Utah WIC Program
Formula and Food Authorization
Infants up to 12 Months of Age

Please complete each section below or formula/foods cannot be issued. Only complete one row for formula amount.

If specific amount per day is not checked/indicated, then the formula cannot be provided.

A. Patient's Name: _____ Patient's DOB: _____

Parent/Guardian Name: _____ Today's Date: _____

Primary Care Physician : _____ Discharging Physician: _____

B. Medical Diagnosis – Check all that apply

❑Allergies ❑GERD ❑Feeding Difficulties ❑Prematurity
❑Cystic fibrosis ❑FTT ❑Malnutrition ❑Other ICD 10 Medical Dx: _____

C. Name of Formula/Product:	
Physical Form of Formula:	❑ powder ❑ concentrated liquid ❑ ready to feed (RTF)
Partially Breastfed Infant Formula Amount (oz/day):	❑ 3 ❑ 6 ❑ 9 ❑ 12 ❑ Other: ____oz/day **(no ranges)**
Fully Formula Fed Infant Formula Amount (oz/day):	❑ 18 ❑ 21 ❑ 24 ❑ 27 ❑ 30 ❑ 32 ❑ Other: ___ oz/day **(no ranges)**
D. WIC Infant Foods	From 6 months until one year of age, WIC infant foods are available in addition to the prescribed formula. **If nothing is marked below, all foods will be issued.**

❑ No infant cereal ❑ No infant fruits and infant vegetables

❑ 6 - 11 month old infant who is medically unable to consume complementary foods. Provide the maximum formula amount of 31 oz/day for a 31 day month or 32 oz/day for a 30 day month.

E. Months of Issuance **(6 months will be issued including current month if nothing is marked)** **See reverse for exceptions	❑ 1 mo. ❑ 2 mo. ❑ 3 mo. ❑ 4 mo. ❑ 5 mo. ❑ 6 mo. **Order will continue through the end of the expired month.**

F. Health Care Provider Information (A written or stamped signature is acceptable.)

State Licensed Prescriptive Authority ❑ MD ❑ DO ❑ NP ❑ PA

Signature _____ Clinic/Hospital _____

Fax# _____ Phone # _____

WIC USE ONLY	Approved by:	Received in Clinic Date: FAFAF Expiration Date:

UTAH | WOMEN, INFANTS & CHILDREN

See Instructions on Back

Utah WIC Program Formula and Food Authorization

Children at 12 Months of Age or Older and Women

Please complete each section below or formula/foods cannot be issued. Only complete one row for formula amount.

If specific amount per day is not checked/indicated, then the formula cannot be provided.

A. Patient's Name: _____ Patient's DOB: _____

Parent/Guardian Name: _____ Today's Date: _____

Primary Care Physician : _____ Discharging Physician:_____

B. Medical Diagnosis – Check all that apply

❑Allergies	❑GERD	❑Feeding Difficulties	❑Prematurity
❑Cystic fibrosis	❑FTT	❑Malnutrition	❑Other ICD 10 Medical Dx: _____

C. Name of Formula/Product:	
Physical Form of Formula:	❑ powder ❑ concentrated liquid ❑ ready to feed (RTF)
Formula Amount (oz/day):	❑ 8 ❑ 16 ❑ 24 ❑ 27 ❑ Other: _____oz/day **(no ranges)**
RTF/Single Serving Product (cans/day):	❑ 1 ❑ 2 ❑ 3 ❑ 3.5

D. WIC Supplemental Foods – **Age appropriate foods will be issued if nothing is marked.**

❑ No milk	❑ No wheat bread/brown rice/tortillas/pasta	❑ No cereal
❑ No cheese	❑ No dry beans/canned beans	❑ No juice
❑ No yogurt	❑ No canned fish	❑ No fresh fruits/vegetables
❑ No eggs	❑ No peanut butter	

E. Whole Milk/Other

Please indicate medical reason/qualifying condition if prescribing whole milk.
Note: Personal preference is not a qualifying condition.

❑ Allow whole milk for a child ≥ 2 years or a woman. WIC participant must have a medical condition, requiring a medical formula, to receive whole milk. ❑For children, allow jarred infant fruits and vegetables. ❑Substitute infant cereal for breakfast cereal.	**Medical Reason/ Qualifying Condition:**

F. Months of Issuance

(6 months will be issued including current month if nothing is marked)

❑ 1 mo. ❑ 2 mo. ❑ 3 mo. ❑ 4 mo. ❑ 5 mo. ❑ 6 mo.

