



Medical Formula and Nutritional Request Form



WIC Agency: _____
 WIC ID#: _____

SECTION I: Participant/Patient and Health Care Information

Patient Name: (First) _____ (Last) _____		Date of Birth: _____
Parent/Caregiver Name: (First) _____ (Last) _____		Phone Number: _____
Height/Length: Current: _____ inches (Date: _____) Within 60 days At birth: _____ inches	Weight: Current: _____ lb _____ oz (Date: _____) Within 60 days At birth: _____ lb _____ oz	
Hemoglobin: _____ (gm/dL) or Hematocrit: _____ %	Lead Test: _____ mcg/dL	Lab Result Date: _____
Breastfeeding (birth to 12 months): <input type="checkbox"/> Fully breastfeeding <input type="checkbox"/> Feeding breastmilk & formula <input type="checkbox"/> Never breastfed <input type="checkbox"/> Discontinued breastfeeding on (Date: _____)		

<p>To Health Care Providers: WIC only provides medically-necessary formula or medical food when they are NOT covered by Medi-Cal. Please refer patient to Medi-Cal for these products.</p>	<p>Patient's Health Insurance:</p> <input type="checkbox"/> Medi-Cal (Note: HCP <u>must</u> submit prior authorization (PA) to Medi-Cal Rx; then send PA and Rx to pharmacy) <input type="checkbox"/> Private (does not cover enteral products)
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SECTION II: Special Formula/Nutritionals and Qualifying Diagnosis

Formula/Medical Food Prescribed (Check below or specify name if not listed):

<p>Premature: <input type="checkbox"/> Enfamil NeuroPro EnfaCare <input type="checkbox"/> Similac NeoSure</p> <p>Nutritional Drinks: <input type="checkbox"/> PediaSure <input type="checkbox"/> PediaSure with Fiber <input type="checkbox"/> PediaSure 1.5 Cal <input type="checkbox"/> PediaSure 1.5 Cal with Fiber</p> <p>Medical Formula: <input type="checkbox"/> Fortini <input type="checkbox"/> Similac PM 60/40</p>	<p>Hypo-Allergenic: <input type="checkbox"/> Alfamino Infant <input type="checkbox"/> Alfamino Junior, Unflavored <input type="checkbox"/> Alfamino Junior, Vanilla <input type="checkbox"/> EleCare Infant <input type="checkbox"/> EleCare Junior, Unflavored <input type="checkbox"/> EleCare Junior, Vanilla <input type="checkbox"/> Extensive HA <input type="checkbox"/> Neocate Infant <input type="checkbox"/> Neocate Junior, Unflavored</p>	<p><input type="checkbox"/> Neocate Syneo Infant <input type="checkbox"/> Nutramigen (liquid concentrate; RTF) <input type="checkbox"/> Nutramigen LGG (powder) <input type="checkbox"/> Pepticate <input type="checkbox"/> PurAmino <input type="checkbox"/> PurAmino Junior <input type="checkbox"/> Similac Alimentum</p>
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Form: (Check one) Powder Concentrate Ready-to-Feed (RTF) (Justification: _____)
Required unless RTF is the only available form

Amount: _____ fluid ounces / ounces per day **Duration:** (Check one) 1 month 2 months 3 months 4 months 5 months 6 months

Qualifying Diagnosis: (Must specify)

<input type="checkbox"/> Prematurity (Adjusted age: _____ months)	<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Low birthweight	<input type="checkbox"/> Dysphagia
<input type="checkbox"/> Food allergy: _____	<input type="checkbox"/> Immune system disorder: _____		
<input type="checkbox"/> Gastrointestinal disorder: _____	<input type="checkbox"/> Life-threatening disorder: _____		
<input type="checkbox"/> Genetic/Metabolic disorder: _____	<input type="checkbox"/> Malabsorption (Nutrient: _____)		
<input type="checkbox"/> Other medical condition(s): _____			

SECTION III: WIC Food Restrictions

(Check one): **No food restrictions** (all WIC foods allowed) **Food restrictions** (specified below)

Infant
(6–11 Months): No infant cereal No infant fruits/vegetables No infant foods, increased formula
 If premature: Provide infant foods after _____ months

Children
(1–5 Years): No milk No cheese No eggs No yogurt No soy No tofu
 No peanut butter No beans No cereal No fruits/vegetables No juice
 No whole grains (Specify type(s): _____)
 Needs purees; provide infant fruits/vegetables No foods (formula only)

Comments:

SECTION IV: Health Care Provider Information

Provider Name (Printed): MD DO NP PA

Medical Office/Clinic Name and Address:

Provider Signature:

Date:

Phone Number:

Please Note:

WIC will not approve medical formula or medical food for the following conditions:

- Non-specific symptoms or diagnoses (e.g., colic, constipation, diarrhea, spitting up, picky eater, poor appetite, cramps, fussiness, gas, etc.)
- Solely to enhance nutrient intake or manage body weight without an underlying condition
- Non-specific formula intolerance or food intolerance
- Patient/caregiver preference or food dislikes

WIC qualifying medical diagnoses/conditions include but are not limited to:

- Severe food allergies that require an elemental formula
- Premature birth
- Low birth weight
- Failure to thrive
- Gastrointestinal disorders
- Malabsorption syndromes
- Immune system disorders
- Life threatening disorders
- Inborn errors of metabolism and metabolic disorders
- Diseases and medical conditions that impair ingestion, digestion, absorption or the utilization of nutrients that could adversely affect the participant's nutrition status

Visit www.wicworks.ca.gov; click *Health Care Providers* for more information on WIC Formulas.

Questions: Contact 1-800-852-5770 or Formula@cdph.ca.gov.