

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 Gentlelease	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

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)	
<p>For intolerance to Similac Advance or Good Start Soy, choose one alternate WIC formula below:</p> <p><input type="checkbox"/> Similac Sensitive (lactose sensitivity or colic)</p> <p><input type="checkbox"/> Similac for Spit-Up (excess spit-up or reflux)</p> <p><input type="checkbox"/> Similac Total Comfort (digestive issues or colic)</p> <p>Formula Amount: _____ oz. per day <i>Maximum allowed may be provided unless a lesser amount is indicated.</i></p> <p>Requested Length of Issuance: _____ month(s) <i>Formula will be issued up to 12 months of age unless otherwise indicated.</i></p>	<p>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:</p> <p>Name of Formula*: _____</p> <p>Formula Amount: _____ oz. per day <i>Maximum allowed may be provided unless a lesser amount is indicated.</i></p> <p>Requested Length of Issuance: _____ month(s)</p> <p><i>*See table 2 on reverse side for formulas no longer available to first time Texas WIC participants.</i></p>

Qualifying Condition/Diagnosis (required; please check all that apply):			
<input type="checkbox"/> Cardiovascular condition	<input type="checkbox"/> GI impairment	<input type="checkbox"/> Malabsorption syndrome	<input type="checkbox"/> Tube feeding
<input type="checkbox"/> Inadequate growth	<input type="checkbox"/> Neurological condition	<input type="checkbox"/> Respiratory condition	<input type="checkbox"/> GER/GERD
<input type="checkbox"/> Increased calorie needs	<input type="checkbox"/> Oral motor feeding issues/aversions	<input type="checkbox"/> Prematurity/LBW	
<input type="checkbox"/> FTT	<input type="checkbox"/> Low maternal weight gain/weight loss	<input type="checkbox"/> Seizure disorder requiring ketogenic diet	
<input type="checkbox"/> Developmental delays (sensory & motor)		<input type="checkbox"/> Renal disease/low mineral condition	
<input type="checkbox"/> Food allergies (cow's milk, soy or intact protein)/FPIES		<input type="checkbox"/> Other medical condition*: _____	
<i>*The following symptoms are not qualifying conditions and will not be accepted: colic, constipation, spitting up or gas.</i>			

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

<p>Infants 6 months of age and older:</p> <p><input type="checkbox"/> Formula only, no foods (due to inability or delay in consuming solids)</p> <p><input type="checkbox"/> Omit Infant Cereal</p> <p><input type="checkbox"/> Omit Baby Foods</p>	<p>Women & Children 12 months of age and older:</p> <p><input type="checkbox"/> Formula only, no foods</p> <p>Omit – check foods to omit from food package</p> <p><input type="checkbox"/> Milk <input type="checkbox"/> Yogurt <input type="checkbox"/> Eggs <input type="checkbox"/> Juice <input type="checkbox"/> Peanut Butter <input type="checkbox"/> Cheese</p> <p><input type="checkbox"/> Whole Grains <input type="checkbox"/> Cereal <input type="checkbox"/> Beans <input type="checkbox"/> Fruits and Vegetables</p> <p><input type="checkbox"/> Provide baby foods and infant cereal instead</p>
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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: _____	