Alabama WIC Child/Woman Formula Prescription
Prescription is subject to WIC Approval Based on Program Policy and Procedure

Date _____
Patient's Name _____ **Date of Birth** _____

ICD-10 Code and/or Medical Diagnosis _____
Federal Regulations prevent formula issuance solely for the purpose of enhancing nutrient intake or managing body weight with no underlying condition.

Formula Prescribed _____

Amount per day ❑ 8ozs (1can QD) ❑ 16ozs (1can BID) ❑ 24ozs (1can TID) ❑ Other*
* *Amount per day cannot exceed 30 ounces (maximum issuance allowed by USDA). Monthly clinic visits are required if 30 ounces per day is prescribed.*

Intended length of use: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 months
- After 6 months a new prescription is required
- If prescription is not renewed, no formula can be issued

Supplemental Food Available: In addition to formula prescribed, the WIC Program may provide supplemental foods as ordered by the health care provider.

••• WIC RD/Nutritionist will determine the food package unless denoted otherwise. •••

Please check all items to be REMOVED from the food package:

❑ Milk
❑ Cheese
❑ Yogurt
❑ Eggs
❑ Juice
❑ Fruit/Vegetables
❑ Cereal
❑ Peanut butter
❑ Brown Rice/Whole Wheat Bread/ Whole Grain Tortillas (Wheat or Corn) Whole Wheat Pasta
❑ Canned or Dry Beans or Peas

Signature of Health Care Provider _____

Health Care Provider's Name (Please Print) _____

Health Care Practice/Clinic _____

Phone (_____) _____ **Fax** (_____) _____

If you have questions please call your local WIC clinic.

WIC Clinic Use Only

Participant ID# _____ **Date Received** _____ **Approved by** _____

Alabama WIC Child/Woman Formula Prescription (ADPH-WIC-111b)
Instructions for Completion of Form

Important – Only this form will be accepted by WIC clinics for special formula requests

Date: Enter date form is being completed.

Participant's Name: Enter name of the participant requiring the special formula.

Date of Birth: Enter the participant's date of birth.

ICD-10 Code and/or Medical Diagnosis: Document the medical diagnosis and/or the corresponding ICD-10 code. The prescription may be accepted if either the medical diagnosis or the ICD-10 code is written. However, the medical diagnosis and/or the ICD-10 code must be a nutrition related medical diagnosis/ICD-10 code.

Formula Prescribed: Enter the name of the special medical formula prescribed.

Amount per Day: Check the box or enter the amount of formula per day. (Maximum issuance per day allowed by USDA is 30 oz.)

Intended length of use: Check the number of months formula is needed. Note that the participant's need for the special formula must be re-evaluated by the health care provider every six (6) months.

Supplemental Foods Available: Check all WIC foods that participant may not consume while receiving special formula. If nothing is checked, WIC RD/Nutritionist will determine the food package.

Signature of Health Care Provider: The health care provider's signature must be entered.

Provider's Name printed: PRINT name of the health care provider.

Health Care Practice/Clinic: Print provider's practice/clinic name.

Phone: Enter the phone number of the health care provider.

Fax: Enter the fax number of the health care provider.

WIC Clinic Use Only: Information is required to be completed.

Participant #: Enter the participant's participant ID number.

Date Received: Enter the date the clinic receives the prescription form.

Approved by: Enter the name of the person approving the acceptance of the prescription.

NOTE: A health care provider is a Physician or someone working under Physician's orders, such as a Physician Assistant or Nurse Practitioner.