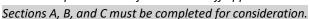


## WIC Medical Formula Request Form

All requests are subject to WIC staff approval.





	Scelions 7	1, <i>D</i> , and <i>C</i>	must be completed j	or considera	1011.	
Healthcare Provider:			Return form to:			
Address:						
Phone: Fax:						
Provider DEA:						
Patient's Name:			Date of Birth:	/ /		Phone #:
Parent/Guardian:			MaineCare ID #:		I	
Pharmacy Name:			Pharmacy Location:			
. Medical Formula/Nut	tritional Products:		,			
Infant Formula	12 months +		Diagnosis*			Notes
□ Neosure □ Alimentum □ Nutramigen □ Pregestimil □ Elecare □ Neocate □ PurAmino □ Special Care 20 □ Enfamil Pre 20 □ Special Care 24 □ Enfamil 24 □ Similac 24 □ Similac PM 60/40 □ Enfaport □ 3232A □ Enfamil AR	<ul> <li>□ Nutramigen Toddler</li> <li>□ PediaSure Peptide 1.0</li> <li>□ PediaSure Peptide 1.5</li> <li>□ Elecare Jr.</li> <li>□ PurAmino Jr</li> <li>□ Neocate Jr</li> <li>□ PediaSure G &amp; G</li> <li>□ PediaSure 1.5</li> <li>□ PediaSure Sidekicks</li> <li>□ PediaSure Enteral1.0</li> <li>□ 3232 A</li> <li>□ Portagen</li> </ul>	☐ Cer☐ Cys☐ Low☐ Eos☐ Fai☐ Ma☐ Ora☐ Dev☐ Sho☐ Tull☐	Prematurity Cerebral Palsy Cystic Fibrosis Low/Very Low Birth Weight Eosinophilic Esophagitis Failure to Thrive Malabsorption Milk Allergy Oral/Motor Feeding Issue or Developmental Delay Short Bowel Syndrome Soy Allergy Tube Feeding Other (specify):		intolerance; fussiness; colic; spitting up; vomiting; gas; or constipation does <b>not</b> qualify for WIC issued medical formula without a specified underlying medical condition.  Provider Notes:	
standard cow's milk or s Similac Total Comfort. 1	trition Program issues only consoy formulas. The current cont These do not require the use of	ract formu	las include: Similac	=		_
. Amount and Duration	on:					
Prescribed ounces or	cc/day:					
Duration: ☐ Until first birthday ☐ Months of age ☐ Other ☐ Discontinue prescribed formula						
Supplemental Foods:						
transition to whole milk formula. If this checkbox	tian may assess for and provid at 12 months, and discontinua is not selected, WIC must hav 224 months or woman (must	tion of pre e written a	scribed formula afte outhorization from F	r 12 months ICP to provid	s) to my p de foods.	patient receiving a prescribed
Signature:			Date:			