



# Colorado WIC Program Physician Authorization Form For WIC Special Formulas and WIC Supplemental Foods

This is a medical documentation request for medical formula and foods.

- This request is subject to WIC approval based on program policy and procedure.
- **Please FAX or return the completed form to your local WIC clinic.**

WIC clinic:	
WIC FAX #:	
Attention:	

Patient's name (Last, First, MI):	DOB:
Parent/Caregiver's Name:	

## I. WIC Supplemental Foods

Medical provider must complete the following if a modified food package is required due to a medical condition:

- Patient requires a modified food package based on a medical condition:
  - Infant  $\geq 6$  months cannot tolerate solid foods; provide additional formula only.
  - Child  $\geq 12$  months receiving special formula and tolerating infant fruits and vegetables; provide infant fruits and vegetables in lieu of fruits and vegetables.

WIC RD/RN will determine appropriate foods unless health care provider indicates otherwise.

- No food restrictions;** provide full amount of age-appropriate WIC foods.
- Omit** the following food(s) based on medical condition(s):
  - Infant 6 - 11 months omit:
 

<input type="checkbox"/> Infant cereal	<input type="checkbox"/> Infant fruits/ vegetables
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  - For children  $\geq 12$  months or women omit:
 

<input type="checkbox"/> Milk	<input type="checkbox"/> Cheese	<input type="checkbox"/> Whole grains
<input type="checkbox"/> Breakfast cereals	<input type="checkbox"/> Legumes	<input type="checkbox"/> Peanut butter
<input type="checkbox"/> Fruits & vegetables	<input type="checkbox"/> Juice	<input type="checkbox"/> Fish (exclusively breastfeeding women only)
	<input type="checkbox"/> Eggs	

Optional:

- Substitute whole milk** or reduced fat (2%): For women and children  $\geq 2$  years; whole milk and 2% milk are **ONLY** available if the patient is receiving special formula or supplement for a medical condition(s).
- Substitute soy milk** or **tofu** for milk or cheese.

Special instructions: \_\_\_\_\_

## II. Health Care Provider Information

Signature of health care provider:		
Provider's name (please print):		
Medical clinic/hospital:		
Phone:	FAX:	Date:
<b>WIC Use Only</b>		
Approved by:	Date:	Rx exp. date:

