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 page two.)

Section 1: Standard Contract CO WIC Formulas

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.	

Section 2: Non-Metabolic Specialty Formulas

Many of these products have been impacted by the recent shortages and the Abbott recall. Therefore, they may not be consistently available. COWIC may provide the following formulas as temporary substitutes.

- First, check a diagnosis category in the left column.
- Second, review the corresponding formulas on the right and check the box. Please strike through any formula choices that are NOT appropriate for your patient. All formulas that are not crossed out (in the row corresponding to the diagnosis category) may be provided to your patient based on availability.
- Please also complete sections A, B, and C on page three to further specify the qualifying medical condition.

☐ **Prematurity:** 22kcal/oz high calorie formulas.	☐ Enfamil Neuropro EnfaCare OR Similac Neosure
☐ **Milk/Soy Allergy or Intolerance/Other:** Hypoallergenic formulas for Infants.	☐ Nutramigen with Enflora LGG OR Nutramigen OR Similac Alimentum OR Comforts Hypoallergenic OR Gerber Extensive HA OR Parent's Choice Hypoallergenic OR UP and UP Hypoallergenic ☐ Pregestimil
☐ **Severe Allergies/FPIES/Other:** Amino acid-based formulas for infants.	☐ Elecare Infant OR Neocate Infant OR Neocate Syneo Infant OR PurAmino Infant OR Alfamino Infant
☐ **Milk/Soy Protein Allergy or Intolerance/Other:** Amino acid-based formulas for children 12 months+.	☐ Elecare Jr. OR Alfamino Jr. OR Neocate Jr. OR Neocate Jr. with Prebiotics OR Neocate Splash OR Equacare Jr. OR Essential Care Jr.

Section 3: Supplements and Metabolic Formulas

In this section, please check all appropriate formulas for your patient

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	☐ 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 ☐ XMet Maxamum ☐ XMTVI Maxamum
Human Milk Fortifier:	☐ Similac Hydrolyzed Protein HMF CL liquid*(*New form required monthly, do not exceed 20 packets/day, stop when infant is above 3.5 kg, 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 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: _____