Texas WIC Medical Request for Formula/Food

Directions

To request a formula that requires medical documentation, completely fill out the prescription form on the reverse side and sign. The form can be faxed to the WIC clinic or the patient can return it to the clinic in person.

WIC Program Information

Federal regulations require all WIC programs to obtain formula rebate contracts to help contain costs. The current contracts are with Abbott Nutrition (for milk-based formula) and Gerber (for soy-based formula). Please review the table below.

Contract Formulas (20 cal/oz): **No prescription required for infants < 12 months of age**	**Contract Formulas (19 cal/oz):** **Prescription required for infants < 12 months of age**
Similac Advance Good Start Soy	Similac Sensitive Similac for Spit-Up Similac Total Comfort

All formulas for children (12 months of age and older) or women require medical documentation. All formulas other than those listed and described above require medical documentation.

*Important: Texas WIC Infant Formula Policy Change - Effective 10/1/2016

Beginning October 1, 2016, the following formulas are not available for first time Texas WIC participants:

Enfamil Newborn	Enfamil AR	Enfamil ProSobee	Good Start Soothe
Enfamil Infant	Enfamil Gentlease	Good Start Gentle	Similac Soy Isomil

WIC is a supplemental food program. Infants who are not receiving breastmilk may require more formula than WIC is able to provide.

Additional Texas WIC Online Resources:

Please visit http://www.texaswic.org. Here you will find:

- Texas WIC Medical Request for Formula/Food form
- Texas WIC Metabolic Request for Formula/Food form
- Texas WIC Formulary

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Texas WIC Medical Request for Formula/Food

All requests are subject to WIC approval and provision based on policy and procedure.
Please fax this completed form to the WIC clinic or have your patient return it to their WIC clinic.

Patient Information (required)

Patient's Full Name:______________________ DOB:______________

Parent/Guardian's Name:______________________ Phone:( )______________

(Optional)

Date of Measurements:______________ Length/Height:__________ Weight:__________

If Premature, Birth Weight: ______________ Weeks Gestation:______________

Formula Requested (required)

For intolerance to Similac Advance or Good Start Soy, choose one alternate WIC formula below:

- ❑Similac Sensitive (lactose sensitivity or colic)
- ❑Similac for Spit-Up (excess spit-up or reflux)
- ❑Similac Total Comfort (digestive issues or colic)

Formula Amount:_______oz. per day

Maximum allowed may be provided unless a lesser amount is indicated.

Requested Length of Issuance: _________month(s)

Formula will be issued up to 12 months of age unless otherwise indicated.

Other Formulas:
If none of the formulas in the left box are appropriate for this patient, select a qualifying condition and fill out the following:

Name of Formula*: ______________________

Formula Amount:______________________ oz. per day

Maximum allowed may be provided unless a lesser amount is indicated.

Requested Length of Issuance:______ month(s)

*See table 2 on reverse side for formulas no longer available to first time Texas WIC participants.

Qualifying Condition/Diagnosis (required; please check all that apply):

❑Cardiovascular condition ❑GI impairment ❑Malabsorption syndrome ❑Tube feeding

❑Inadequate growth ❑Neurological condition ❑Respiratory condition ❑GER/GERD

❑Increased calorie needs ❑Oral motor feeding issues/aversions ❑Prematurity/LBW

❑FTT ❑Low maternal weight gain/weight loss ❑Seizure disorder requiring ketogenic diet

❑Developmental delays (sensory & motor) ❑Renal disease/low mineral condition

❑Food allergies (cow's milk, soy or intact protein)/FPIES ❑Other medical condition*:______________

*The following symptoms are not qualifying conditions and will not be accepted: colic, constipation, spitting up or gas.

WIC Supplemental Foods (optional): *Unless indicated below, all supplemental foods will be provided. The RD/Nutritionist can also determine foods if left blank.*

Infants 6 months of age and older:

❑Formula only, no foods
(due to inability or delay in consuming solids)

❑Omit Infant Cereal

❑Omit Baby Foods

Women & Children 12 months of age and older:

❑Formula only, no foods

Omit – check foods to omit from food package

❑Milk ❑Yogurt ❑Eggs ❑Juice ❑Peanut Butter ❑Cheese

❑Whole Grains ❑Cereal ❑Beans ❑Fruits and Vegetables

❑Provide baby foods and infant cereal instead

Health Care Provider Information (required):

(MD, DO, PA-C, NP) Signature/Stamp: ______________________ Date: __________

Provider's Name (please print):______________________ Facility Name:______________

Phone:( )______________ Fax:( )______________

For WIC use only

WIC Clinic:______________ Phone: ______________ Fax: ______________