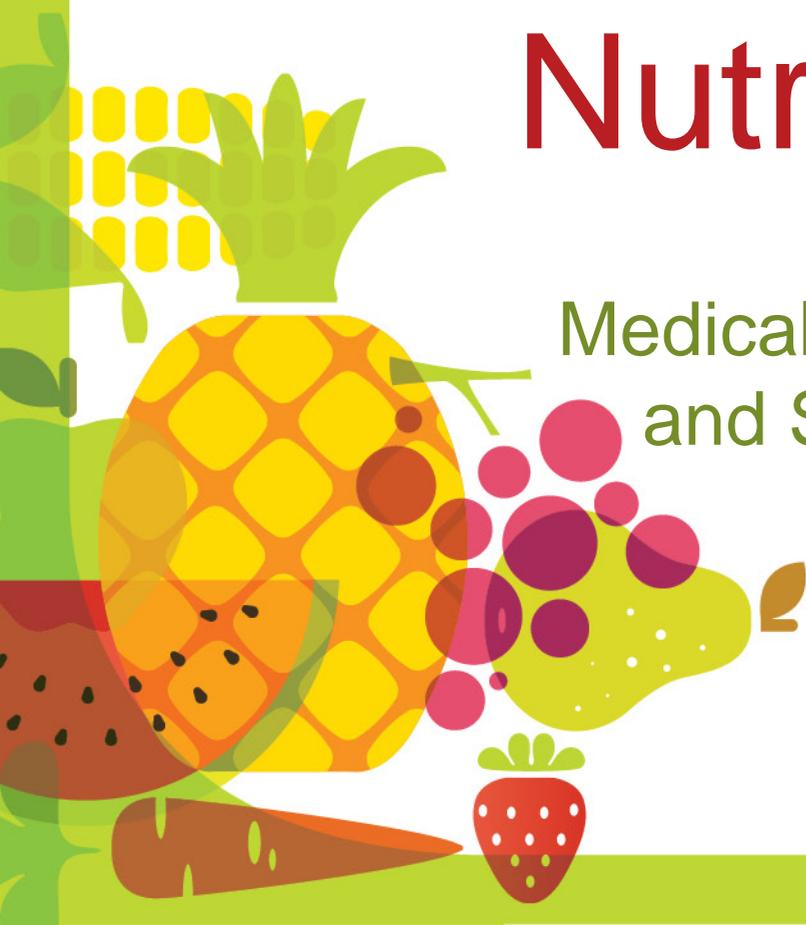


# Nutrition Training

Medically Necessary WIC Approved  
and Similac Formula Requests



# Introduction

**WIC participants with qualifying medical conditions are eligible to receive medical formula and foods.**

The objective for today is to:

- Review the Medically Necessary and Similac WIC Forms
- What steps are needed for approvals
- Common formulas and reasons for issuance
- Issuance

# MEDICALLY NECESSARY WIC APPROVED FORMULA FORM



## Medically Necessary WIC Approved Formula Request Form



Prescribing Medical Formula and Supplemental Foods  
for Montana WIC Participants

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please complete Parts A and B to prescribe a Medical Formula. All requests are subject to WIC staff approval.

A. Medical Formulas/Nutritional Products		
Please check the requested formula, specify the amount, include the diagnosis, and the length of time the formula is necessary. Prescribed Amount: <input type="checkbox"/> Maximum Allowable OR _____ per day		
<b>Infant Products:</b> <i>Hypoallergenic:</i> <input type="checkbox"/> Alfamino <input type="checkbox"/> Alimentum <input type="checkbox"/> Elecare <input type="checkbox"/> Neocate <input type="checkbox"/> Nutramigen Enflora LGG <input type="checkbox"/> Pregestimil <input type="checkbox"/> PurAmino  <i>Premature/Low Birth Weight:</i> <input type="checkbox"/> Enfacare <input type="checkbox"/> Neosure  <i>Contract Formula:</i> <input type="checkbox"/> Gerber Good Start Soy <input type="checkbox"/> Similac Advance <input type="checkbox"/> Similac Sensitive <input type="checkbox"/> Similac for Spit Up <input type="checkbox"/> Similac Total Comfort  <i>Other:</i> <input type="checkbox"/> _____	<b>Pediatric and Adult Products:</b> <input type="checkbox"/> Alfamino Junior <input type="checkbox"/> Boost Kid Essentials <input type="checkbox"/> Boost Original (adult) <input type="checkbox"/> Bright Beginnings Pediatric Drink (Soy) <input type="checkbox"/> Carnation Breakfast Essentials <input type="checkbox"/> Compleat Pediatric <input type="checkbox"/> Elecare Junior <input type="checkbox"/> Ensure (adult) <input type="checkbox"/> EO28 Splash <input type="checkbox"/> Neocate Junior <input type="checkbox"/> Nutren Junior <input type="checkbox"/> Nutramigen Toddler <input type="checkbox"/> Pediasure <input type="checkbox"/> Pediasure Peptide <input type="checkbox"/> Peptamen Junior <input type="checkbox"/> Tolorex <input type="checkbox"/> Vivonex Pediatric <input type="checkbox"/> Other: _____ <i style="font-size: small;">Specify special versions of formula (i.e. 1.5 kcal/oz., with fiber, enteral, etc.)</i>	<b>Diagnosis:</b> <input type="checkbox"/> Milk protein allergy <input type="checkbox"/> Soy protein allergy <input type="checkbox"/> Malabsorption <input type="checkbox"/> Prematurity <input type="checkbox"/> Low or Very Low Birth Weight <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Oral Motor Feeding Problems <input type="checkbox"/> Other (please specify): _____  <b>Length of Time Formula is Requested:</b> <input type="checkbox"/> Months of Age*: _____ <input type="checkbox"/> To 1 year adjusted age <input type="checkbox"/> To the end of certification <input type="checkbox"/> Other Date: _____  <i>*Infants should be re-assessed at 6 months for supplemental food readiness</i>
B. Supplemental Foods (for Infants 6 months and older, Children and Women)		
Please review the food packages to be issued on the back and check the appropriate issuance for the participant below, or; <input type="checkbox"/> Defer to Local WIC Registered Dietitian to determine appropriate supplemental foods and length of time of their issuance.		
<b>Infants (6-12 months)</b> <input type="checkbox"/> Provide full food package <input type="checkbox"/> Issue medical formula only (no foods)  Delete the following items from the food package: <input type="checkbox"/> Infant cereal <input type="checkbox"/> Infant vegetables/fruit <input type="checkbox"/> Fruit/Vegetable Benefit 9-11 mo (partial substitution) <input type="checkbox"/> Infant meats	<b>Children and Women</b> <input type="checkbox"/> Provide full food package <input type="checkbox"/> Issue Whole Milk (children >2 and women) <i>in addition to medical formula (Part A)</i> <input type="checkbox"/> Issue medical formula only (no foods)  Delete the following items from the food package: <input type="checkbox"/> Cow's Milk <input type="checkbox"/> Cheese <input type="checkbox"/> Peanut Butter <input type="checkbox"/> Cereal <input type="checkbox"/> Eggs <input type="checkbox"/> Fruits/Vegetables <input type="checkbox"/> Whole Grains <input type="checkbox"/> Dry/Canned Beans <input type="checkbox"/> Tuna/Salmon <input type="checkbox"/> Juice	<b>Special Instructions/Restrictions</b> <input type="checkbox"/> Substitute soy beverage for cow's milk <input type="checkbox"/> Substitute goat's milk for cow's milk <input type="checkbox"/> Substitute infant cereal for child <input type="checkbox"/> Substitute infant fruits/vegetables for fruits/vegetables cash benefit child or woman <input type="checkbox"/> Other: _____

