



# Medical Formula and Nutritionals Request Form

WIC Agency: \_\_\_\_\_

WIC ID#: \_\_\_\_\_

## SECTION I: Participant/Patient and Health Care Information

<b>Patient Name:</b> (First) _____ (Last) _____		<b>Date of Birth:</b> _____
<b>Parent/Caregiver Name:</b> (First) _____ (Last) _____		<b>Phone Number:</b> _____
<b>Height/Length:</b> Current: _____ inches (Date: _____) Within 60 days At birth: _____ inches		<b>Weight:</b> Current: _____ lb _____ oz (Date: _____) Within 60 days At birth: _____ lb _____ oz
<b>Hemoglobin:</b> _____ (gm/dL) or <b>Hematocrit:</b> _____ %		<b>Lead Test:</b> _____ mcg/dL
<b>Lab Result Date:</b> _____		
<b>Breastfeeding</b> (birth to 12 months): <input type="checkbox"/> Fully breastfeeding <input type="checkbox"/> Feeding breastmilk & formula <input type="checkbox"/> Never breastfed <input type="checkbox"/> Discontinued breastfeeding on (Date: _____)		

**To Health Care Providers:** WIC **only** provides medically-necessary formula or medical food when they are **NOT** covered by Medi-Cal. Please refer patient to Medi-Cal for these products.

### Patient's Health Insurance:

- ☐ **Medi-Cal** (Note: HCP must submit prior authorization (PA) to Medi-Cal Rx; then send PA and Rx to pharmacy)
- ☐ **Private** (does not cover enteral products)

## SECTION II: Special Formula/Nutritionals and Qualifying Diagnosis

### Formula/Medical Food Prescribed (Check below or specify name if not listed):

<b>Premature:</b> <input type="checkbox"/> Enfamil NeuroPro EnfaCare <input type="checkbox"/> Similac NeoSure	<b>Hypo-Allergenic:</b> <input type="checkbox"/> Alfamino Infant <input type="checkbox"/> Alfamino Junior, Unflavored <input type="checkbox"/> Alfamino Junior, Vanilla <input type="checkbox"/> EleCare Infant <input type="checkbox"/> EleCare Junior, Unflavored <input type="checkbox"/> EleCare Junior, Vanilla <input type="checkbox"/> Extensive HA <input type="checkbox"/> Neocate Infant <input type="checkbox"/> Neocate Junior, Unflavored	<input type="checkbox"/> Neocate Syneo Infant <input type="checkbox"/> Nutramigen (liquid concentrate; RTF) <input type="checkbox"/> Nutramigen LGG (powder) <input type="checkbox"/> Pepticate <input type="checkbox"/> PurAmino <input type="checkbox"/> PurAmino Junior <input type="checkbox"/> Similac Alimentum
<b>Nutritional Drinks:</b> <input type="checkbox"/> PediaSure <input type="checkbox"/> PediaSure with Fiber <input type="checkbox"/> PediaSure 1.5 Cal <input type="checkbox"/> PediaSure 1.5 Cal with Fiber		
<b>Medical Formula:</b> <input type="checkbox"/> Fortini <input type="checkbox"/> Similac PM 60/40		

**Form:** (Check one) ☐ Powder ☐ Concentrate ☐ Ready-to-Feed (RTF) (Justification: \_\_\_\_\_)  
 Required unless RTF is the only available form

**Amount:** \_\_\_\_\_ fluid ounces / ounces per day **Duration:** (Check one) ☐ 1 month ☐ 3 months ☐ 5 months  
☐ 2 months ☐ 4 months ☐ 6 months

**Qualifying Diagnosis:** (Must specify)

<input type="checkbox"/> Prematurity (Adjusted age: _____ months)	<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Low birthweight	<input type="checkbox"/> Dysphagia
<input type="checkbox"/> Food allergy: _____	<input type="checkbox"/> Immune system disorder: _____		
<input type="checkbox"/> Gastrointestinal disorder: _____	<input type="checkbox"/> Life-threatening disorder: _____		
<input type="checkbox"/> Genetic/Metabolic disorder: _____	<input type="checkbox"/> Malabsorption (Nutrient: _____)		
<input type="checkbox"/> Other medical condition(s): _____			

### SECTION III: WIC Food Restrictions

(Check one): ☐ **No food restrictions** (all WIC foods allowed) ☐ **Food restrictions** (specified below)

**Infant**  
(6–11 Months): ☐ No infant cereal ☐ No infant fruits/vegetables ☐ No infant foods, increased formula  
☐ If premature: Provide infant foods after \_\_\_\_\_ months

**Children**  
(1–5 Years): ☐ No milk ☐ No cheese ☐ No eggs ☐ No yogurt ☐ No soy ☐ No tofu  
☐ No peanut butter ☐ No beans ☐ No cereal ☐ No fruits/vegetables ☐ No juice  
☐ No whole grains (Specify type(s): \_\_\_\_\_)  
☐ Needs purees; provide infant fruits/vegetables ☐ No foods (formula only)

**Comments:**

### SECTION IV: Health Care Provider Information

**Provider Name** (Printed): ☐ MD ☐ DO ☐ NP ☐ PA

**Medical Office/Clinic Name and Address:**

**Provider Signature:**

**Date:**

**Phone Number:**

#### Please Note:

##### WIC will not approve medical formula or medical food for the following conditions:

- Non-specific symptoms or diagnoses (e.g., colic, constipation, diarrhea, spitting up, picky eater, poor appetite, cramps, fussiness, gas, etc.)
- Solely to enhance nutrient intake or manage body weight without an underlying condition
- Non-specific formula intolerance or food intolerance
- Patient/caregiver preference or food dislikes

##### WIC qualifying medical diagnoses/conditions include but are not limited to:

- |   |   |   |
|---|---|---|
| • Severe food allergies that require an elemental formula | • Gastrointestinal disorders                          | • Diseases and medical conditions that impair ingestion, digestion, absorption or the utilization of nutrients that could adversely affect the participant's nutrition status |
| • Premature birth   | • Malabsorption syndromes                             |   |
| • Low birth weight  | • Immune system disorders                             |   |
| • Failure to thrive                                       | • Life threatening disorders                          |   |
|   | • Inborn errors of metabolism and metabolic disorders |   |

Visit [www.wicworks.ca.gov](http://www.wicworks.ca.gov); click *Health Care Providers* for more information on WIC Formulas.

**Questions:** Contact 1-800-852-5770 or [Formula@cdph.ca.gov](mailto:Formula@cdph.ca.gov).