Order will continue through the end of the expired month.

G. Health Care Provider Information (A written or stamped signature is acceptable.)

State Licensed Prescriptive Authority ❑ MD ❑ DO ❑ NP ❑ PA

Signature _____ Clinic/Hospital _____

Fax# _____ Phone # _____

WIC USE ONLY	Approved by:	Received in Clinic Date: FAFAF Expiration Date:

See Instructions on Back

Instructions to Complete
Utah WIC Formula and Food Authorization Form
Children at 12 Months of Age or Older and Women

Step A: Complete patient information.

Step B: Indicate all medical diagnoses that apply to patient. If diagnosis is not listed, please write in the ICD 10 Medical Diagnosis that applies.

Step C: Formula/Product

- List name and brand of formula required.
  Authorization should be based on medical need and not patient preference.
- Specify if the requested formula is powder, concentrated liquid, or ready to feed.
- Indicate quantity of authorized food or formula needed per day. Please give specific amount needed -no ranges can be accepted.
  NOTE: Breastfeeding mothers may request less.

Step D: Please indicate if WIC supplemental foods are allowed or if there are any restrictions. Full provision of WIC food packages are listed below.

Step E: WIC can only give clients ≥ 2 years of age whole milk if they are receiving a medical specialty formula and require additional calories.

Step F: Specify the length of time this formula and food authorization will be valid.

Step G: Health Care Provider Information must be signed by a Utah state licensed prescriptive authority.

Full Provision of WIC Foods*	
Children and Women	
• **Eggs** - 1 dozen/month • **Fruits/Vegetables** - $8-$11 • **Cereal** - 36 oz/month • **Milk -** up to 4 gal/month (Children approximately 13 -17 oz/day)	• **Juice** - 1 gal/month (Children approximately 4 oz/day) • **Whole Grains** - 1-2 lbs/month • **Beans** - 1 lb/month • **Peanut Butter** - 16 - 18 oz/month
***If formula is needed, maximum allowance 29-30 oz/day based on number of days in month or no more than 910 oz per month.**	

UTAH | WOMEN, INFANTS & CHILDREN

Instructions to Complete
Utah WIC
Formula and Food Authorization Form
Infants up to 12 Months of Age

Step A: Complete patient information.
Step B: Indicate all medical diagnoses that apply to patient. If diagnosis is not listed, please write in the ICD 10 Medical Diagnosis that applies.
Step C: Formula/Product
NOTE: Please see list of WIC contract formulas that do not require this authorization for infants < 12 months.

- List name and brand of formula required.
  Authorization should be based on medical need and not patient preference.
- Specify if the requested formula is powder, concentrated liquid, or ready to feed.
- Indicate quantity of authorized food or formula needed per day. Please give specific amount needed - no ranges can be accepted.
  NOTE: Breastfeeding mothers may request less than full formula feeding mothers.

Step D: Please indicate if WIC Complementary Foods are allowed or if there are any restrictions. For infants, foods are given at ≥ 6 months of age. Infant meats are only available for fully breastfeeding infants. (Full provision of WIC food packages are listed below.)
Step E: Specify the length of time this formula and food authorization will be valid.
**Pharmacy-ordered premature formulas must be requested monthly.
Step F: Health Care Provider Information must be signed by a Utah state licensed prescriptive authority.

Utah WIC Rebate Formulas

Issuing the following contract formula doesn't require the use of this form and will be more cost effective allowing the Utah WIC Program to serve more participants

Similac Advance | Gerber Good Start Soy | Gerber Graduates Soy

The following formulas must be ordered by the health care provider, using this form, and will still result in a rebate

Similac Sensitive | Similac for Spit Up | Similac Total Comfort

Full Provision of WIC Formula and Food*

Infants

0-3 months of age:
- 28/29 oz formula/day

4-5 months of age:
- 30/32 oz formula/day

*Amounts based off of 30/31 day months

6-11 months of age:
- 22/23 oz formula/day,
- 24 oz infant cereal/month,
- 32 jars (4 oz. size) of infant food fruits/vegetables/month

9-11 months of age:
- may get fresh fruits and vegetables to replace some jarred infant food