

# Pennsylvania WIC PROGRAM

## Prescription for Special Formula

Client's First & Last Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Parent/Caregiver(s) First & Last Name \_\_\_\_\_

### PLEASE NOTE

- Health care providers must answer/complete all **bolded** questions below
- No authorization is necessary for Nestle's Good Start Gentle Plus, Protect Plus, Soy Plus or Nourish Plus
- The WIC program does **not** provide any low-iron formula
- PA WIC does **not** provide other brands of standard infant formulas for medical reasons (i.e. Enfamil, Prosobee, Similac, Isomil, etc)
- Listed at the bottom of this form are the most *commonly* provided formulas and fortifiers; other formulas may be available

### 1. Formula/Fortifier Requested \_\_\_\_\_

**Amount requested:** \_\_\_ oz/day (if formula) \_\_\_ pkg/day (if fortifier) \_\_\_ Tbsp/day (if modular formula)

**Intended length of use:**  1 month  3 months  6 months

*(Monthly renewal is required for premature formulas or breast milk fortifiers)*

**Via tube feeding?**  Yes  No

Special instructions for preparation and use (if necessary): \_\_\_\_\_

### 2. Qualifying Medical Condition(s): \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

*Justifies the prescription of above formula or fortifier.*

### 3. Restricted Foods? Yes No

*If yes, please check the foods below that your client should **not** receive from WIC as well as length of restriction.*

**Infants (6-11 months):**  infant cereal  infant vegetable or fruit  infant meat

**Children & Women:**  juice  breakfast cereal  whole wheat bread or other whole grains  
 eggs  vegetables & fruits  milk or milk substitutes (see other side)  
 legumes  fish (tuna/salmon/sardine)  peanut butter (only available after age 2)

Length of restriction:  1 month  3 months  6 months  Other: \_\_\_\_\_

Reasons/Instructions/Comments: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Physician, Certified Registered Nurse Practitioner, Physician Assistant

**Printed Name:** \_\_\_\_\_

**Medical Office/ Clinic:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

### Formulas and fortifiers commonly provided through Pennsylvania WIC

#### Hydrolyzed Protein (Infants)

Similac Alimentum  
 Nutramigen Lipil  
 Pregestimil Lipil

#### Intact Protein (Children)

Nutren Jr  
 Nutren Jr w/ Fiber  
 Pediasure  
 Pediasure w/ Fiber

#### Amino Acid Based (Infants)

Elecare  
 Neocate Infant Formula

#### Peptide/Amino Acid Based (Children)

Elecare  
 Neocate 1 Plus  
 E028 Splash  
 Peptamen Junior  
 Vivonex/ten or Vivonex Pediatric

#### Premature Formulas/Breastmilk Fortifier

Similac Special Care 20 or 24 w/ Iron  
 Enfamil Premature Lipil 20 or 24 w/ Iron  
 Enfamil Human Milk Fortifier  
 Similac Human Milk Fortifier  
Standard Formulas (for Infants >9 mo)  
 Good Start Gentle Plus 2  
 Good Start Soy Plus 2  
 Good Start Protect Plus 2

#### Premature Post Discharge

Similac Neosure  
 Enfacare Lipil

#### Modular Formulas

Polycose Powder  
 MCT Oil

#### Other Special Formulas (Infants)

Similac Isomil DF  
 Similac PM 60/40



WIC is an equal opportunity provider.



# Pennsylvania WIC PROGRAM

## Authorization for Milk Substitutes

Client's First & Last Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Parent/Caregiver('s) First & Last Name \_\_\_\_\_

**PLEASE NOTE:** No authorization/prescription is needed for lactose-reduced or lactose-free milk

### WIC provides Children (ages 1 – 5 years) with:

#### COW'S MILK

- Whole milk (for ages 1-2 yrs)   ■ Low-fat milk (for children >2 yrs)

#### 1. Please check authorized substitutes to give in place of cow's milk:

- >1 pound of cheese/month    soy beverage or tofu    whole milk (instead of low-fat milk, only if >2 yrs and on a special formula)

#### 2. Specify for how long the substitution is needed:

- 6 months    1 year

#### 3. Reason for Substitution:

- participant/cultural preference    food sensitivity    other: \_\_\_\_\_

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### WIC provides Women with:

#### COW'S MILK or SOY BEVERAGE

#### 1. Please check authorized substitutes:

- >1 pound of cheese/month\*    >4 lbs of tofu/month\*    whole milk  
(Only for women on a special formula)

#### 2. Specify for how long the substitution is needed:

- 6 months    1 year

#### 3. Reason for Substitution:

- participant/cultural preference    food sensitivity    other: \_\_\_\_\_

\* **Note:** WIC women participants can request some cheese and tofu without needing medical documentation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician, Certified Registered Nurse Practitioner, Physician Assistant

Printed Name: \_\_\_\_\_

Medical Office/ Clinic: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_



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