



# WIC Medical Formula Request Form

All requests are subject to WIC staff approval.  
Sections A, B, and C must be completed for consideration.



Healthcare Provider:	Return form to:	
Address:		
Phone: _____ Fax: _____		
Provider DEA:		
Patient's Name:	Date of Birth:    /    /	Phone #:
Parent/Guardian:	MaineCare ID #:	
Pharmacy Name:	Pharmacy Location:	

## A. Medical Formula/Nutritional Products:

Infant Formula	12 months +	Diagnosis*	Notes
<input type="checkbox"/> Enfamil Enfacare <input type="checkbox"/> Neosure <input type="checkbox"/> Alimentum <input type="checkbox"/> Nutramigen <input type="checkbox"/> Pregestimil <input type="checkbox"/> Elecare <input type="checkbox"/> Neocate <input type="checkbox"/> PurAmino <input type="checkbox"/> Special Care 20 <input type="checkbox"/> Enfamil Pre 20 <input type="checkbox"/> Special Care 24 <input type="checkbox"/> Enfamil 24 <input type="checkbox"/> Similac 24 <input type="checkbox"/> Similac PM 60/40 <input type="checkbox"/> Enfaport <input type="checkbox"/> 3232A	<input type="checkbox"/> Nutramigen Toddler <input type="checkbox"/> Pediasure Peptide 1.0 <input type="checkbox"/> Pediasure Peptide 1.5 <input type="checkbox"/> Elecare Jr. <input type="checkbox"/> PurAmino Jr <input type="checkbox"/> Neocate Jr <input type="checkbox"/> PediaSure G & G <input type="checkbox"/> Pediasure 1.5 <input type="checkbox"/> Pediasure Sidekicks <input type="checkbox"/> PediaSure 1.0 <input type="checkbox"/> 3232 A <input type="checkbox"/> Portagen	<input type="checkbox"/> Prematurity <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Low/Very Birth Weight <input type="checkbox"/> Eosinophilic Esophagitis <input type="checkbox"/> Failure to Thrive <input type="checkbox"/> Malabsorption <input type="checkbox"/> Milk Allergy <input type="checkbox"/> Oral/Motor Feeding Issue or Developmental Delay <input type="checkbox"/> Short Bowel Syndrome <input type="checkbox"/> Soy Allergy <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Other (specify):	<p>*Weight gain, loss, or maintenance; rash; intolerance; fussiness; colic; spitting up; vomiting; gas; or constipation does <b>not</b> qualify for WIC issued medical formula without a specified underlying medical condition.</p> <p>Provider Notes:</p>

Other Formula Requested (include justification if similar formula is listed above):

The Maine CDC WIC Nutrition Program issues only contract infant formula for partially breastfed or non-breastfed infants who are using standard cow's milk or soy formulas. The current contract formulas include: **Similac Advance, Similac Isomil, Similac Sensitive, Similac Total Comfort, and Similac for Spit-Up.** These do not require the use of this form.

## B. Amount and Duration:

Prescribed ounces or cc/day: \_\_\_\_\_

Duration:     Until first birthday     Months of age \_\_\_\_\_     Other \_\_\_\_\_     Discontinue prescribed formula

## Supplemental Foods:

Foods to be omitted in patient's diet:     None     Omit: \_\_\_\_\_

**WIC Registered Dietitian may assess for and provide appropriate WIC foods** (such as provision of infant solids at 6 months of age, transition to whole milk at 12 months, and discontinuation of prescribed formula after 12 months) to my patient receiving a prescribed formula. If this checkbox is not selected, WIC must have written authorization from HCP to provide foods.

**Whole Milk for child  $\geq$  24 months or woman** (must also be prescribed medical formula for qualifying medical condition)

## C. Healthcare Provider Credential

Signature:

Date: