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: _____

Parent/Caregiver's Name:_____ Weeks Born Early *(if applicable):* _____

Medical Diagnosis/Condition :_____

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

B. Required Special Formula Information

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 either Similac Advance with Early Shield or Similac Soy Isomil been completed?: ☐ Yes ☐ No

If "No," please indicate why:_____

Infants

☐ EleCare for Infants
☐ Enfamil EnfaCare
☐ Enfamil Nutramigen
☐ Enfamil Nutramigen w/ Enflora LGG
☐ Neocate Infant w/ DHA & ARA
☐ Neocate Nutra (≥ 6 mo. age)
☐ Pregestimil
☐ PurAmino DHA/ARA
☐ Similac Expert Care Alimentum
☐ Similac Expert Care NeoSure
☐ Similac Sensitive
☐ Similac for Spit-Up
☐ Similac PM 60/40

Children

☐ Boost Breeze
☐ Boost Kid Essentials 1.0 Cal (retail)
☐ Boost Kid Essentials 1.5 Cal
☐ Boost Kid Essentials with Fiber 1.5 Cal
☐ Bright Beginnings Soy Pediatric Drink
☐ Carnation Breakfast Essentials
☐ Compleat Pediatric
☐ Compleat Pediatric Reduced Calorie
☐ Elecare Junior
☐ EO28 Splash
☐ Neocate Junior
☐ Neocate Jr. w/ Prebiotics
☐ Neocate Splash Unflavored
☐ Nutren Junior
☐ Nutren Junior with Fiber
☐ PediaSure
☐ PediaSure Enteral
☐ PediaSure with Fiber
☐ PediaSure with Fiber Enteral
☐ PediaSure 1.5 Cal
☐ PediaSure 1.5 Cal with Fiber
☐ PediaSure Peptide
☐ PediaSure Peptide 1.5 Cal
☐ Peptamen Junior
☐ Peptamen Junior with Fiber
☐ Peptamen Junior with Prebio[1]
☐ Peptamen Junior 1.5 Cal
☐ Similac Advance (≤ 12 mo corrected age)
☐ Similac Soy Isomil
☐ Super Soluble Duocal

Women

☐ Boost ☐ Boost Breeze ☐ Carnation Breakfast Essentials ☐ Ensure ☐ Super Soluble Duocal

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

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

Health Care Provider's Signature:_____ Date:_____

Instructions for use of this form:

All special formula requests are subject to WIC approval and provision based on program policy and procedure.

Medical documentation is federally required to issue special formulas.

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 RTF is requested, this form of formula will require additional justification and will need to meet WIC standards.
- 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.
- It must be noted if a trial of Similac Advance with Early Shield and/or Similac Soy Isomil has occurred for infants requesting Similac Sensitive or Similac for Spit-Up. If a trial has not been completed, it must be indicated as to why.
- Only one formula can be selected on this form. WIC cannot provide more than one formula in a month.

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, whole low lactose/lactose free milk, or cheese are to be provided, the 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, nurse practitioner, or physician's assistant may sign off on this form. No other health care providers are authorized to sign. Health care providers must clearly print their name *in addition to* their signature or stamp. The date the form was signed must be provided.