

Ohio WIC Prescribed Formula and Food Request Form



All requests are subject to WIC approval and provision based on program policy and procedure. Medical documentation is federally required to issue special formulas. Please complete sections A-D of this form in full.

A. Required Patient Information

Patient's Name: _____ Date of Birth: _____ Weeks Born Early (if applicable): _____

Parent/Caregiver's Name: _____ Weight*: _____ Length*: _____ Date measured: _____

* recommended not required

Medical Diagnosis/Condition: _____

(Medical diagnosis must be specific and correlate to the requested formula.)

B. Required Special Formula Information **For infants, select the top 2-3 formulas that meet the participant's needs indicating 1st, 2nd, and 3rd recommended formulas.

Amount of formula to be provided per DAY (must be measurable): _____

Special Instructions/Comments: _____

Intended length of use: 1 month 2 months 3 months 4 months 5 months 6 months (maximum)

Has a trial with Enfamil Infant, Enfamil Gentlease, Enfamil Reguline, or Enfamil ProSobee been completed?: Yes No

If "No," please indicate why: _____

Infants**

*Or store brand equivalent

<input type="checkbox"/> Alfamino Infant	<input type="checkbox"/> Enfamil Premature 24 Calorie	<input type="checkbox"/> Nutramigen	<input type="checkbox"/> Similac Alimentum*
<input type="checkbox"/> EleCare for Infants	<input type="checkbox"/> Gerber Extensive HA	<input type="checkbox"/> Nutramigen w/ Enflora LGG* (powder only)	<input type="checkbox"/> Similac Human Milk Fortifier
<input type="checkbox"/> Enfamil AR	<input type="checkbox"/> Neocate Infant w/ DHA & ARA		<input type="checkbox"/> Similac NeoSure
<input type="checkbox"/> Enfamil NeuroPro EnfaCare	<input type="checkbox"/> Neocate Nutra (≥ 6 mo. age)	<input type="checkbox"/> Pregestimil	<input type="checkbox"/> Similac PM 60/40
<input type="checkbox"/> Enfamil Human Milk Fortifier	<input type="checkbox"/> Neocate Syneo Infant	<input type="checkbox"/> PurAmino DHA/ARA	<input type="checkbox"/> Similac Special Care Premature 24 calorie

Children**

*Or store brand equivalent

<input type="checkbox"/> Alfamino Junior	<input type="checkbox"/> EleCare Junior	<input type="checkbox"/> PediaSure	<input type="checkbox"/> Peptamen Junior 1.5 Cal
<input type="checkbox"/> Boost Breeze	<input type="checkbox"/> Encala	<input type="checkbox"/> PediaSure 1.5 Cal	<input type="checkbox"/> Peptamen Junior w/Fiber
<input type="checkbox"/> Boost Kid Essentials 1.0 Cal	<input type="checkbox"/> Neocate Junior (unflavored)	<input type="checkbox"/> PediaSure 1.5 Cal w/ Fiber	<input type="checkbox"/> Pregestimil
<input type="checkbox"/> Boost Kid Essentials 1.5 Cal	<input type="checkbox"/> Neocate Junior w/ Prebiotics	<input type="checkbox"/> PediaSure Enteral	<input type="checkbox"/> PurAmino Junior
<input type="checkbox"/> Boost Kid Essentials 1.5 Cal w/ Fiber	<input type="checkbox"/> Neocate Nutra	<input type="checkbox"/> PediaSure Enteral w/ Fiber	<input type="checkbox"/> Similac Alimentum*
<input type="checkbox"/> Bright Beginnings Soy Pediatric Drink	<input type="checkbox"/> Neocate Splash	<input type="checkbox"/> PediaSure w/ Fiber	<input type="checkbox"/> Similac PM 60/40
<input type="checkbox"/> Carnation Breakfast Essentials	<input type="checkbox"/> Nutramigen	<input type="checkbox"/> PediaSure Harvest	<input type="checkbox"/> Super Soluble Duocal
<input type="checkbox"/> Compleat Pediatric	<input type="checkbox"/> Nutramigen w/ Enflora LGG* (powder only)	<input type="checkbox"/> PediaSure Peptide	
<input type="checkbox"/> Compleat Pediatric Peptide 1.5 Cal	<input type="checkbox"/> Nutren Junior	<input type="checkbox"/> PediaSure Peptide 1.5 Cal	
<input type="checkbox"/> Compleat Pediatric Reduced Cal	<input type="checkbox"/> Nutren Junior w/ Fiber	<input type="checkbox"/> Peptamen Junior	