WIC participants with qualifying medical conditions are eligible to receive medical formula with the maximum amount based on the participant's age and category. Infants six months and older, children and women may also receive supplemental foods for their category, as listed below.

If a participant may receive the full amount of formula as listed below, please check the "Maximum Allowable" box under Medical Formula (Part A) on the front page. If a participant is to receive less, or an item is to be deleted, please indicate the item in the same box.

For Supplemental Foods, Part B, please review the WIC supplemental foods below and indicate on the front page which foods to delete or substitute for the participant. If a participant may receive the full food package, please mark the box indicating this. Please add any special instructions or information if you would prefer to have the WIC RD select and assign the supplemental foods please check the box in part B.

	0-3 months	4-5 months	6-11 months	6-11 months (when solids are contraindicated)
<b>Infant Formula:</b>				
Powder (reconstituted)	Up to 870 oz.	Up to 960 oz.	Up to 696 oz.	Up to 960 oz.
Concentrate (reconstituted)	Up to 823 oz.	Up to 896 oz.	Up to 630 oz.	Up to 896 oz.
Ready-to-feed	Up to 832 oz.	Up to 913 oz.	Up to 643 oz.	Up to 913 oz.
<b>Infant Foods:</b>				
Infant Cereal	None	None	3 8-oz. containers	None
Infant Vegetables/Fruits	None	None	32 4-oz. jars (formula fed) 64 4-oz. jars (fully breastfed)	None
Infant Meats (Fully breastfed only)	None	None	31 4-oz. jars	

Children 1-5 years
Up to 910 oz. formula
4 gallons milk*
2 64-oz. bottles juice
36 oz. cereal
1 dozen eggs
\$8 fruit and vegetable benefit
18 oz. peanut butter or 1 lb. dry beans or 4 16-oz. canned beans
2 lb. whole wheat bread or brown rice or whole wheat tortillas or soft corn tortillas

\*Cheese may be substituted for some milk.

Fully Breastfeeding Women	Pregnant or Substantially Breastfeeding Women	Partially and Non-Breastfeeding Women
Up to 910 oz. formula	Up to 910 oz. formula	Up to 910 oz. formula
6 gallons milk and 1 lb. cheese	5 1/2 gallons milk*	4 gallons milk*
3 12-oz. juice (frozen)	3 12-oz. juice (frozen)	2 12-oz. juice (frozen)
36 oz. cereal	36 oz. cereal	36 oz. cereal
2 dozen eggs	1 dozen eggs	1 dozen eggs
\$11 fruit and vegetable benefit	\$11 fruit and vegetable benefit	\$11 fruit and vegetable benefit
18 oz. peanut butter AND 1 lb. dry beans or 4 16-oz. cans beans	18 oz. peanut butter AND 1 lb. dry beans or 4 16-oz. cans beans	18 oz. peanut butter or 1 lb. dry beans or 4 16-oz. cans beans
1 lb. whole wheat bread or brown rice or whole wheat tortillas or soft corn tortillas	1 lb. whole wheat bread or brown rice or whole wheat tortillas or soft corn tortillas	None
30 oz. tuna or pink salmon	None	None

Please contact your local WIC agency with any questions.

Health Care Provider Name \_\_\_\_\_  
 And Credentials(Printed): \_\_\_\_\_ (Signature): \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Effective 06/23/2016



## Medically Necessary WIC Approved Formula Request Form



Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please complete **Parts A and B** to prescribe a **Medical Formula**. All requests are subject to WIC staff approval.

