



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):	*Weight gain, loss, or maintenance; rash; intolerance; fussiness; colic; spitting up; vomiting; gas; or constipation does not qualify for WIC issued medical formula without a specified underlying medical condition. Provider Notes:

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: