



# 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 <b>omit</b> :                   | <input type="checkbox"/> Infant cereal       | <input type="checkbox"/> Infant fruits/ vegetables                   |
| • For children $\geq 12$ months or women <b>omit</b> : | <input type="checkbox"/> Milk                | <input type="checkbox"/> Cheese                                      |
|  | <input type="checkbox"/> Breakfast cereals   | <input type="checkbox"/> Legumes                                     |
|  | <input type="checkbox"/> Fruits & vegetables | <input type="checkbox"/> Juice                                       |
|  |  | <input type="checkbox"/> Eggs  |
|  |  | <input type="checkbox"/> Whole grains                                |
|  |  | <input type="checkbox"/> Peanut butter                               |
|  |  | <input type="checkbox"/> Fish (exclusively breastfeeding women only) |

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 ProSobee	<input type="checkbox"/> Enfamil Gentlease <input type="checkbox"/> Enfamil Reguline <input type="checkbox"/> Enfamil AR	<ul style="list-style-type: none"> <li>● <b>NO PRESCRIPTION IS NEEDED FOR INFANTS (up to age 12 months)</b></li> <li>● A prescription is needed to issue standard formula for children older than 12 months of age.</li> <li>● A prescription is needed to issue additional formula to 6- to 11-month-old infants who cannot tolerate solidfoods.</li> </ul>
Premature/ Calorie Dense Formulas:	<input type="checkbox"/> Enfamil EnfaCare <input type="checkbox"/> Similac NeoSure		
Hypoallergenic Formulas/ Supplements:	<input type="checkbox"/> Comforts Hypoallergenic <input type="checkbox"/> Gerber Extensive HA <input type="checkbox"/> EleCare Infant <input type="checkbox"/> EleCare Junior <input type="checkbox"/> Neocate Infant	<input type="checkbox"/> Neocate Junior <input type="checkbox"/> Neocate Junior with Prebiotics <input type="checkbox"/> Neocate Splash <input type="checkbox"/> Neocate Syneo <input type="checkbox"/> Nutramigen	<input type="checkbox"/> Nutramigen with Enflora LGG <input type="checkbox"/> Parent's Choice Hypoallergenic <input type="checkbox"/> Pregestimil <input type="checkbox"/> PurAmino <input type="checkbox"/> Similac Alimentum
Supplements:	<input type="checkbox"/> Boost High Protein <input type="checkbox"/> Boost Kid Essentials 1.5 cal <input type="checkbox"/> Boost Kid Essentials 1.5 cal with fiber <input type="checkbox"/> Bright Beginnings Soy <input type="checkbox"/> Pediatric Drink <input type="checkbox"/> Compleat Pediatric	<input type="checkbox"/> Ensure <input type="checkbox"/> Ensure Plus <input type="checkbox"/> Nutren Junior <input type="checkbox"/> Nutren Junior with Prebio Fiber <input type="checkbox"/> Nutren 1.0 <input type="checkbox"/> Nutren 1.0 with Fiber <input type="checkbox"/> Nutren 1.5	<input type="checkbox"/> Nutren 2.0 <input type="checkbox"/> Osmolite 1 Cal <input type="checkbox"/> PediaSure <input type="checkbox"/> PediaSure with Fiber <input type="checkbox"/> PediaSure Enteral <input type="checkbox"/> PediaSure Enteral with Fiber <input type="checkbox"/> PediaSure 1.5 cal <input type="checkbox"/> PediaSure 1.5 cal with Fiber
Supplements for Special Medical Needs:	<input type="checkbox"/> Enfaport <input type="checkbox"/> Peptamen <input type="checkbox"/> Peptamen with Prebio Fiber <input type="checkbox"/> Peptamen Junior	<input type="checkbox"/> Peptamen Junior with Prebio Fiber <input type="checkbox"/> Portagen <input type="checkbox"/> Similac PM 60/40	<input type="checkbox"/> Tolerex <input type="checkbox"/> Vivonex Pediatric <input type="checkbox"/> Vivonex T.E.N.
Formulas for Inherited Metabolic Diseases:	<input type="checkbox"/> Calcilo-XD <input type="checkbox"/> Cyclinex-1 & 2 <input type="checkbox"/> Glutarex-1 & 2 <input type="checkbox"/> GA-1 Anamix Early Years <input type="checkbox"/> HCU Anamix Early Years <input type="checkbox"/> Hominex-1 & 2 <input type="checkbox"/> IVA Anamix Early Years <input type="checkbox"/> I Valex-1 & 2 <input type="checkbox"/> Ketonex-1 & 2 <input type="checkbox"/> MMA/PA Anamix Early Years	<input type="checkbox"/> MSUD Anamix Early Years <input type="checkbox"/> MSUD Maxamum <input type="checkbox"/> Phenex-1 & 2 <input type="checkbox"/> PhenylAde Essential Drink Mix <input type="checkbox"/> Phenyl-Free 1 & 2 <input type="checkbox"/> Phenyl-Free 2 HP <input type="checkbox"/> PKU Periflex Early Years <input type="checkbox"/> PKU Periflex Junior Plus <input type="checkbox"/> Pro-Phree <input type="checkbox"/> Propimex-1 & 2	<input type="checkbox"/> ProViMin <input type="checkbox"/> RCF <input type="checkbox"/> Tyrex-1 & 2 <input type="checkbox"/> TYROS-1 & 2 <input type="checkbox"/> XPhe Maxamum <input type="checkbox"/> TYR Anamix Early Years <input type="checkbox"/> XLeu Maxamum <input type="checkbox"/> XMet Maxamum <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.

<b>A. Qualifying medical condition(s):</b> <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: _____) Metabolic disorder (please specify: _____) <input type="checkbox"/> Other (please specify: _____)		
<b>B. Quantity:</b> 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 _____								
<b>C. Duration:</b> <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: \_\_\_\_\_