A. Medical Formulas/Nutritional Products		
Please check the requested formula, specify the amount, include the diagnosis, and the length of time the formula is necessary.		
Prescribed Amount: <input type="checkbox"/> Maximum Allowable    OR    _____ per day		
<p><b>Infant Products:</b></p> <p><i>Hypoallergenic:</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Alfamino</li> <li><input type="checkbox"/> Alimentum</li> <li><input type="checkbox"/> Elecare</li> <li><input type="checkbox"/> Neocate</li> <li><input type="checkbox"/> Nutramigen Enflora LGG</li> <li><input type="checkbox"/> Pregestimil</li> <li><input type="checkbox"/> PurAmino</li> </ul> <p><i>Premature/Low Birth Weight:</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Enfacare</li> <li><input type="checkbox"/> Neosure</li> </ul> <p><i>Contract Formula:</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Gerber Good Start Soy</li> <li><input type="checkbox"/> Similac Advance</li> <li><input type="checkbox"/> Similac Sensitive</li> <li><input type="checkbox"/> Similac for Spit Up</li> <li><input type="checkbox"/> Similac Total Comfort</li> </ul> <p><i>Other:</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> _____</li> </ul>	<p><b>Pediatric and Adult Products:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Alfamino Junior</li> <li><input type="checkbox"/> Boost Kid Essentials</li> <li><input type="checkbox"/> Boost Original (adult)</li> <li><input type="checkbox"/> Bright Beginnings Pediatric Drink (Soy)</li> <li><input type="checkbox"/> Carnation Breakfast Essentials</li> <li><input type="checkbox"/> Compleat Pediatric</li> <li><input type="checkbox"/> Elecare Junior</li> <li><input type="checkbox"/> Ensure (adult)</li> <li><input type="checkbox"/> EO28 Splash</li> <li><input type="checkbox"/> Neocate Junior</li> <li><input type="checkbox"/> Nutren Junior</li> <li><input type="checkbox"/> Nutramigen Toddler</li> <li><input type="checkbox"/> Pediasure</li> <li><input type="checkbox"/> Pediasure Peptide</li> <li><input type="checkbox"/> Peptamen Junior</li> <li><input type="checkbox"/> Tolerex</li> <li><input type="checkbox"/> Vivonex Pediatric</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p style="text-align: center;"><i>Specify special versions of formula (i.e 1.5 kcal/oz., with fiber, enteral, etc.)</i></p>	<p><b>Diagnosis:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Milk protein allergy</li> <li><input type="checkbox"/> Soy protein allergy</li> <li><input type="checkbox"/> Malabsorption</li> <li><input type="checkbox"/> Prematurity</li> <li><input type="checkbox"/> Low or Very Low Birth Weight</li> <li><input type="checkbox"/> Tube Feeding</li> <li><input type="checkbox"/> Oral Motor Feeding Problems</li> <li><input type="checkbox"/> Other (please specify): _____</li> </ul> <p><b>Length of Time Formula is Requested:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Months of Age*: _____</li> <li><input type="checkbox"/> To 1 year adjusted age</li> <li><input type="checkbox"/> To the end of certification</li> <li><input type="checkbox"/> Other Date: _____</li> </ul> <p style="font-size: small;"><i>*Infants should be re-assessed at 6 months for supplemental food readiness</i></p>



**B. Supplemental Foods (for Infants 6 months and older, Children and Women)**

Please review the food packages to be issued on the back and check the appropriate issuance for the participant below, or;

- Defer to Local WIC Registered Dietitian to determine appropriate supplemental foods and length of time of their issuance.

**Infants (6-12 months)**

- Provide full food package  
 Issue medical formula only (no foods)

Delete the following items from the food package:

- Infant cereal  
 Infant vegetables/fruit  
 Fruit/Vegetable Benefit 9-11 mo (partial substitution)  
 Infant meats

**Children and Women**

- Provide full food package  
 Issue Whole Milk (children >2 and women) *in addition to* medical formula (Part A)  
 Issue medical formula only (no foods)

Delete the following items from the food package:

- |  |  |
|--|--|
| <input type="checkbox"/> Cow's Milk    | <input type="checkbox"/> Cheese            |
| <input type="checkbox"/> Peanut Butter | <input type="checkbox"/> Cereal            |
| <input type="checkbox"/> Eggs          | <input type="checkbox"/> Fruits/Vegetables |
| <input type="checkbox"/> Whole Grains  | <input type="checkbox"/> Dry/Canned Beans  |
| <input type="checkbox"/> Tuna/Salmon   | <input type="checkbox"/> Juice             |

**Special Instructions/Restrictions**

- Substitute soy beverage for cow's milk  
 Substitute goat's milk for cow's milk  
 Substitute infant cereal for child  
 Substitute infant fruits/vegetables for fruits/vegetables cash benefit child or woman  
 Other:

Health Care Provider Name  
and Credentials(Printed): \_\_\_\_\_

(Signature): \_\_\_\_\_

Phone Number: \_\_\_\_\_

Effective 06/23/2016

**Prescribing Medical Formula and Supplemental Foods  
for Montana WIC Participants**

WIC participants with qualifying medical conditions are eligible to receive medical formula with the maximum amount based on the participant's age and category. Infants six months and older, children and women may also receive supplemental foods for their category, as listed below.

If a participant may receive the full amount of formula as listed below, please check the "Maximum Allowable" box under Medical Formula (Part A) on the front page. If a participant is to receive less, or an item is to be deleted, please indicate the item in the same box.

For Supplemental Foods, Part B, please review the WIC supplemental foods below and indicate on the front page which foods to delete or substitute for the participant. If a participant may receive the full food package, please mark the box indicating this. Please add any special instructions or information if you would prefer to have the WIC RD select and assign the supplemental foods please check the box in part B.

	0-3 months	4-5 months	6-11 months	6-11 months (when solids are contraindicated)
<b>Infant Formula:</b>				
Powder (reconstituted)	Up to 870 oz.	Up to 960 oz.	Up to 696 oz.	Up to 960 oz.
Concentrate (reconstituted)	Up to 823 oz.	Up to 896 oz.	Up to 630 oz.	Up to 896 oz.
Ready-to-feed	Up to 832 oz.	Up to 913 oz.	Up to 643 oz.	Up to 913oz.
<b>Infant Foods:</b>				
Infant Cereal	None	None	3 8-oz. containers	None
Infant Vegetables/Fruits	None	None	32 4-oz. jars (formula fed) 64 4-oz. jars (fully breastfed)	None
Infant Meats (Fully breastfed only)	None	None	31 4-oz. jars	

Children 1-5 years
Up to 910 oz. formula
4 gallons milk*
2 64-oz. bottles juice
36 oz. cereal
1 dozen eggs
\$8 fruit and vegetable benefit
18 oz. peanut butter or 1 lb. dry beans or 4 16-oz. cans beans
2 lb. whole wheat bread or brown rice or whole wheat tortillas or soft corn tortillas

\*Cheese may be substituted for some milk.

