



WOMEN, INFANTS and CHILDREN (WIC)

October 2009

PHYSICIAN GUIDE to the **Ohio**
WIC Prescribed Food and
Formula form

A new form is required when prescribing “special formulas” for your patients who are on WIC.

Ohio WIC Prescribed Formula and Food Request Form

Ohio WIC Prescribed Formula and Food Request - Women, Infants, and Children	
Please complete this Ohio WIC Prescribed Formula and Food Request form in full.	
Patient's name (please print)	Date of birth
Caregiver's name (please print)	Phone
Parts 1-5 REQUIRED FOR APPROVAL - Please complete the following information:	
1. Amount of infant/child/adult formula to be provided per DAY: _____	
2. Intended length of use (must not exceed 6 months at a time): _____	
3. ICD-9 code: _____ and Medical diagnosis (please print): _____	
Describe condition or symptoms causing need for specialized formula: _____	
4. Prescribed Formulas: Infants and Children	
WIC receives a rebate for Similac Advance and Similac Isomil Advance. Rebates help WIC provide services to more participants. A trial with either of these formulas is required prior to ordering any of the formulas listed in the box below.	
Please indicate if the infant has tried either Similac Advance or Similac Isomil Advance formulas: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please explain: _____ Is re-lactation an option? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> EleCare Unflavored <input type="checkbox"/> Enfamil Nutramigen Lipil w/ Enfora LGG (powder only) <input type="checkbox"/> Neocate Infant with DHA & ARA <input type="checkbox"/> EleCare Unflavored with DHA & ARA <input type="checkbox"/> Enfamil Nutramigen Lipil (liq conc & RTF only) <input type="checkbox"/> Similac Alimentum <input type="checkbox"/> Enfamil EnfaCare Lipil (≤ 12 mo corrected age) <input type="checkbox"/> Enfamil Pregestimil Lipil <input type="checkbox"/> Similac Sensitive (≤ 12 mo corrected age) <input type="checkbox"/> Enfamil Enfaport Lipil <input type="checkbox"/> Neocate Infant <input type="checkbox"/> Similac NeoSure (≤ 12 mo corrected age) <input type="checkbox"/> Similac PM 60/40	
Infant Foods: Indicate which infant foods listed below are contraindicated or require restrictions.	
<input type="checkbox"/> Infant Cereal <input type="checkbox"/> Fruits (baby food textures) <input type="checkbox"/> Vegetables (baby food textures) <input type="checkbox"/> Do not provide any of the infant WIC foods listed	
Children Only	
<input type="checkbox"/> Boost Kid Essentials 1.0 Cal <input type="checkbox"/> Neocate One + <input type="checkbox"/> Peptamen Junior with Fiber <input type="checkbox"/> Boost Kid Essentials 1.5 Cal <input type="checkbox"/> Nutren Junior <input type="checkbox"/> Peptamen Junior 1.5 Cal <input type="checkbox"/> Boost Kid Essentials with Fiber 1.5 Cal <input type="checkbox"/> Nutren Junior with Fiber <input type="checkbox"/> Portagen <input type="checkbox"/> Bright Beginnings Soy Pediatric Drink <input type="checkbox"/> PediaSure <input type="checkbox"/> Similac Advance (≤ 12 mo corrected age) <input type="checkbox"/> Compleat Pediatric <input type="checkbox"/> PediaSure with Fiber <input type="checkbox"/> Similac Isomil Advance <input type="checkbox"/> E028 Splash <input type="checkbox"/> PediaSure Enteral <input type="checkbox"/> Super Soluble Duocal <input type="checkbox"/> Monogen <input type="checkbox"/> PediaSure with Fiber Enteral <input type="checkbox"/> Vital Jr. <input type="checkbox"/> Neocate Junior <input type="checkbox"/> Peptamen Junior <input type="checkbox"/> Vivonex Pediatric	
Adult	
<input type="checkbox"/> A-Soy <input type="checkbox"/> Ensure <input type="checkbox"/> Portagen <input type="checkbox"/> Super Soluble Duocal <input type="checkbox"/> Boost <input type="checkbox"/> Monogen <input type="checkbox"/> Resource Breeze	
For PKU and Metabolic Needs: WIC collaborates with the Ohio Metabolic Formula Program which supplies certain PKU and metabolic formulas prescribed by an Ohio Department of Health (ODH) approved metabolic service provider. A separate form must be completed. Please contact your WIC office for more information.	
5. WIC Foods: Participants on Prescribed Formulas may receive the following foods offered by WIC.	
Please indicate the appropriateness of the following foods to accompany the prescribed formula.	
WIC Foods That May Be Provided (12 Months and Older, Adults) <input type="checkbox"/> Check this box to give authority to the WIC health professional (RD/LD, RN or DTR) to prescribe the foods listed below based upon the complete nutritional assessment. Are there any contraindications or restrictions for any of these foods? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> Milk <input type="checkbox"/> Beans, dried peas and legumes <input type="checkbox"/> Juice <input type="checkbox"/> Peanut butter <input type="checkbox"/> Breakfast cereal <input type="checkbox"/> Whole grains <input type="checkbox"/> Eggs <input type="checkbox"/> (bread, brown rice, oatmeal, corn/whole wheat tortillas) <input type="checkbox"/> Fruits <input type="checkbox"/> Fish (women only, as applicable) <input type="checkbox"/> Vegetables <input type="checkbox"/> Infant cereal (child only) <input type="checkbox"/> Do not provide any of the above WIC foods	Milk Substitutions: (Children Age 2 Years and Older & Adults) Indicate which foods are to be substituted for reduced fat, low fat or skim milk for the following diagnoses: Lactose intolerance, FTT, slow weight gain, low/under weight, or other qualifying conditions. <input type="checkbox"/> Whole milk <input type="checkbox"/> Cheese <input type="checkbox"/> Not Applicable <input type="checkbox"/> Lactaid® whole milk
Health Care Provider's Name (please print)	Phone
Health Care Provider's Signature	Date
(Rev. 10/1/09) PPL 174 This institution is an equal opportunity provider. ODH 3989.23	

