Virginia WIC Request for Special Prescription

WIC-395 Form

Requests are subject to approval based on Virginia WIC policy.
Additional information located at www.vdh.virginia.gov/wic/healthcare-providers

Full completion of Sections A – E required at submission

INFANT FORM

A. Patient Information

Infant Name:

DOB:

Guardian Name:

Phone: ( )

B. Anthropometric Data

- **Provide most recent data collected on the same date.**
- **Both values are required.**

Weight: lbs. oz. **Length:** in.

Collection Date:

C. Formula Information

Please include ALL products requested for patient on single form

Product(s) requested: _____ **Is RTF medically required?:** ☐ No ☐ Yes

If yes, provide RTF justification: _____

Amount per day: ☐ Standard WIC amount or _____ oz/day **Calories per ounce:** ☐ Standard dilution or _____ kcal/oz

Length of use: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

Diagnosis with ICD code: _____

- **The following are considered non-qualifying conditions and will <u>not</u> be approved-** colic, constipation, diarrhea, gas, fussiness, weight loss, slow or poor weight gain, non-specific feeding difficulties, spitting-up, vomiting, non-specific formula intolerances or allergies or personal preference.
- All Failure to Thrive diagnoses <u>must</u> be supported by a current weight that is < 3rd percentile for age, current weight < 80% of ideal weight for height/age, or documented decrease in growth along infant's previously defined growth curve.
- <u>WIC is a supplemental program</u> and the formula and food benefits provided are not intended to meet the full nutritional needs of participants. Formula amounts over the standard WIC amounts are <u>only</u> available for infants who have qualifying Virginia Medicaid coverage and a qualifying diagnosis.
- Contract WIC formulas (Similac Advance, Soy Isomil, Sensitive, Total Comfort, and Spit-up) <u>cannot</u> be issued in amounts over the standard WIC amount and RTF forms of these products <u>cannot</u> be issued for reasons related to tolerance.

D. Allowable WIC Foods

Selection of at least 1 option is REQUIRED

Beginning at 6 months of age, WIC provides supplemental foods to infants in addition to prescribed formula.
Please indicate any restrictions required for the duration of this prescription-

☐ No restrictions or infant is under 6 months of age for duration of prescription

☐ Delay WIC foods until _____ months of age

☐ Remove Infant Cereal

☐ Remove Infant Pureed Fruits/Vegetables

E. Health Care Provider Information

Printed Name:

☐ MD ☐ DO ☐ PA ☐ ARNP

Address:

Phone:

Fax:

Signature of healthcare provider authorized to write medical prescription under state law **Date**

WIC STAFF USE ONLY

Family ID: **Issuance Day:**

Approved: ☐ Yes ☐ No If no, provide details below :

Medicaid: ☐Yes ☐No **OTM**: ☐Yes ☐No If yes, provide calculations:

Printed Name:

☐ RD ☐ CPA ☐ CPPA

Staff Signature **Date**

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Full completion of Sections A – E required at submission

CHILD FORM

A. Patient Information

Child Name:

DOB:

Guardian Name:

Phone: ( )

B. Anthropometric Data

- **Provide most recent data collected on the same date.**
- **Both values are required.**

Weight: lbs. oz. **Height**: in.

Collection Date:

C. Formula Information

Please include ALL products requested for patient on single form

Product(s) requested: _____ **Is RTF medically required?:** ☐ No ☐ Yes

If yes, provide RTF justification: _____

Amount per day: _____ oz/day **Calories per ounce:** ☐ Standard dilution or _____ kcal/oz

Length of use: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

Diagnosis with ICD code: _____

- **The following are considered non-qualifying conditions and will not be approved-** colic, constipation, diarrhea, gas, fussiness, weight loss, slow or poor weight gain, non-specific feeding difficulties, spitting-up, vomiting, non-specific formula intolerances or allergies, picky eating, enhancing nutrient intake or managing body weight without a documented underlying medical condition, food intolerances or allergies that can be managed with regular foods, or preference.
- All Failure to Thrive diagnoses must be supported by a current weight that is < 3rd percentile for age, current weight < 80% of ideal weight for height/age, or documented decrease in growth along child's previously defined growth curve.
- WIC is a supplemental program and the formula and food benefits provided are not intended to meet the full nutritional needs of participants. Formula amounts over the standard WIC amounts are only available for children who have qualifying Virginia Medicaid coverage and a qualifying diagnosis.