Fully Breastfeeding Women	Pregnant or Substantially Breastfeeding Women	Partially and Non-Breastfeeding Women
Up to 910 oz. formula	Up to 910 oz. formula	Up to 910 oz. formula
6 gallons milk and 1 lb. cheese	5 1/2 gallons milk*	4 gallons milk*
3 12-oz. juice (frozen)	3 12-oz. juice (frozen)	2 12-oz. juice (frozen)
36 oz. cereal	36 oz. cereal	36 oz. cereal
2 dozen eggs	1 dozen eggs	1 dozen eggs
\$11 fruit and vegetable benefit	\$11 fruit and vegetable benefit	\$11 fruit and vegetable benefit
18 oz. peanut butter AND 1 lb. dry beans or 4 16-oz. cans beans	18 oz. peanut butter AND 1 lb. dry beans or 4 16-oz. cans beans	18 oz. peanut butter or 1 lb. dry beans or 4 16-oz. cans beans
1 lb. whole wheat bread or brown rice or whole wheat tortillas or soft corn tortillas	1 lb. whole wheat bread or brown rice or whole wheat tortillas or soft corn tortillas	None
30 oz. tuna or pink salmon	None	None

Please contact your local WIC agency with any questions.



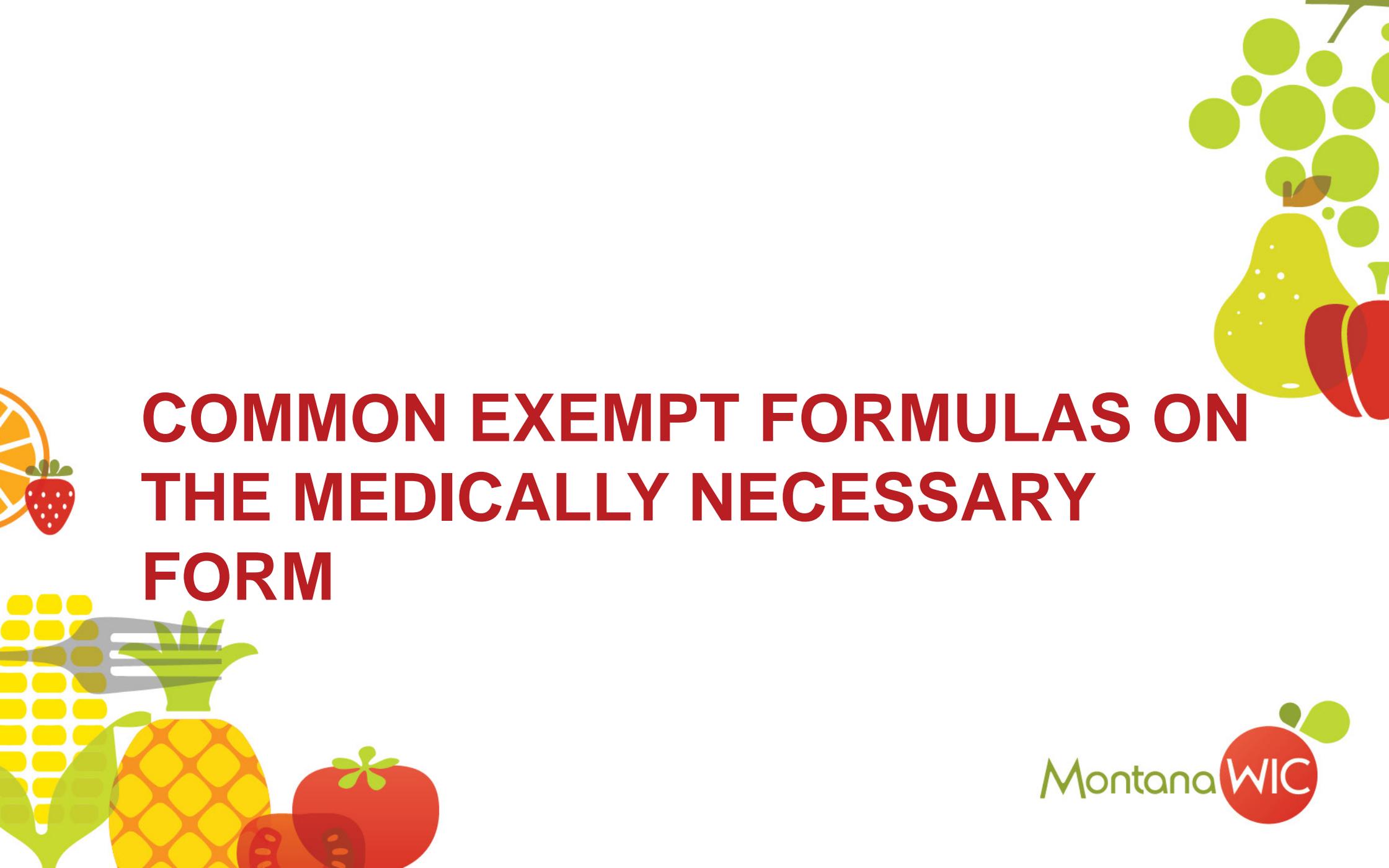
# STEPS FOR APPROVAL WITH MEDICALLY NECESSARY FORMULA



# Food Package III

- WIC Eligible formulas and nutritional products that include enteral WIC-eligible nutritional products which are specifically formulated to provide nutritional support for individuals with a diagnosed medical condition(s) when the use of conventional food is precluded, restricted or inadequate.
- Not all products that meet the definition of a nutritional are eligible to be issued by WIC.

