy LIPIL)
Tolerex	E028 Splash-All Flavors
Vivonex T.E.N.	<b>The ** indicates that the formula can also be issued to women whose medical condition qualifies them.</b>

For complete listing of WIC Approved Formulas & Supplemental Food refer to <http://www.dhss.mo.gov/wic/FoodPackages/InfoforHealthCareProviders.html>.

**WIC USE ONLY - MUST COMPLETE SECTION IN ITS ENTIRETY.**

PARTICIPANT'S NAME		STATE WIC ID	
REASON(S) FOR REQUESTING READY-TO-USE/FEED (RTU/RTF)			
<input type="checkbox"/> Poor Water Quality	<input type="checkbox"/> Tube Feeding	<input type="checkbox"/> Poor Refrigeration	
<input type="checkbox"/> Product only available in RTU/RTF	<input type="checkbox"/> Better accommodates the participants condition	<input type="checkbox"/> Mixing/Dilution Difficulty	
<input type="checkbox"/> Improves the participants compliance in consuming the product			
<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED		IF DISAPPROVED, WAS HEALTH CARE PROVIDER (HCP) CONTACTED?	DID HCP AGREE TO SUGGESTED CHANGES?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
MONTH(S) APPROVED		QUESTIONS/CONCERNS/CHANGES	
<input type="checkbox"/> Jan	<input type="checkbox"/> Feb	<input type="checkbox"/> Mar	<input type="checkbox"/> Apr
<input type="checkbox"/> May	<input type="checkbox"/> Jun	<input type="checkbox"/> July	<input type="checkbox"/> Aug
<input type="checkbox"/> Sept	<input type="checkbox"/> Oct	<input type="checkbox"/> Nov	<input type="checkbox"/> Dec
DOES THIS APPROVAL EXTEND BEYOND THE CURRENT CERTIFICATION?			
<input type="checkbox"/> YES <input type="checkbox"/> NO    IF YES, SET AN ALERT FOR REMAINING APPROVAL PERIOD.			
CHEESE AMOUNT APPROVED	TOFU AMOUNT APPROVED	PRIMARY MILK AMOUNT APPROVED	SOY BEVERAGE AMOUNT APPROVED
APPROVED BY			DATE
			<input type="checkbox"/> RD <input type="checkbox"/> Nutritionist <input type="checkbox"/> RN
AGENCY NAME			AGENCY NUMBER
<b>COMPLETE THIS SECTION WHEN LWP RECEIVES APPROVAL FROM THE STATE OFFICE</b>			
NAME OF STATE NUTRITIONIST		<input type="checkbox"/> Approval Letter on File	DATE APPROVED

**LOCAL WIC PROVIDER – SCAN COMPLETED DOCUMENT IN MOWINS**