Women

<input type="checkbox"/> Boost	<input type="checkbox"/> Boost Breeze	<input type="checkbox"/> Carnation Breakfast Essentials	<input type="checkbox"/> Encala	<input type="checkbox"/> Ensure	<input type="checkbox"/> Super Soluble Duocal
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For PKU and Metabolic Needs: WIC collaborates with the Ohio Metabolic Formula Program which supplies certain metabolic formulas prescribed by an Ohio Department of Health (ODH) approved metabolic service provider. A separate form must be completed. Please contact your WIC office for more information.

C. Required Supplemental Food Information

WIC health professional will issue age appropriate supplemental food unless indicated below.

No WIC supplemental foods: provide formula only.

Issue a modified food package **OMITTING** the supplemental foods checked below:

Infants (6-11 months): Infant cereal Infant fruits and vegetables

Children and Women: Milk Juice Breakfast cereal Whole grains Fruits and vegetables

Beans Peanut butter Eggs Cheese Fish (fully breastfeeding women only)

It is medically warranted for this patient to receive the following foods in addition to special formula:

Whole milk Whole low lactose/lactose free milk Cheese

D. Required Health Care Provider Information

Prescribing Health Care Provider's Name (please print): _____ Phone: _____

Prescribing Health Care Provider's Signature: _____ Date: _____

Instructions for use of this form:

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Section A

Section A must be completed in full for all patients. Medical diagnoses or conditions must be specific, and correlate with the indications for use of the requested formula. Special formulas cannot be provided by WIC solely for the purpose of enhancing nutrient intake or managing body weight. Pediatric beverages cannot be issued solely for the following: a child refuses to take a multivitamin; a child is a picky eater; a child is underweight, but is not diagnosed as having failure to thrive, and the diet can be managed using regular foods; a child is assessed to be at risk for or is overweight; or, a child is assessed to be at an average Body Mass Index.

Section B

Section B must be completed for all patients.

- The amount of formula provided per day must be measurable. Quantities such as “maximum,” “prn,” or “as needed” will not be accepted.
- The space for special instructions or comments can be used as needed. An open line of communication to the local WIC office is encouraged by including more information in this area, which may lead to more timely approval of the special formula requested.
- Please note that if a ready to feed (RTF) product is requested, it will require additional justification and will need to meet WIC standards. RTF products can be provided if the water supply has been determined to be unsafe; the ability of the caregiver to properly mix concentrate or powder formula is in question; for premature, low birth weight, or otherwise immunocompromised infants; or the participant has a medically relevant health condition which necessitates the use of RTF formula (i.e. continuous tube feeds). RTF formula cannot be issued for basic tolerance issues or participant preference.
- An intended length of use must be indicated. Six (6) months is the maximum length of time WIC can provide a special formula without a new Ohio WIC Prescribed Formula and Food Request Form.

Section C

If Section C is not completed, the WIC Health Professional will issue a food package as appropriate based on objective interview and patient preference. However, if whole milk or whole low lactose/lactose free milk are to be provided, the prescribing health care provider must indicate that in the bottom part of Section C.

Section D

Section D must be completed in full for all patients. Only a physician, physician’s assistant, certified nurse practitioner, clinical nurse specialist, or certified nurse midwife may sign off on this form. No other health care providers are authorized to sign. Prescribing health care providers must clearly print their name *in addition* to their signature or signature stamp. The date the form was signed must be provided.