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 and is subject to WIC approval based on program policy and procedure.

- **Return form to your local WIC clinic via FAX, email, or a paper copy.**

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. Medical 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:

Determine formula need	Choose formula (you may check more than one option if acceptable/appropriate. WIC RD/RN will determine which one to issue based on availability and client preference).
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
Hypoallergenic Formulas/ Supplements:	☐ Comforts Hypoallergenic ☐ Gerber Extensive HA ☐ EleCare Infant ☐ EleCare Junior ☐ Neocate Infant ☐ Alfamino Infant ☐ Neocate Junior ☐ Neocate Junior with Prebiotics ☐ Neocate Splash ☐ Neocate Syneo ☐ Nutramigen ☐ Alfamino Jr ☐ Nutramigen with Enflora LGG ☐ Parent's Choice Hypoallergenic ☐ Pregestimil ☐ PurAmino ☐ Similac Alimentum ☐ Kate Farms Pediatric Peptide 1.5 ☐ Kate Farms Pediatric Peptide 1.0
Supplements:	☐ Boost High Protein ☐ Boost Kid Essentials 1.5 cal ☐ Boost Kid Essentials 1.5 cal with fiber ☐ Compleat Pediatric ☐ Ensure ☐ Ensure Plus ☐ Kate Farms Pediatric Standard 1.2 ☐ Kate Farms Standard 1.0 ☐ Nutren Junior ☐ Nutren Junior with Prebio Fiber ☐ Nutren 1.0 ☐ Nutren 1.0 with Fiber ☐ Nutren 1.5 ☐ Nutren 2.0 ☐ Osmolite 1 Cal ☐ Parent's Choice Pediatric Shake ☐ 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	Please see list of options at the link below and navigate to the Allowable Metabolic Formula table. https://drive.google.com/file/d/10PP7oHEX_JozGJaLGtLATXk0NmlUBVs2/view Write in desired formula:
Human Milk Fortifier	☐ Similac Hydrolyzed Protein HMF CL (Liquid)* *New physician authorization form required every month, do not exceed 20 packets/day, stop when infant is above 3.5 kb, only for premature infants with criteria according to NICU CO guidelines

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
☐ 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: ___________

WIC COLORADO