Colorado WIC Program

Physician Authorization Form

For WIC Special Formulas and WIC Supplemental Foods

This is a medical documentation request for medical formula and foods.

- This request is subject to WIC approval based on program policy and procedure.
- **Please FAX or return the completed form to your local WIC clinic.**

WIC clinic:	
WIC FAX #:	
Attention:	

Patient's name (Last, First, MI):	DOB:
Parent/Caregiver's Name:	

I. WIC Supplemental Foods

Medical provider must complete the following if a modified food package is required due to a medical condition:

❑ Patient requires a modified food package based on a medical condition:
  ❑ **Infant ≥6 months cannot tolerate solid foods**; provide additional formula only.
  ❑ **Child ≥12 months** receiving special formula and tolerating infant fruits and vegetables; provide infant fruits and vegetables in lieu of fruits and vegetables.

WIC RD/RN will determine appropriate foods unless health care provider indicates otherwise.

❑ **No food restrictions**; provide full amount of age-appropriate WIC foods.
❑ **Omit** the following food(s) based on medical condition(s):

- Infant 6 - 11 months **omit**: ❑ Infant cereal ❑ Infant fruits/ vegetables
- For children ≥12 months or women **omit**: ❑ Milk ❑ Breakfast cereals ❑ Fruits & vegetables ❑ Cheese ❑ Legumes ❑ Juice ❑ Eggs ❑ Whole grains ❑ Peanut butter ❑ Fish (exclusively breastfeeding women only)

Optional:

❑ **Substitute whole milk** or reduced fat (2%): For women and **children ≥2 years**; whole milk and 2% milk are ONLY available if the patient is receiving special formula or supplement for a medical condition(s).
❑ **Substitute soy milk or tofu** for milk or cheese.

Special instructions: ____

II. Health Care Provider Information

Signature of health care provider:		
Provider's name (please print):		
Medical clinic/hospital:		
Phone:	FAX:	Date:
WIC Use Only		
Approved by:	Date:	Rx exp. date:

III. Formula (Please select from list on back of page)

Determine formula need	Choose formula:		
Standard Contract CO WIC Formulas:	❑ Enfamil Infant ❑ Enfamil ProSobee	❑ Enfamil Gentlease ❑ Enfamil Reguline ❑ Enfamil AR	
	● **NO PRESCRIPTION IS NEEDED FOR INFANTS (up to age 12 months)** ● A prescription is needed to issue standard formula for children older than 12 months of age. ● A prescription is needed to issue additional formula to 6- to 11-month-old infants who cannot tolerate solid foods.		
Premature/ Calorie Dense Formulas:	❑ Enfamil EnfaCare ❑ Similac NeoSure		
Hypoallergic Formulas/ Supplements:	❑ EleCare Infant ❑ EleCare Junior ❑ Neocate Infant ❑ Neocate Junior	❑ Neocate Junior with Prebiotics ❑ Neocate Splash ❑ Neocate Syneo ❑ Nutramigen	❑ Nutramigen with Enflora LGG ❑ Pregestimil ❑ PurAmino ❑ Similac Alimentum
Supplements:	❑ Boost High Protein ❑ Boost Kid Essentials 1.5 cal ❑ Boost Kid Essentials 1.5 cal with fiber ❑ Bright Beginnings Soy Pediatric Drink ❑ Compleat Pediatric	❑ Enfagrow Toddler Transitions Soy ❑ Ensure ❑ Ensure Plus ❑ Nutren Junior ❑ Nutren Junior with Prebio Fiber ❑ Nutren 1.0 ❑ Nutren 1.0 with Fiber ❑ Nutren 1.5	❑ Nutren 2.0 ❑ Osmolite 1 Cal ❑ PediaSure ❑ PediaSure with Fiber ❑ PediaSure Enteral ❑ PediaSure Enteral with Fiber ❑ PediaSure 1.5 cal ❑ PediaSure 1.5 cal with Fiber
Supplements for Special Medical Needs:	❑ Enfaport ❑ Peptamen ❑ Peptamen with Prebio Fiber ❑ Peptamen Junior	❑ Peptamen Junior with Prebio Fiber ❑ Portagen ❑ Similac PM 60/40	❑ Tolerex ❑ Vivonex Pediatric ❑ Vivonex T.E.N.
Formulas for Inherited Metabolic Diseases:	❑ Calcilo-XD ❑ Cyclinex-1 & 2 ❑ Glutarex-1 & 2 ❑ GA-1 Anamix Early Years ❑ HCU Anamix Early Years ❑ Hominex-1 & 2 ❑ IVA Anamix Early Years ❑ I Valex-1 & 2 ❑ Ketonex-1 & 2 ❑ MMA/PA Anamix Early Years	❑ MSUD Anamix Early Years ❑ MSUD Maxamum ❑ Phenex-1 & 2 ❑ PhenylAde Essential Drink Mix ❑ Phenyl-Free 1 & 2 ❑ Phenyl-Free 2 HP ❑ PKU Periflex Early Years ❑ PKU Periflex Junior Plus ❑ Pro-Phree ❑ Propimex-1 & 2	❑ ProViMin ❑ RCF ❑ Tyrex-1 & 2 ❑ TYROS-1 & 2 ❑ XPhe Maxamum ❑ TYR Anamix Early Years ❑ XLeu Maxamum ❑ XLys, XTrp Maxamum ❑ XMet Maxamum ❑ XMTVI Maxamum
Human Milk Fortifier	❑ Similac Human Milk Fortifier Powder* *New physician authorization form required every month.		

Medical provider must complete Sections A, B and C.

A. Qualifying medical condition(s):

- ❑ Prematurity
- ❑ LBW
- ❑ SGA
- ❑ Underweight
- ❑ Slow weight gain
- ❑ Weight loss
- ❑ FTT
- ❑ Developmentally not ready for solids
- ❑ Feeding issues
- ❑ Chewing/swallowing issues
- ❑ Multiple or severe food allergy
- ❑ Milk allergy
- ❑ Soy allergy
- ❑ Gastrointestinal disorders
- ❑ Persistent vomiting/diarrhea
- ❑ Tube feeding
- ❑ Impaired nutrient absorption or nutritional deficiency (please specify: _______________)
- ❑ Medical condition (please specify: ____________________)
- ❑ Metabolic disorder (please specify: ____________________)
- ❑ Other (please specify: ____________________)

B. Quantity:

Daily amount (choose one): ❑ Max allowable ❑ Ounces/day _______ ❑ Containers/day ________ ❑ Packets per day________

C. Duration:

❑ 1 month ❑ 2 months ❑ 3 months ❑ 4 months ❑ 5 months ❑ 6 months

Special Instructions ____

Patient's name: ______________________________________ DOB: _____________

COLORADO
Department of Public Health & Environment