- A CPA will ensure:
  - The medical diagnosis or condition is appropriate for the medical formula or nutritional.
  - If the box deferring to the RD is checked-then the RD must complete as assessment.
  - Based on the prescription completion, length is determined
- CPA or RD will document decision in participant folder
- If formula is not available locally, the state office will order the formula at the request of the local agency



# COMMON EXEMPT FORMULAS ON THE MEDICALLY NECESSARY FORM

# Locally Available Exempt Formulas and WIC-eligible nutritionals

Locally Available Exempt Formulas and WIC-eligible Nutritionals	Reason for Issuance
<u>Alimentum</u>	Milk and/or soy protein allergy
<u>Nutramigen Enflora</u>	Milk and/or soy protein allergy
<u>Neosure</u>	Prematurity
<u>EnfaCare LIPIL</u>	Prematurity or low birth weight
<u>Pediasure</u> , <u>Pediasure w/ Fiber</u> and <u>Ensure</u>	Tube-feeding, oral/motor problems or medical conditions which increase nutrient needs (for children over 1 year of age and women)

\*Contract formula may be issued to children over the age of 1 and in select cases to an infant.

# State Ordered Formulas

\*Contract formula may be issued to children over the age of 1 and in select cases to an infant.

Examples of State Ordered Formulas	Reason for Issuance
Resource Just for Kids, Resource Just for Kids w/ Fiber, Nutren Junior	Tube feeding, oral motor problems or medical conditions which increase nutrient needs (for children over 1 year of age)
Elecare, Neocate, PurAmino	Severe malabsorption or allergy to intact proteins
Peptamen Junior, Vivonex Pediatric, Pediasure Peptide	Severe malabsorption or allergy to intact proteins (for children over 1 year of age)
Pregestimil	Malabsorption; milk and/or soy protein allergy
Similac PM 60/40	Renal, cardiac or other conditions that require lowered mineral intake
Metabolic Formulas	Metabolic disorders

\*Contract formula may be issued to children over the age of 1 and in select cases to an infant.

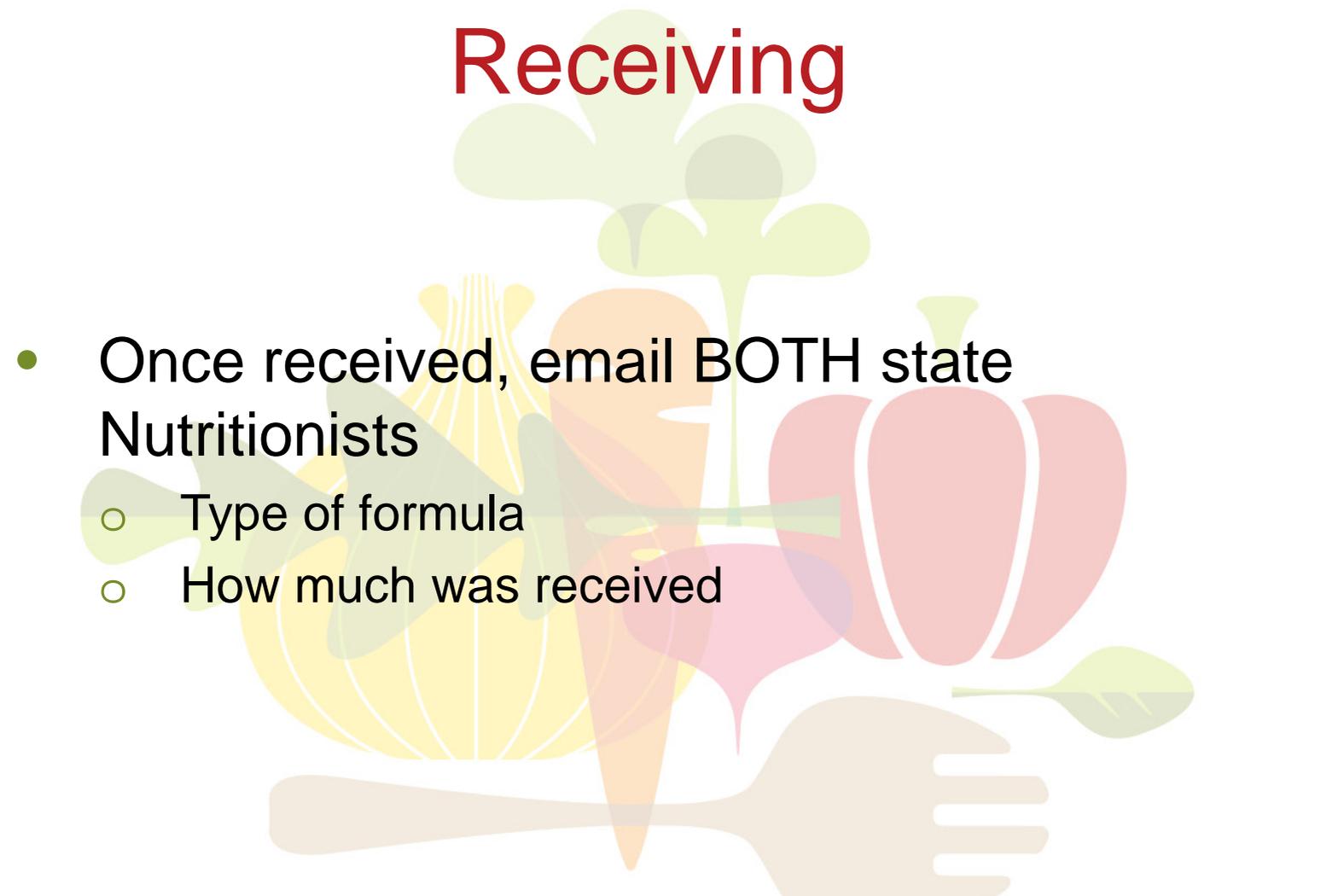
# **DIRECTIONS FOR ORDERING, RECEIVING AND DISTRIBUTING FOR MEDICALLY NECESSARY FORMULAS**