D. Allowable Foods

Selection of at least 1 option is REQUIRED

☐ **No restrictions, issue all WIC foods in addition to formula**

☐ **Provide formula only, remove ALL other WIC foods**

☐ **Remove the following WIC foods:**

☐ Milk/Yogurt/Cheese ☐ 100% Juice ☐ Cereal ☐ Beans/Legumes
☐ Whole Grains ☐ Eggs ☐ Fruits/Vegetables ☐ Peanut Butter

☐ **Provide the following modifications in addition to the requested formula:**

☐ Substitute pureed fruits/vegetables for regular fruits/vegetables

☐ Substitute whole milk for 1% and skim milk (age 2 and older, only)

☐ Substitute 2% milk for 1% and skim milk (age 2 and older, only)

E. Health Care Provider Information

Printed Name:

☐ MD ☐ DO ☐ PA ☐ ARNP

Address:

Phone:

Fax:

Signature of healthcare provider authorized to write medical prescription under state law **Date**

WIC STAFF USE ONLY

Family ID: **Issuance Day:**

Approved: ☐ Yes ☐ No If no, provide details below :

Medicaid: ☐Yes ☐No **OTM**: ☐Yes ☐No If yes, provide calculations:

Printed Name:

☐ RD ☐ CPA ☐ CPPA

Staff Signature **Date**

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Full completion of Sections A – E required at submission

WOMAN FORM

A. Patient Information	
Name:	
DOB:	
Phone: ( )	

B. Anthropometric/Clinical Data				
Weight:	lbs.	oz.	**Height:**	in.
Collection date:				
EDD or pregnancy end date:				

C. Formula Information

Please include ALL products requested for patient on single form

Product(s) requested: _____

Amount per day: _____ oz/day **Calories per ounce:** ☐ Standard dilution or _____ kcal/oz

Length of use: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

Diagnosis, please select ALL that apply:

- ☐ Low maternal weight gain / maternal weight loss, O26.1 *pregnant women only*
- ☐ Hyperemesis Gravidarum, O21.0 *pregnant women only*
- ☐ Current or pre-pregnancy BMI < 18.5, R63.6 *pregnant and breastfeeding women only*
- ☐ Severe allergies, MUST specify and include ICD: _____
- ☐ Other, MUST specify and include ICD: _____

D. Allowable Foods

Selection of at least 1 option is REQUIRED

☐ **No restrictions, issue all WIC foods in addition to formula** ☐ **Provide formula only, remove ALL other WIC foods**

☐ **Remove the following WIC foods:**

☐ Milk/Yogurt/Cheese ☐ 100% Juice ☐ Cereal ☐ Beans/Legumes
☐ Whole Grains ☐ Eggs ☐ Fruits/Vegetables ☐ Peanut Butter
☐ Canned Fish (women who are pregnant with multiples or fully breastfeeding only)

☐ **Provide the following modifications in addition to the requested formula:**

☐ Substitute pureed fruits/vegetables for regular fruits/vegetables
☐ Substitute whole milk for 1% and skim milk
☐ Substitute 2% milk for 1% and skim milk

E. Health Care Provider Information

Printed Name:

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Address:

Phone:

Fax:

Signature of healthcare provider authorized to write medical prescription under state law **Date**

WIC STAFF USE ONLY

Family ID: **Issuance Day:**

Approved: ☐ Yes ☐ No If no, provide details below:

Printed Name:

☐ RD ☐ CPA ☐ CPPA

Staff Signature **Date**