New Hampshire WIC Nutrition and Medicaid Program
Request for Special Formula
and Authorization for WIC Supplemental Foods

For dually enrolled participants on WIC and Medicaid, NH Medicaid/Managed Care Organization (MCO) determines and provides special formulas. Healthcare providers should work directly with the participant's MCO for the requirements/additional forms/prior authorization for the provision of special formulas. Because WIC may need to provide the special formula prescribed temporarily a completed WIC Request for Special Formula form is needed. **Request for Special formula are subject to WIC approval. The continued need for a special formula will be re-evaluated on a periodic basis.**

Return to WIC agency: **Fax #:**

A. Patient/participant information

Patient's Name: (Last, First, MI):	**DOB:**
Parent/Caregiver's Name:	**Medicaid #:**

Medical Diagnosis & ICD code(s):

- ❑ Allergy, Food: _____ (K52.5)
- ❑ Autoimmune Disorder (M35.9)
- ❑ Anomaly, Respiratory (Q34.9)
- ❑ Anomaly, GI (Q45.9)
- ❑ Conditions Originating in the Perinatal Period (P00-P96); specify: _____
- ❑ Congenital Heart Disease (Q24.9)
- ❑ Delay, Developmental (R62.0)
- ❑ Diabetes Mellitus Type I (E10)
- ❑ Diseases of the Digestive System (K00-K95); specify: _____
- ❑ Endocrine, Nutritional & Metabolic Diseases, and Immunity Disorders (E00-E89); specify: _____
- ❑ FTT/Inadequate Growth (R62.51)
- ❑ Immunodeficiency (D80-D84)
- ❑ Lactose Intolerance (E73)
- ❑ Malnutrition (E43)
- ❑ Neonatal Abstinence Syndrome (P96.1)
- ❑ Neuromuscular Disorder (G70.9)
- ❑ Pregnancy, Multiple Gestation (O30)
- ❑ Prematurity (P07.3)
- ❑ Other: specify nutrition-related condition and ICD code: _____

B. Special formula *(Approved NH WIC formulary can be viewed at www.dhhs.nh.gov/dphs/nhp/wic/physician.htm)*

Formula requested:

Prescribed amount: ❑ maximum allowable by WIC* **OR** ❑ _____ oz./day

* WIC Federal regulations allow: Infants 0-3months ~28oz/day; 4-5months ~30oz/day; 6-12months ~22oz/day. Children/Women: ~30oz/day.

Time needed: ❑ 1 month ❑ 3 months ❑ 6 months ❑ 12 months ❑ _____ months (Not to exceed 12 months.)

C. WIC supplemental foods

I authorize the NH WIC nutritionist to determine appropriate WIC supplemental foods, amounts, and length of issuance required for the participant.

❑ I do not agree with the statement above, issue a modified food package omitting the WIC foods checked below.

- ❑ Infant cereal
- ❑ Infant fruits
- ❑ Infant vegetables
- ❑ Infant meats-(exclusively breastfeed infants only)
- ❑ Milk/cheese/yogurt
- ❑ Soymilk/tofu
- ❑ Eggs
- ❑ Fruits
- ❑ Juice
- ❑ Vegetables
- ❑ Breakfast cereals
- ❑ Whole grains-bread/rice/tortillas/oatmeal/pasta
- ❑ Beans/peas/lentils
- ❑ Peanut butter
- ❑ Fish-(exclusively breastfeeding women only)
- ❑ OMIT ALL Foods

D. Healthcare provider information

Medical documentation is federally required to ensure that the patient under your care has a medical condition that requires the use of special formula and that WIC foods are precluded, restricted, or inadequate to meet their special nutritional needs. By signing this form, you are verifying you have seen and evaluated the patient's nutrition and feeding problem(s) and symptoms determining he/she has a serious medical condition.

Signature of healthcare provider: **Date:**

Provider's name: (please print or stamp) ❑ **MD** ❑ **DO** ❑ **NP** ❑ **PA**

Medical office/clinic:

Phone #: **Fax#:**

E. Release of information

I authorize the above healthcare provider and NH WIC staff to disclose/discuss information regarding this request.
I understand that I may change my mind and cancel this permission at any time with my written request to my healthcare provider and that it will not affect my WIC eligibility.

Participant/Parent/Caregiver Signature: _____ Printed Name: _____ Date: _____

WIC USE ONLY: Approved by: Date: