

WIC FORMULA and MEDICAL NUTRITIONAL PRESCRIPTIONS

All components of this form are required and must be completed by a medical provider to receive Medically Prescribed Formulas through the WIC program. Personally identifiable information is used to determine WIC services (e.g., certification/enrollment and food package issuance) and may be disclosed to others only as allowed by state and federal laws.

Patient

_____ Last Name _____ First Name _____ Birthdate (mm/dd/yyyy) _____

Parent/Caregiver

_____ Last Name _____ First Name _____

1. FORMULA PRESCRIPTION

Casein Hydrolysate

- Nutramigen w/Enflora LGG (powder)
- Pregestimil (powder)
- Alimentum (powder)
- Alimentum (RTF)

Premature & Transitional

- Enfamil NeuroPro EnfaCare (powder)
- Similac NeoSure (powder)
- Similac NeoSure (RTF)

Infants (6 months no foods) *

- Enfamil Infant (powder)
 - Enfamil Gentlease (powder)
- *must be unable to tolerate infant foods

Nutrient Dense

- Nutren Junior with or without fiber
- PediaSure with or without fiber
- PediaSure 1.5 cal with or without fiber

Amino Acid Based

- Elecare (powder)
- Elecare Junior (powder)
- Neocate Splash (drink box)
- Neocate Infant (powder)
- Neocate Syneo Infant (powder)
- Neocate Junior (powder)
- PurAmino DHA & ARA (powder)

Other Specialized Products

- Similac PM 60/40 (powder)
- Peptamen Junior with or without fiber (RTF)
- PediaSure Peptide 1.0 cal (RTF)

Children requiring Infant formula

- Enfamil Infant (powder)
- Enfamil Gentlease (powder)
- Enfamil Reguline (powder)
- Enfamil ProSobee (powder)
- Enfamil AR (powder)

Nutrient Dense -Women Only

- Boost with fiber or Boost Plus
- Ensure or Ensure Plus

Note: Nutrient Dense formulas are not allowed for growth concerns or managing body weight only (see section 3), must have an underlying medical condition

2. FOOD PRESCRIPTION

Infants (0-12 months)

- Formula and foods* beginning at 6 months
- Formula **ONLY** (no foods during duration of this prescription)

Children (1 -5 years) and Women

- Formula and foods*
- Formula **ONLY** (no foods during duration of this prescription)
- Jarred Infant Foods Fruits/Vegetables (children 1-5 years)

*WIC foods may include the following, based upon program category:

Infants (6-12 months):

- Infant Cereal
- Jarred Infant Foods
- Fresh Fruits/Vegetables **and** Jarred Infant Foods

Children (1-5 years) & Women:

- Milk/Tofu/Yogurt
- Cheese
- Eggs
- Cereal
- Whole wheat Bread/Buns/Pasta/Tortillas
- Brown Rice/Oatmeal/Corn Tortillas/Bulgur
- Peanut Butter
- Beans
- Canned Fish (exclusive breastfeeding)
- 100% Juice
- Fruits/Vegetables

Special Instructions: (i.e. foods not allowed): _____

3. DIAGNOSIS, AMOUNT, DURATION

Medical Diagnosis Justifying Formula:

*Note: WIC Federal Regulations **do not allow the following conditions** for issuance of medical formulas: managing body weight, growth concerns, unconfirmed allergies, lactose intolerance, or intolerance symptoms. Please specify the underlying medical condition(s).*

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Prematurity (up to 2 years) | <input type="checkbox"/> Tube Fed NPO or Pleasure Feeds |
| <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Eosinophilic GI Disorders | <input type="checkbox"/> Hyperemesis Gravidarum | <input type="checkbox"/> Tube Fed with formula / foods (complete # 2) |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Gastroesophageal Reflux | <input type="checkbox"/> Confirmed Allergy (specify): _____ | <input type="checkbox"/> Other Medical Diagnosis (specify): _____ |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Intestinal Malabsorption | | |

Prescribed amount: _____ Maximum amount WIC provides **OR** _____ Ounces per day **OR** _____ Cans per day

Duration: 1 month 2 months 3 months 4 months 5 months 6 months (maximum duration)

Health Care Provider/WIC Clinic Comments: _____

4. HEALTH CARE PROVIDER'S SIGNATURE, LOCATION, DATE PRESCRIBED

Health Care Provider's Signature _____ Date Signed: _____
 (Physician, Physician Assistant or Advanced Practice Nurse Practitioner signature is required for prescriptions of the above formulas or medical foods.)

Printed Name of Health Care Provider _____

Medical Office/Clinic _____

Address _____ Telephone _____