Ohio WIC Prescribed Formula and Food Request Form Reasons for Use

Patient's name (please print)	Date of birth
Caregiver's name (please print)	Phone

Parts 1-5 REQUIRED FOR APPROVAL - Please complete the following information:

1. Amount of infant/child/adult formula to be provided per **DAY**: _____
2. Intended length of use (**must not exceed 6 months at a time**): _____
3. ICD-9 code: ____ . ____ **and** Medical diagnosis (please print): _____
Describe condition or symptoms causing need for specialized formula: _____

- Complete demographic information
- New requirement-daily quantity must be documented
- Length of time special formula is needed – Maximum allowed is 6 months
- ICD-9, medical diagnosis and brief description of condition or symptoms

Infant Formula Tolerance Problems

- Nonspecific intolerance problems may not qualify for special formulas.
- Relactation is a recommended option for intolerance problems. WIC can help.
- A Trial with Similac Advance (Similac Advance Early Shield) or Isomil Advance Formulas is requested to determine if healthy, full-term infant can tolerate intact protein formulas before prescribing a specialized formula.

Infant Formula Tolerance Problems

4. Prescribed Formulas:

Infants and Children

WIC receives a rebate for Similac Advance and Similac Isomil Advance. Rebates help WIC provide services to more participants.

A trial with **either** of these formulas is required **prior** to ordering any of the formulas listed in the box below.

Please indicate if the infant has tried **either** Similac Advance or Similac Isomil Advance formulas: Yes No

If no, please explain: _____ Is re-lactation an option? Yes No

- | | | |
|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> EleCare Unflavored | <input type="checkbox"/> Enfamil Nutramigen Lipil w/ Enflora LGG (powder only) | <input type="checkbox"/> Neocate Infant with DHA & ARA |
| <input type="checkbox"/> EleCare Unflavored with DHA & ARA | <input type="checkbox"/> Enfamil Nutramigen Lipil (liq conc & RTF only) | <input type="checkbox"/> Similac Alimentum |
| <input type="checkbox"/> Enfamil EnfaCare Lipil (\leq 12 mo corrected age) | <input type="checkbox"/> Enfamil Pregestimil Lipil | <input type="checkbox"/> Similac Sensitive (\leq 12 mo corrected age) |
| <input type="checkbox"/> Enfamil EnfaPort Lipil | <input type="checkbox"/> Neocate Infant | <input type="checkbox"/> Similac NeoSure (\leq 12 mo corrected age) |
| | | <input type="checkbox"/> Similac PM 60/40 |

Infant Foods: Indicate which infant foods listed below are contraindicated or require restrictions.

