

**Directions:** Please complete all sections and return this form to the participant’s WIC Clinic. Email or Fax is acceptable.

*\*All requests are subject to WIC approval which is based on program policies and procedures.  
The signed and dated request must be less than **60 days old** when received by the clinic staff.*

Required Patient Information		
Last Name:	First Name:	DOB:
Parent/Caregiver’s Name:		
Qualifying Diagnosis/ICD-10 Code/WIC NRC: (list here)		
<input type="checkbox"/> Severe Allergy, confirmed (K52.29) <b>353</b>	<input type="checkbox"/> Prematurity (P07.10) <b>142 (&lt; 24 months of age)</b>	
<input type="checkbox"/> Developmental Sensory/Motor Delays (R62.50) <b>362</b>	<input type="checkbox"/> Intestinal Malabsorption (K90.9) <b>342</b>	
<input type="checkbox"/> Gastroesophageal Reflux (K21.9) <b>342</b>	<input type="checkbox"/> Low Birth Weight (P07.10) <b>141 (&lt; 24 months of age)</b>	
<input type="checkbox"/> Slow/Faltering Growth Pattern (P05) <b>135 (infants &lt; 6 months)</b>	<input type="checkbox"/> Metabolic Disorders (E88.9) <b>351</b>	
<input type="checkbox"/> Failure to Thrive (P92.6, R62.51) <b>134</b>	<input type="checkbox"/> <b>Other:</b>	

**\*\*NOT ALLOWED:** Constipation, diarrhea, unconfirmed allergies, milk protein or soy allergy, managing body weight, lactose intolerance, intolerance, or growth concerns UNLESS there is an underlying medical condition.

Measurements					
Date:	Length/Height:	Weight:	Birth Weight:	Weeks’ Gestation:	Hgb/Hct:

**Name of Formula** (from options on reverse side) **Write in Formula name below**

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**Requested Length of Issuance**  
\*\*Maximum allowed by federal guidelines of 6 months will be issued unless otherwise indicated.

<input type="checkbox"/> <b>1 Month</b>  <input type="checkbox"/> <b>3 Months</b>  <input type="checkbox"/> <b>6 Months</b>	<b>Formula Amount _____ per day*</b>  *Maximum amount allowed by federal guidelines (for infant/child age and feeding type) will be provided <u>UNLESS</u> a decreased amount is indicated here.	<b>Length of Issuance: _____ months</b>
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Infants (6-12 Months Old)	Children (1-5 Years Old)										
Full amount of formula and infant foods will be given <u>UNLESS</u> checked below.	All appropriate WIC foods, will be issued with a prescribed formula <u>UNLESS</u> checked below.										
<input type="checkbox"/> Provide <b>only</b> formula past 6 months of age due to inability or delay in consuming solid foods.  <b>Check WIC Supplemental Food to OMIT at 6 months of age</b>	<input type="checkbox"/> Provide infant foods, specify (infant cereal/food/both): _____  <input type="checkbox"/> No supplemental foods, provide formula ONLY										
<table style="width:100%;"> <tr> <td style="width: 50%; text-align: center;"><input type="checkbox"/> Infant Cereal</td> <td style="width: 50%; text-align: center;"><input type="checkbox"/> Baby Food (Fruit and/or Vegetables)</td> </tr> </table>	<input type="checkbox"/> Infant Cereal	<input type="checkbox"/> Baby Food (Fruit and/or Vegetables)	<b>Check WIC Supplemental Foods to OMIT from Food Package</b> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Dairy/milk</td> <td><input type="checkbox"/> Peanut Butter</td> <td><input type="checkbox"/> Cereal</td> <td><input type="checkbox"/> Juice</td> </tr> <tr> <td><input type="checkbox"/> Eggs</td> <td><input type="checkbox"/> Beans</td> <td><input type="checkbox"/> Whole Grains</td> <td><input type="checkbox"/> Fruits/Veg</td> </tr> </table>	<input type="checkbox"/> Dairy/milk	<input type="checkbox"/> Peanut Butter	<input type="checkbox"/> Cereal	<input type="checkbox"/> Juice	<input type="checkbox"/> Eggs	<input type="checkbox"/> Beans	<input type="checkbox"/> Whole Grains	<input type="checkbox"/> Fruits/Veg
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Medical Provider Notes:

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Required Health Care Provider Information			
Signature of Health Care Provider (MD/DO/PA/CNP):			Date:
Provider Name (Please Print):	Phone #:	Fax #:	Email:

