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| **Healthcare Provider:** | **Return form to:** |
| **Address:** |
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| **Phone: Fax:** |
| **Provider DEA:** |
| Patient’s Name: Date of Birth: / / | |
| MaineCare ID#: Parent/Guardian: | |
| Pharmacy Name: Pharmacy Address: | |
| Pharmacy Fax: Pharmacy NABP/NPI #: | |
|  | |
| **Please specify the underlying qualifying medical diagnosis(es):** Please note that non-specific conditions such as rash, intolerance, underweight, fussiness, colic, spitting up, vomiting, gas, or constipation, or requests strictly for management of body weight will not be considered indications for a medical formula.  **🞏** Prematurity (<37 weeks gestation) 🞏 Developmental Delay  **🞏** Food Allergies (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **🞏**  GI Disorder/Malabsorption Syndrome (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **🞏**  Failure to Thrive (specify underlying medical condition): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **🞏** Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 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 (20 kcal/oz), Similac Isomil (20kcal/oz), Similac Sensitive (19kcal/oz), Similac Total Comfort (19 kcal/oz)** and **Similac for Spit-Up (19 kcal/oz).**  **The 19kcal/oz formulas require medical documentation prior to issuance.**  All prescriptions for medical formulas are subject to WIC approval and provision based on program policies. Please refer to the Maine CDC WIC Nutrition Program formulary for more information: <http://www.maine.gov/dhhs/mecdc/health-equity/wic/health/index.shtml#F>  **Formula Prescribed:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescribed ounces or cc/day \_\_\_\_\_\_\_\_\_\_\_\_\_  Tube feeding 🞏 Yes 🞏 No  Special instructions for preparation, dilution or tube feeding (if applicable):  **Duration**: 🞏 1 month 🞏 2 months 🞏 3 months 🞏 6 months 🞏 12 months 🞏 Until first birthday   🞏 Discontinue prescribed formula | |
| **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 > 24 months or woman** (must also be prescribed medical formula for qualifying medical condition) | |
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| **HEALTH CARE PROVIDER SIGNATURE** (MD, DO, PA, NP)**: Date:**  Printed Name (Health Care Provider): | |