- Infant Cereal Fruits (baby food textures) Vegetables (baby food textures) Do not provide any of the infant WIC foods listed

- Check box to indicate if the infant has tried Similac Advance (Similac Advance Early Shield) **OR** Similac Isomil formulas **OR** if re-lactation is an option
- Check box for special infant formula being prescribed
- Document any contraindications for infant cereal, fruits or vegetables for infants over 6 month old
- If **child** requires infant formula, check appropriate formula

Children Only

Children Only

- | | | |
|------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Boost Kid Essentials 1.0 Cal | <input type="checkbox"/> Neocate One + | <input type="checkbox"/> Peptamen Junior with Fiber |
| <input type="checkbox"/> Boost Kid Essentials 1.5 cal | <input type="checkbox"/> Nutren Junior | <input type="checkbox"/> Peptamen Junior 1.5 Cal |
| <input type="checkbox"/> Boost Kid Essentials with Fiber 1.5 Cal | <input type="checkbox"/> Nutren Junior with Fiber | <input type="checkbox"/> Portagen |
| <input type="checkbox"/> Bright Beginnings Soy Pediatric Drink | <input type="checkbox"/> PediaSure | <input type="checkbox"/> Similac Advance (≤ 12 mo corrected age) |
| <input type="checkbox"/> Compleat Pediatric | <input type="checkbox"/> PediaSure with Fiber | <input type="checkbox"/> Similac Isomil Advance |
| <input type="checkbox"/> E028 Splash | <input type="checkbox"/> PediaSure Enteral | <input type="checkbox"/> Super Soluble Duocal |
| <input type="checkbox"/> Monogen | <input type="checkbox"/> PediaSure with Fiber Enteral | <input type="checkbox"/> Vital Jr. |
| <input type="checkbox"/> Neocate Junior | <input type="checkbox"/> Peptamen Junior | <input type="checkbox"/> Vivonex Pediatric |

- Check box for special formula being prescribed for the child

Adult

A-Soy
 Boost

Ensure
 Monogen

Portagen
 Resource Breeze

Super Soluble Duocal

- Check box for special formula being prescribed for women

WIC Foods

WIC Foods That May Be Provided (12 Months and Older, Adults)

Check this box to give authority to the WIC health professional (RD/LD, RN or DTR) to prescribe the foods listed below based upon the complete nutritional assessment.

Are there any contraindications or restrictions for any of these foods?

No Yes, specify:

- | | |
|-------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Milk | <input type="checkbox"/> Beans, dried peas and legumes |
| <input type="checkbox"/> Juice | <input type="checkbox"/> Peanut butter |
| <input type="checkbox"/> Breakfast cereal | <input type="checkbox"/> Whole grains |
| <input type="checkbox"/> Eggs | (bread, brown rice, oatmeal, corn/whole wheat tortillas) |
| <input type="checkbox"/> Fruits | <input type="checkbox"/> Fish (women only, as applicable) |
| <input type="checkbox"/> Vegetables | <input type="checkbox"/> Infant cereal (child only) |

Do not provide any of the above WIC foods

Milk Substitutions:

(Children Age 2 Years and Older & Adults)

Indicate which foods are to be **substituted** for reduced fat, low fat or skim milk for the following diagnoses: *Lactose intolerance, FTT, slow weight gain, low/under weight, or other qualifying conditions.*

- | | | |
|----------------------------------------------|---------------------------------|-----------------------------------------|
| <input type="checkbox"/> Whole milk | <input type="checkbox"/> Cheese | <input type="checkbox"/> Not Applicable |
| <input type="checkbox"/> Lactaid® whole milk | | |

- Check box for any contraindications to the listed foods or check first box to give authority to the WIC health professional to prescribe types and amounts of food.
- Women or children age 2 or older can **only** receive whole milk and or cheese if they also require a special formula.
- Complete the “Milk Substitutions” section if whole milk and/or cheese is needed.

Final steps

- Complete the signature block
- Give completed form to the participant
- OR fax to the local WIC office

Thank you for your continued
partnership!

If there are any questions,
please contact your local WIC
office.