# Ordering

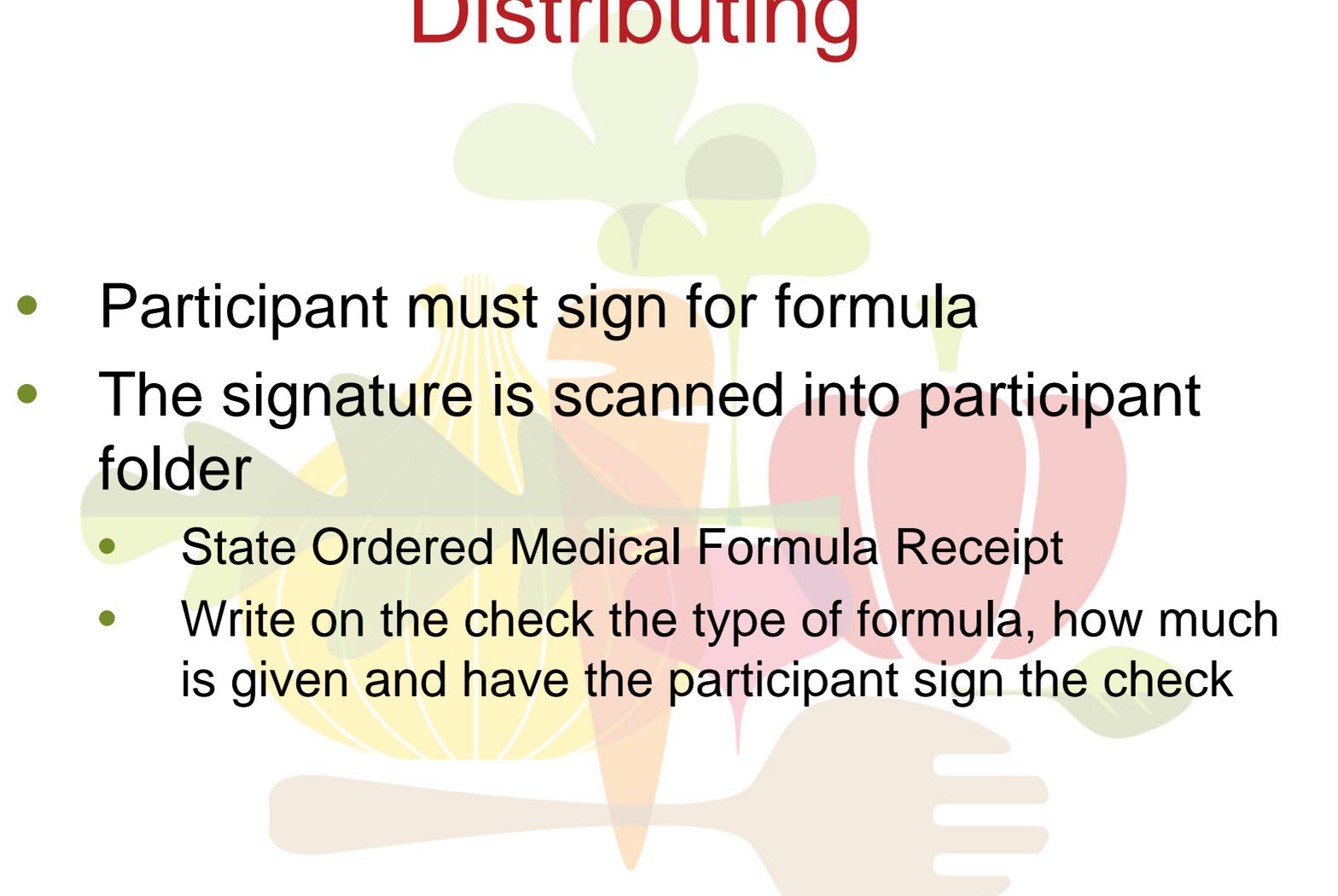
- Send email to BOTH state Nutritionists
  - Participant number
  - Type of formula
  - How much formula to order (Policy 8.8 for guidance)
- Once ordered, 7-10 business days for delivery
  - Rush shipping is available at discretion of the state Nutritionists

# Receiving

A background illustration featuring a variety of vegetables including a green bell pepper, a yellow bell pepper, a carrot, a pink bell pepper, and a red bell pepper. A light brown fork is positioned at the bottom center. The vegetables are rendered in a soft, watercolor-like style with overlapping colors.

- Once received, email BOTH state Nutritionists
  - Type of formula
  - How much was received

# Distributing



- Participant must sign for formula
- The signature is scanned into participant folder
  - State Ordered Medical Formula Receipt
  - Write on the check the type of formula, how much is given and have the participant sign the check

# MEDICAID REFERRALS

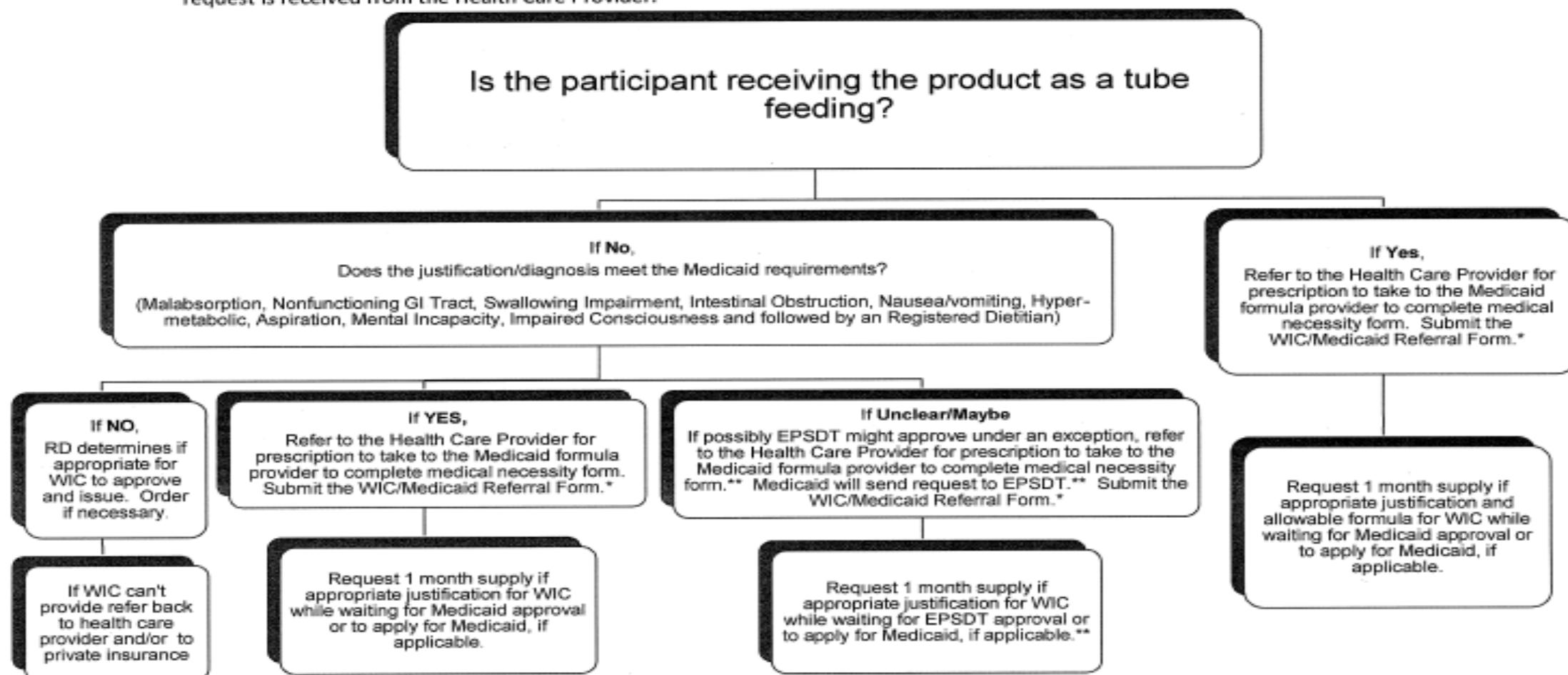


# Steps for Montana WIC/Medicaid

- Medicaid is first payer
- When a RX comes in, follow the flowsheet to see if this is something Medicaid may cover.
- If you believe this should go to Medicaid, complete the referral form and submit the information.
- While waiting for Medicaid approval or to apply for Medicaid, request 1 month supply from the state office.

# Montana WIC/Medicaid Nutrition Referral Flowsheet

Montana Medicaid and Montana WIC are requesting this process when considering the issuance of formula, exempt formula and medical foods. Have the participant sign a release so that WIC can share this information with Montana Medicaid. The official request for Medical Necessity must come from the Health Care Provider but this referral from WIC allows for complete processing once the request is received from the Health Care Provider.



\*Fax the completed WIC/Medicaid Nutrition Referral Form to Medicaid DME Officer at 406-444-1861. Scan a copy into the participant's chart.

\*\*EPSDT (Early Periodic Screening, Diagnostic and Treatment Services) for information <http://medicaidprovider.mt.gov/04> and General Provider Manual p 3.1 or call 406-444-0950.

## Montana WIC/Medicaid Nutrition Referral Form

### Complete the following:

1. Client's name: \_\_\_\_\_
2. Guardian's name (if applicable):  
\_\_\_\_\_
3. Name and address of the WIC clinic:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. WIC phone number \_\_\_\_\_
5. Signature of WIC staff person: \_\_\_\_\_ Date: \_\_\_\_\_

### Check the applicable box:

- Client is **not** eligible for the Montana WIC Nutrition Program. Refer to Medicaid, if applicable.
- Client is eligible for the Montana WIC Nutrition Program **but** the requested formula is not approved for issuance through the Montana WIC program (complete this form and fax to Montana Medicaid, ATTN: Medicaid DME Officer at 406-444-1861; send a copy of this form with the participant for reference with pharmacy and PCP)  
Name of the requested formula \_\_\_\_\_  
\*Instruct the client to go to their PCP and have them request the formula from Montana Medicaid.
- Client is eligible for the Montana WIC Nutrition Program **but** the medical formula and medical condition may\*\* qualify for coverage through Medicaid as first payer (tube feed or chronic/significant medical condition which impairs nutrient absorption and is being followed by PCP, specialists and/or RD).  
Name of the formula (complete this form and fax to Montana Medicaid, ATTN: Medicaid DME Officer at 406-444-1861 send a copy of this form with the participant for reference with pharmacy and PCP)  
Name of formula requested \_\_\_\_\_  
\*Instruct the client to go to their PCP and have them request the formula from Montana Medicaid.

\*\* Montana WIC may continue to cover WIC eligible formula until Medicaid coverage is assessed and approved. Please have a release of information on file to communicate with PCP and Medicaid to coordinate coverage of formula by the appropriate entity.



# REQUEST FOR SIMILAC FORMULA FORM



## Request for Similac Formula



 Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

A. Formula (Required)		
Prescribed Amount: <input type="checkbox"/> Maximum Allowable OR _____ per day		
<b>Formula (select one):</b>  <input type="checkbox"/> Similac Sensitive (Low lactose)  <input type="checkbox"/> Similac Total Comfort (Partially hydrolyzed whey protein, low lactose)  <input type="checkbox"/> Similac for Spit Up (Rice starch added, low lactose)  No other formula may be requested with this form.	<b>Reason for issuance:</b>  <input type="checkbox"/> Malabsorption <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Reflux <input type="checkbox"/> Colic <input type="checkbox"/> Other: _____	<b>Length of time formula is required:</b>  <input type="checkbox"/> Until first birthday (end of the month) <input type="checkbox"/> Other date _____





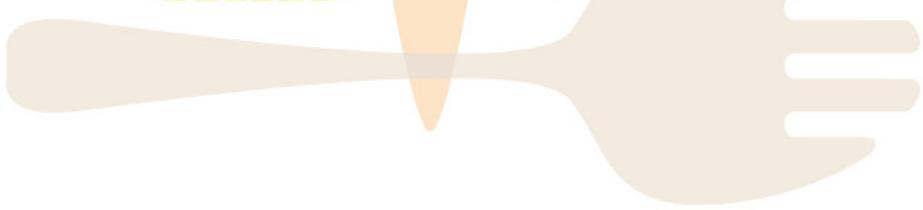
B. Supplemental Foods (for Infants 6 months and older)	
<p><b>Infants (6-12 months):</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Provide full food package</li><li><input type="checkbox"/> Do not provide any foods at this time; issue formula only</li><li><input type="checkbox"/> Provide a modified food package including the following foods:<ul style="list-style-type: none"><li><input type="checkbox"/> Infant cereal</li><li><input type="checkbox"/> Infant vegetables/fruit</li></ul></li></ul>	<p><b>Special Instructions/Restrictions:</b></p>



