Ohio WIC Prescribed Formula and Food Request Form

Ohio Department of Health

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:_____ Weeks Born Early (if applicable):_____

Parent/Caregiver's Name:_____ Weight*: _____ Length*:_____ Date measured:_____

* recommended not required

Medical Diagnosis/Condition:_____

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

B. Required Special Formula Information ***For infants, select the top 2-3 formulas that meet the participant's needs indicating 1st, 2nd, and 3rd recommended formulas.**

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 Enfamil Infant, Enfamil Gentlease, Enfamil Reguline, or Enfamil ProSobee been completed?: ☐ Yes ☐ No

If "No," please indicate why:_____

Infants**

***Or store brand equivalent**

☐ Alfamino Infant	☐ Enfamil Premature 24 Calorie	☐ Nutramigen	☐ Similac Alimentum*
☐ EleCare for Infants	☐ Gerber Extensive HA	☐ Nutramigen w/ Enflora LGG* **(powder only)**	☐ Similac Human Milk Fortifier
☐ Enfamil AR	☐ Neocate Infant w/ DHA & ARA		☐ Similac NeoSure
☐ Enfamil NeuroPro EnfaCare	☐ Neocate Nutra (≥ 6 mo. age)	☐ Pregestimil	☐ Similac PM 60/40
☐ Enfamil Human Milk Fortifier	☐ Neocate Syneo Infant	☐ PurAmino DHA/ARA	☐ Similac Special Care Premature 24 calorie

Children**

***Or store brand equivalent**

☐ Alfamino Junior	☐ EleCare Junior	☐ PediaSure	☐ Peptamen Junior 1.5 Cal
☐ Boost Breeze	☐ Encala	☐ PediaSure 1.5 Cal	☐ Peptamen Junior w/Fiber
☐ Boost Kid Essentials 1.0 Cal	☐ Neocate Junior (unflavored)	☐ PediaSure 1.5 Cal w/ Fiber	☐ Pregestimil
☐ Boost Kid Essentials 1.5 Cal	☐ Neocate Junior w/ Prebiotics	☐ PediaSure Enteral	☐ PurAmino Junior
☐ Boost Kid Essentials 1.5 Cal w/ Fiber	☐ Neocate Nutra	☐ PediaSure Enteral w/ Fiber	☐ Similac Alimentum*
☐ Bright Beginnings Soy Pediatric Drink	☐ Neocate Splash	☐ PediaSure w/ Fiber	☐ Similac PM 60/40
☐ Carnation Breakfast Essentials	☐ Nutramigen	☐ PediaSure Harvest	☐ Super Soluble Duocal
☐ Compleat Pediatric	☐ Nutramigen w/ Enflora LGG* **(powder only)**	☐ PediaSure Peptide	
☐ Compleat Pediatric Peptide 1.5 Cal	☐ Nutren Junior	☐ PediaSure Peptide 1.5 Cal	
☐ Compleat Pediatric Reduced Cal	☐ Nutren Junior w/ Fiber	☐ Peptamen Junior	

Women

☐ Boost	☐ Boost Breeze	☐ Carnation Breakfast Essentials	☐ Encala	☐ 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

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

Prescribing Health Care Provider's Signature:_____ Date:_____

Instructions for use of this form:

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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 a ready to feed (RTF) product is requested, it will require additional justification and will need to meet WIC standards. RTF products can be provided if the water supply has been determined to be unsafe; the ability of the caregiver to properly mix concentrate or powder formula is in question; for premature, low birth weight, or otherwise immunocompromised infants; or the participant has a medically relevant health condition which necessitates the use of RTF f ormula (i.e. continuous tube feeds). RTF formula cannot be issued for basic tolerance issues or participant preference.
- 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.

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