

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/Soy Milk

☐ Cereal

☐ Cheese

☐ Peanut/Nut/Seed Butter

☐ Yogurt

☐ Canned Fish (Tuna/Salmon)

☐ Eggs

☐ Whole Grain Bread/Tortilla/Pasta/
Brown Rice/Oats

☐ Juice

☐ Fruit/Vegetables

☐ 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.