Health Care Provider Name (Printed): \_\_\_\_\_ (Signature): \_\_\_\_\_ Phone Number: \_\_\_\_\_



<b>Submit to:</b>		
Local agency: _____	Phone Number: _____	Fax Number: _____



# STEPS FOR APPROVAL FOR SIMILAC PRESCRIPTIONS



- A CPA will ensure:
  - The medical diagnosis or condition is appropriate for the formula.
- CPA will document approval in participant folder



# FORMULAS AVAILABLE ON THE SIMILAC FORM

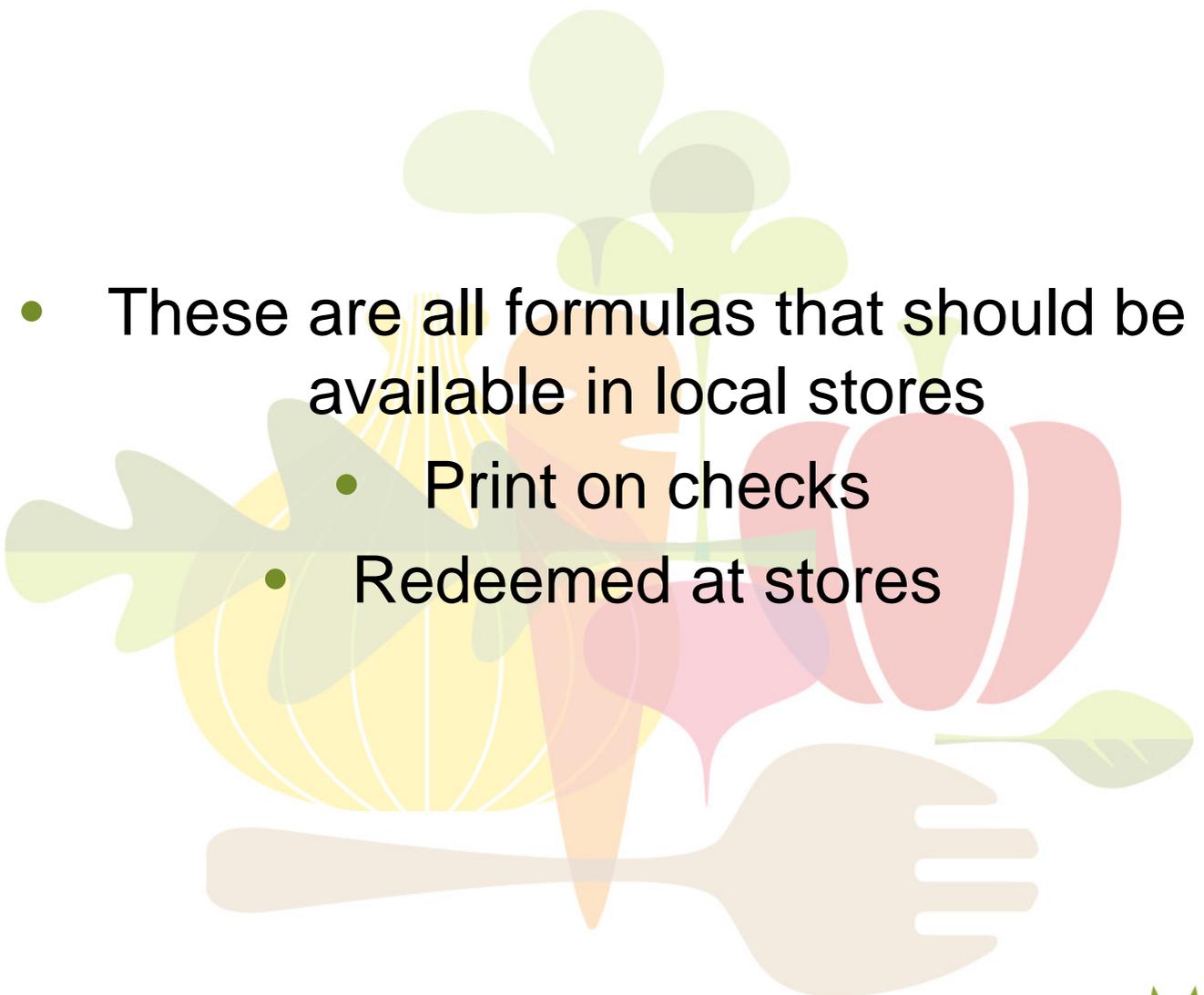
**Formula (select one):**

- Similac Sensitive  
(Low lactose)
  
- Similac Total Comfort  
(Partially hydrolyzed whey protein, low lactose)
  
- Similac for Spit Up  
(Rice starch added, low lactose)

**No other formula may be requested with this form.**



# **DIRECTIONS FOR ORDERING, RECEIVING AND DISTRIBUTING FOR SIMILAC PRESCRIPTIONS**

- 
- A background illustration featuring a variety of vegetables and a fork. At the top is a green leafy vegetable. Below it are a yellow onion, a carrot, a pink radish, and a red tomato. At the bottom is a light brown fork. The vegetables are rendered in a soft, watercolor-like style with overlapping colors.
- These are all formulas that should be available in local stores
    - Print on checks
    - Redeemed at stores

# Overview

- Similac Request
  - Approved by CPA
  - These are 19 kcal/oz formulas
  - Do not meet the definition of standard formula for USDA
  - They do not meet the exempt formula definition but they are contracted and must be rebatable for WIC issuance.
  - This is why there is a RX but they do not count for food package III
  - They cannot be allowed past one year
  - They cannot sub more formula past 6 months in place of food
- Medically Necessary WIC Approved Formula
  - Approved by CPA/RD
  - Specific requirements
  - Food Package III is required
  - More formula can be issued in place of food
  - They cannot be approved for longer than the prescription or certification period.

Questions?

