



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

WIC Clinic Information:

Please complete each section below or formula/foods cannot be issued.

A. Patient's Name: _____ Patient's DOB: _____
 Parent/Guardian Name: _____ Today's Date: _____

B. Medical Diagnosis – Check all that apply

| | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dysphagia | <input type="checkbox"/> GERD | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Other ICD 10 Medical Dx: _____ |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Feeding difficulties | <input type="checkbox"/> Lack of growth | <input type="checkbox"/> Nausea/Vomiting | |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> FTT | <input type="checkbox"/> Malabsorption (pro/cho/fat) | <input type="checkbox"/> PKU | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Gastritis | | <input type="checkbox"/> Prematurity | |

WIC contract formulas which do not require this authorization form:

- Similac Advance EarlyShield (Prebiotics)
- Similac Sensitive
- Similac Sensitive for Spit Up
- Similac Soy Isomil

Issuing contract formula will allow Utah WIC to serve increased numbers of participants.

C. Formula/Product

| | |
|---|---|
| Name of Formula/Product: | _____ |
| Physical Form of Formula: | <input type="checkbox"/> powder <input type="checkbox"/> concentrated liquid <input type="checkbox"/> ready to feed (RTF) |
| Partially Breastfed Infant Formula Amount (oz/day): | <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 9 <input type="checkbox"/> 12 <input type="checkbox"/> Other: _____ oz/day (no ranges) |
| Fully Formula Fed Infant Formula Amount (oz/day): | <input type="checkbox"/> 20 <input type="checkbox"/> 24 <input type="checkbox"/> 27 <input type="checkbox"/> 29 <input type="checkbox"/> Other: _____ oz/day (no ranges) <input type="checkbox"/> Full WIC Formula Provision (Issued if nothing is marked) |

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, all foods will be issued.**

No infant cereal No infant fruits and infant vegetables

E. Requested Length of Issuance 1 mo. 2 mo. 3 mo. 4 mo. 5 mo. 6 mo.
 (6 months will be issued if nothing is marked) **See reverse for exceptions

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: _____ | Date: _____ |
| Package: _____ | FAFAP expires: _____ | |

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. **The full WIC formula and food provision (see table below) will be issued unless other instructions are noted.** Please give specific amount needed - no ranges can be accepted.
NOTE: Breastfeeding mothers may request less than the full WIC formula provision to supplement their breast milk.

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 Contract Formulas

Issuing contract formula will allow Utah WIC to serve more participants.

Utah WIC offers four Abbott formulas which **do not** require this authorization form for infants.

- | | |
|--|----------------------|
| • Similac Advance EarlyShield (Prebiotics) | • Similac Sensitive |
| • Similac Sensitive for Spit Up | • Similac Soy Isomil |

Full Provision of WIC Formula and Food

Infants

0-3 months of age:

- 26 oz formula/day

4-5 months of age:

- 29 oz formula/day

6-11 months of age:

- 20 oz formula/day,
- 24 oz infant cereal/month,
- 32 jars (4 oz. size) of infant food fruits/vegetables/month

WIC USE ONLY

A:

P:



Utah WIC Program Formula and Food Authorization

**Children at 12 Months of Age
or Older and Women**

WIC Clinic Information:

Please complete each appropriate section below or formula/foods cannot be issued.

A. Patient's Name: _____ Patient's DOB: _____
 Parent/Guardian Name: _____ Today's Date: _____

B. Medical Diagnosis – Check all that apply

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Lack of growth | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Other ICD 10 Medical Dx: _____ |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Feeding difficulties | <input type="checkbox"/> Malabsorption (pro/cho/fat) | <input type="checkbox"/> PKU | |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> FTT | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Prematurity | |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Gastritis | | | |
| <input type="checkbox"/> Diarrhea | | | | |

C. Formula/Product

| | |
|---|---|
| Name of Formula/Product: | _____ |
| Physical Form of Formula: | <input type="checkbox"/> powder <input type="checkbox"/> concentrated liquid <input type="checkbox"/> ready to feed (RTF) |
| Formula Amount (oz/day): | <input type="checkbox"/> 24 <input type="checkbox"/> 27 <input type="checkbox"/> 29 <input type="checkbox"/> Other: _____ oz/day (no ranges) |
| RTF/Single Serving Product (cans/day): | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 3.5 <input type="checkbox"/> Other: _____ oz/day (no ranges) <input type="checkbox"/> Full WIC Formula Provision (issued if nothing is marked) |

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

- | | | |
|---|--|---|
| <input type="checkbox"/> No milk | <input type="checkbox"/> No whole wheat bread/brown rice/tortillas | <input type="checkbox"/> No cereal |
| <input type="checkbox"/> No cheese | <input type="checkbox"/> No dry beans/canned beans | <input type="checkbox"/> No juice |
| <input type="checkbox"/> No eggs | <input type="checkbox"/> No canned fish | <input type="checkbox"/> No fresh fruits/vegetables |
| <input type="checkbox"/> No peanut butter | | |

E. Milk Substitution

Please indicate medical reason/qualifying condition if prescribing any of the following foods.
Note: Personal preference is not a qualifying condition.

| | |
|--|---|
| <input type="checkbox"/> 2 lbs cheese/month <input type="checkbox"/> 3 lbs cheese/month <input type="checkbox"/> Allow whole milk for a child \geq 2 years or a woman. WIC participant must also be receiving a medical formula to receive whole milk. | Medical Reason/ Qualifying Condition: _____ |
|--|---|

F. Requested Length of Issuance

- 1 mo. 2 mo. 3 mo. 4 mo. 5 mo. 6 mo.
 (6 months will be issued if nothing is marked)

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: _____ | Date: _____ |
| Package: _____ | FAFAP expires: _____ | |

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. **The full WIC provision (see table below) will be issued unless other instructions are noted.** Please give specific amount needed -no ranges can be accepted.
NOTE: Breastfeeding mothers may request less than the full WIC provision to supplement their breast milk.

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: If appropriate, milk substitution provides the option to authorize additional cheese greater than the standard 1 lb. for medical reasons. Participants who receive more cheese will be issued less milk. WIC can only give clients ≥ 2 years of age whole milk if they are receiving specialty formula and require additional calories. Children < 2 years of age can only be issued whole milk.

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.

Special Note: Non-breastfeeding women do not receive whole wheat bread and only fully breastfeeding women receive fish.

| Full Provision of WIC Foods* | |
|---|--|
| Children and Women | |
| <ul style="list-style-type: none"> • Eggs - 1 dozen/month • Fruits/Vegetables - \$6-\$10 • Cereal - 36 oz/month • Milk - up to 4 gal/month (Children approximately 13 -17 oz/day) | <ul style="list-style-type: none"> • Juice - 1 gal/month (Children approximately 4 oz/day) • Whole Grains - 1-2 lbs/month • Beans - 1 lb/month • Peanut Butter - 18 oz/month |
| *If formula is needed, maximum allowance is approximately 29 oz/day | |

| WIC USE ONLY |
|---------------------|
| A: |
| P: |