

## 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 Illinois 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

**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)**

Must be unable to tolerate infant foods.

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

**Nutrient Dense**

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

**Nutrient Dense - Women Only**

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

**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 (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)

### 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 the duration of the prescription)
- Jarred infant fruits/vegetables (children 1-5 years)

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

**Infants (6-12 months):**

- Infant cereal
- 6+ months -Jarred infant fruits/vegetables
- 9-12 months - Fresh **and** jarred infant fruit/vegetables

**Children (1-5 years) and Women**

- |        |                   |                |   |
|--------|-------------------|----------------|---|
| Milk   | Peanut butter     | Cereal         | Whole wheat bread/tortillas/buns/pasta        |
| Cheese | Beans             | Corn tortillas | Canned Fish (Exclusively breastfeeding women) |
| Yogurt | Eggs              | Bulgur         | Jarred infant fruits/vegetables (1-5 years)   |
| Tofu   | 100% juice        | Brown rice     | Physician Rx must indicate above.             |
|        | Fruits/Vegetables | Oatmeal        |   |

**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 (max. 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 Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

4/9/2020

This institution is an equal opportunity provider.