

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
<ul style="list-style-type: none"> ➤ 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?: <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, provide RTF justification: _____	
Amount per day: <input type="checkbox"/> Standard WIC amount or _____ oz/day	Calories per ounce: <input type="checkbox"/> Standard dilution or _____ kcal/oz
Length of use: <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months <input type="checkbox"/> 5 months <input type="checkbox"/> 6 months	
Diagnosis with ICD code: _____	
<ul style="list-style-type: none"> ➤ 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 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-	
<input type="checkbox"/> No restrictions or infant is under 6 months of age for duration of prescription	<input type="checkbox"/> Delay WIC foods until _____ months of age
<input type="checkbox"/> Remove Infant Cereal	<input type="checkbox"/> Remove Infant Pureed Fruits/Vegetables

E. Health Care Provider Information
Printed Name: _____
<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide details below :	
Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No OTM: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide calculations:	
Printed Name: _____	
<input type="checkbox"/> RD <input type="checkbox"/> CPA <input type="checkbox"/> CPPA	
Staff Signature _____	Date _____

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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?: <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, provide RTF justification: _____	
Amount per day: _____ oz/day	Calories per ounce: <input type="checkbox"/> Standard dilution or _____ kcal/oz
Length of use: <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months <input type="checkbox"/> 5 months <input type="checkbox"/> 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 <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 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 <u>only</u> available for children who have qualifying Virginia Medicaid coverage and a qualifying diagnosis.	

D. Allowable Foods	
Selection of at least 1 option is REQUIRED	
<input type="checkbox"/> No restrictions, issue all WIC foods in addition to formula	<input type="checkbox"/> Provide formula only, remove ALL other WIC foods
<input type="checkbox"/> Remove the following WIC foods:	
<input type="checkbox"/> Milk/Yogurt/Cheese	<input type="checkbox"/> 100% Juice
<input type="checkbox"/> Whole Grains	<input type="checkbox"/> Eggs
<input type="checkbox"/> Cereal	<input type="checkbox"/> Beans/Legumes
<input type="checkbox"/> Fruits/Vegetables	<input type="checkbox"/> Peanut Butter
<input type="checkbox"/> Provide the following modifications in addition to the requested formula:	
<input type="checkbox"/> Substitute pureed fruits/vegetables for regular fruits/vegetables	<input type="checkbox"/> Substitute whole milk for 1% and skim milk (age 2 and older, only)
<input type="checkbox"/> Substitute 2% milk for 1% and skim milk (age 2 and older, only)	

E. Health Care Provider Information	
Printed Name:	
	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide details below :	
Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No OTM: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide calculations:	
Printed Name:	<input type="checkbox"/> RD <input type="checkbox"/> CPA <input type="checkbox"/> CPPA
Staff Signature	Date

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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:	<input type="checkbox"/> Standard dilution or _____ kcal/oz
Length of use:	<input type="checkbox"/> 1 month	<input type="checkbox"/> 2 months
	<input type="checkbox"/> 3 months	<input type="checkbox"/> 4 months
	<input type="checkbox"/> 5 months	<input type="checkbox"/> 6 months
Diagnosis, please select ALL that apply:		
<input type="checkbox"/>	Low maternal weight gain / maternal weight loss, O26.1 <i>pregnant women only</i>	
<input type="checkbox"/>	Hyperemesis Gravidarum, O21.0 <i>pregnant women only</i>	
<input type="checkbox"/>	Current or pre-pregnancy BMI < 18.5, R63.6 <i>pregnant and breastfeeding women only</i>	
<input type="checkbox"/>	Severe allergies, MUST specify and include ICD: _____	
<input type="checkbox"/>	Other, MUST specify and include ICD: _____	

D. Allowable Foods		Selection of at least 1 option is REQUIRED
<input type="checkbox"/>	No restrictions, issue all WIC foods in addition to formula	<input type="checkbox"/>
		Provide formula only, remove ALL other WIC foods
<input type="checkbox"/>	Remove the following WIC foods:	
<input type="checkbox"/>	Milk/Yogurt/Cheese	<input type="checkbox"/>
	100% Juice	<input type="checkbox"/>
	Cereal	<input type="checkbox"/>
	Whole Grains	<input type="checkbox"/>
	Eggs	<input type="checkbox"/>
	Fruits/Vegetables	<input type="checkbox"/>
	Canned Fish (women who are pregnant with multiples or fully breastfeeding only)	<input type="checkbox"/>
	Beans/Legumes	<input type="checkbox"/>
	Peanut Butter	
<input type="checkbox"/>	Provide the following modifications in addition to the requested formula:	
<input type="checkbox"/>	Substitute pureed fruits/vegetables for regular fruits/vegetables	<input type="checkbox"/>
	Substitute whole milk for 1% and skim milk	<input type="checkbox"/>
	Substitute 2% milk for 1% and skim milk	

E. Health Care Provider Information	
Printed Name:	
	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide details below:	
Printed Name:	<input type="checkbox"/> RD <input type="checkbox"/> CPA <input type="checkbox"/> CPPA
Staff Signature	Date