## III. Formula (Please select from list on back of page)



Determine formula need	Choose formula:
Standard Contract CO WIC Formulas:	<input type="checkbox"/> Enfamil Infant <input type="checkbox"/> Enfamil Gentlease <input type="checkbox"/> Enfamil ProSobee <input type="checkbox"/> Enfamil Reguline <input type="checkbox"/> Enfamil AR <p>● <b>NO PRESCRIPTION IS NEEDED FOR INFANTS (up to age 12 months)</b>          ● A prescription is needed to issue standard formula for children older than 12 months of age.          ● A prescription is needed to issue additional formula to 6- to 11-month-old infants who cannot tolerate solid foods.</p>
Premature/ Calorie Dense Formulas:	<input type="checkbox"/> Enfamil EnfaCare <input type="checkbox"/> Similac NeoSure
Hypoallergic Formulas/ Supplements:	<input type="checkbox"/> E028 Splash <input type="checkbox"/> Neocate Junior <input type="checkbox"/> Nutramigen with Enflora LGG <input type="checkbox"/> EleCare Infant <input type="checkbox"/> Neocate Junior with Prebiotics <input type="checkbox"/> Pregestimil <input type="checkbox"/> EleCare Junior <input type="checkbox"/> Neocate Splash <input type="checkbox"/> PurAmino <input type="checkbox"/> Neocate Infant <input type="checkbox"/> Neocate Syneo <input type="checkbox"/> Similac Alimentum <input type="checkbox"/> Nutramigen
Supplements:	<input type="checkbox"/> Boost High Protein <input type="checkbox"/> Enfagrow Toddler Transitions Soy <input type="checkbox"/> Nutren 2.0 <input type="checkbox"/> Boost Kid Essentials 1.5 cal <input type="checkbox"/> Ensure <input type="checkbox"/> Osmolite 1 Cal <input type="checkbox"/> Boost Kid Essentials 1.5 cal with fiber <input type="checkbox"/> Ensure Plus <input type="checkbox"/> PediaSure <input type="checkbox"/> Bright Beginnings Soy Pediatric Drink <input type="checkbox"/> Nutren Junior <input type="checkbox"/> PediaSure with Fiber <input type="checkbox"/> Compleat Pediatric <input type="checkbox"/> Nutren Junior with Prebio Fiber <input type="checkbox"/> PediaSure Enteral <input type="checkbox"/> Nutren 1.0 <input type="checkbox"/> PediaSure Enteral with Fiber <input type="checkbox"/> Nutren 1.0 with Fiber <input type="checkbox"/> PediaSure 1.5 cal <input type="checkbox"/> Nutren 1.5 <input type="checkbox"/> PediaSure 1.5 cal with Fiber
Supplements for Special Medical Needs:	<input type="checkbox"/> Enfaport <input type="checkbox"/> Peptamen Junior with Prebio Fiber <input type="checkbox"/> Tolerex <input type="checkbox"/> Peptamen <input type="checkbox"/> Portagen <input type="checkbox"/> Vivonex Pediatric <input type="checkbox"/> Peptamen with Prebio Fiber <input type="checkbox"/> Similac PM 60/40 <input type="checkbox"/> Vivonex T.E.N. <input type="checkbox"/> Peptamen Junior
Formulas for Inherited Metabolic Diseases:	<input type="checkbox"/> Calcilo-XD <input type="checkbox"/> MSUD Anamix Early Years <input type="checkbox"/> ProViMin <input type="checkbox"/> Cyclinex-1 & 2 <input type="checkbox"/> MSUD Maxamum <input type="checkbox"/> RCF <input type="checkbox"/> Glutarex-1 & 2 <input type="checkbox"/> Phenex-1 & 2 <input type="checkbox"/> Tyrex-1 & 2 <input type="checkbox"/> GA-1 Anamix Early Years <input type="checkbox"/> PhenylAde Essential Drink Mix <input type="checkbox"/> TYROS-1 & 2 <input type="checkbox"/> HCU Anamix Early Years <input type="checkbox"/> Phenyl-Free 1 & 2 <input type="checkbox"/> XPhe Maxamum <input type="checkbox"/> Hominex-1 & 2 <input type="checkbox"/> Phenyl-Free 2 HP <input type="checkbox"/> TYR Anamix Early Years <input type="checkbox"/> IVA Anamix Early Years <input type="checkbox"/> PKU Periflex Early Years <input type="checkbox"/> XLeu Maxamum <input type="checkbox"/> I Valex-1 & 2 <input type="checkbox"/> PKU Periflex Junior Plus <input type="checkbox"/> XLys, XTrp Maxamum <input type="checkbox"/> Ketonex-1 & 2 <input type="checkbox"/> Pro-Phree <input type="checkbox"/> XMet Maxamum <input type="checkbox"/> MMA/PA Anamix Early Years <input type="checkbox"/> Propimex-1 & 2 <input type="checkbox"/> XMTVI Maxamum
Human Milk Fortifier	<input type="checkbox"/> Similac Human Milk Fortifier Powder* *New physician authorization form required every month.

Medical provider must complete Sections A, B and C.

A. Qualifying medical condition(s):		
<input type="checkbox"/> Prematurity <input type="checkbox"/> LBW <input type="checkbox"/> SGA <input type="checkbox"/> Underweight <input type="checkbox"/> Slow weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> FTT <input type="checkbox"/> Developmentally not ready for solids	<input type="checkbox"/> Feeding issues <input type="checkbox"/> Chewing/swallowing issues <input type="checkbox"/> Multiple or severe food allergy <input type="checkbox"/> Milk allergy <input type="checkbox"/> Soy allergy <input type="checkbox"/> Gastrointestinal disorders <input type="checkbox"/> Persistent vomiting/diarrhea <input type="checkbox"/> Tube feeding	<input type="checkbox"/> Impaired nutrient absorption or nutritional deficiency (please specify: _____) <input type="checkbox"/> Medical condition (please specify: _____) <input type="checkbox"/> Metabolic disorder (please specify: _____) <input type="checkbox"/> Other (please specify: _____)
B. Quantity:		
Daily amount (choose one): <input type="checkbox"/> Max allowable <input type="checkbox"/> Ounces/day _____ <input type="checkbox"/> Containers/day _____ <input type="checkbox"/> Packets per day _____		
C. Duration:		
<input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months <input type="checkbox"/> 5 months <input type="checkbox"/> 6 months		
Special Instructions _____		

Patient's name: \_\_\_\_\_                      DOB: \_\_\_\_\_