Rx Required WIC Clinic Issued Formulas (Issued Monthly)	Rx Required WIC Card Issued Formulas (Purchased at WIC Authorized Stores)
Alfamino powder 14.1 oz.	Enfamil Enfacare Neuropro Powder 22 cal 13.6 oz.
Elecare DHA/ARA powder 14.1 oz.	Neosure Powder 22 cal 13.1 oz
Enfamil 24 cal 2oz	Nutramigen Concentrate 13 oz.
Enfamil AR RTF 2 oz.* and powder 12.9 oz.	Nutramigen w/Enflora LGG Powder 12.6 oz
Enfamil Enfacare Neuropro 22 cal RTF 2oz *	Nutramigen RTF 32 oz. *
Enfamil Enfaport 30 cal RTF 6 oz	Pediasure Grow & Gain w/Fiber RTF 8 oz. 240 cal
Enfamil Premature 20 cal; RTF 2 oz.	Pediasure Grow & Gain RTF 8 oz. 240 cal
Enfamil Premature 24 cal RTF 2 oz.	Pregestimil Powder 20 cal 16 oz
Extensive HA 14.1 oz. Powder	Similac Alimentum Powder 12.1 oz.
Neocate DHA/ARA Powder 14.1 oz.	Similac Alimentum RTF 32 oz. *
Neocate Syneo Powder 14.1 oz	Pepticate Infant Powder 13.2 oz
Neosure 22 cal RTF 2 oz. *	Pur Amino DHA/ARA Powder 14.1 oz
Nutramigen w/ Iron RTF 2 oz. *	
Pregestimil 20 cal RTF 2 oz. *	
Pregestimil 24 cal RTF 2 oz.	
Similac PM 60/40 Powder 14.1 oz	
Similac Alimentum RTF 2 oz. *	
Similac Special Care 24 cal w/ Iron RTF 2 oz.	
Similac Special Care High Protein 24 cal w/ Iron RTF 2 oz.	
Similac Special Care 30 cal w/ Iron RTF 2 oz.	
Children (1-5 years of age) Formulas Rx Required (Issued Monthly)	Standard Milk and Soy WIC Card Issued Formulas No Rx required for Infants, Rx is required for Children
Alfamino Junior powder 14.1 oz. (unflavored, vanilla)	Similac Advance w/Iron Powder 12.4 oz.
Neocate Jr. powder 14 oz. (unflavored, van, choc, straw, tropical)	Similac Advance w/Iron Concentrate 13 oz
Neocate Jr. without prebiotics powder 14 oz. (unflavored)	Similac Advance w/Iron RTF 32 oz. *
Pediasure Enteral 1.0 RTF 8 oz. (vanilla)	Similac Sensitive w/Iron Powder 12.5 oz.
Pediasure Enteral w/ Fiber 1.0 RTF 8 oz.	Similac Sensitive w/Iron RTF 32 oz. *
PurAmino Jr. powder 14.1 oz. (unflavored & vanilla)	Similac Total Comfort w/Iron Powder 12.6 oz
Pediasure Peptide 1.0 RTF 8oz oz. (unflavored, vanilla , chocolate, straw)	Similac Soy Isomil w/Iron Powder 12.4 oz.
Boost Kid Essentials 1.5 RTF 8 oz. (vanilla, chocolate, strawberry)	Similac Soy Isomil w/Iron Concentrate 13 oz.
Boost Kid Essentials 1.5 w /Fiber RTF 8 oz. (vanilla)	Similac Soy Isomil w/Iron RTF 32 oz. *
Elecare Jr. Powder 14.1 oz. (unflavored, van, choc, banana)	Similac Total Care 360 (8 and 32 oz.) RTF *
Neocate Syneo Junior powder 14.1 oz	Similac Total Care 360 Sensitive (8 and 32 oz.) RTF *
Peptamen Junior 1.0 cal 8.45 oz (unflavored, vanilla, strawberry)	
<i>* Federal Regulations require all WIC programs to obtain a formula rebate contract for cost containment. The current Louisiana WIC contract is with Abbott.</i>	<i>Available formulas are subject to change. For more information and to find the most current version of this form, please visit <a href="http://louisianawic.org/community/">http://louisianawic.org/community/</a></i>
<b>This institution is an equal opportunity provider.</b>	<b>*- justification for RTF must be met</b>