



ARKANSAS DEPARTMENT OF HEALTH – WIC SPECIAL FORMULA REQUEST

Patient Name _____ DOB _____

Weight _____ Length/Height _____ Date of Measurement _____

Instructions on back. Approval subject to review per WIC policy. All sections required, unless indicated.

A) Amount & Duration	B) Formula Requested	C) Corresponding Diagnosis
_____ oz/day 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 <input type="checkbox"/> Optional: Patient receives <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Any breastmilk Previous formulas tried:	Alfamino Infant powder <input type="checkbox"/>	<input type="checkbox"/> Multiple food allergies <input type="checkbox"/> CMPA <input type="checkbox"/> Malabsorptive condition
	Alfamino Junior powder <input type="checkbox"/>	<input type="checkbox"/> Eosinophilic GI disorder <input type="checkbox"/> Short bowel syndrome
	Alimentum powder <input type="checkbox"/>	<input type="checkbox"/> CMPA <input type="checkbox"/> Soy allergy <input type="checkbox"/> Corn allergy <input type="checkbox"/> Chronic diarrhea
	Alimentum RTU <input type="checkbox"/>	<input type="checkbox"/> Short bowel syndrome <input type="checkbox"/> Severe malnutrition
	EnfaCare NeuroPro powder <input type="checkbox"/>	<input type="checkbox"/> Preterm <37 weeks (_____ weeks gestation)
	Extensive HA powder <input type="checkbox"/>	<input type="checkbox"/> CMPA <input type="checkbox"/> Intolerance to cow's milk protein
	Nutramigen Enflora LGG pwd. <input type="checkbox"/>	<input type="checkbox"/> CMPA <input type="checkbox"/> CMPA and soy protein allergy <input type="checkbox"/> GI bleeds
	Nutramigen DHA/ARA conc. <input type="checkbox"/>	<input type="checkbox"/> Sensitivity to intact protein <input type="checkbox"/> Chronic diarrhea
	Nutramigen DHA/ARA RTU <input type="checkbox"/>	
	Neosure powder <input type="checkbox"/>	<input type="checkbox"/> Preterm <37 weeks (_____ weeks gestation)
	Neosure RTU <input type="checkbox"/>	
	Periflex Early Years powder <input type="checkbox"/>	<input type="checkbox"/> PKU <input type="checkbox"/> Hyperphenylalaninemia
	Periflex Junior Plus powder <input type="checkbox"/>	
	Portagen powder <input type="checkbox"/>	<input type="checkbox"/> Pancreatic insufficiency <input type="checkbox"/> Bile acid deficiency <input type="checkbox"/> Biliary atresia <input type="checkbox"/> Liver disease <input type="checkbox"/> Lymphatic abnormalities <input type="checkbox"/> Chylothorax
	Pregestimil powder <input type="checkbox"/>	<input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Cow and soy protein allergy <input type="checkbox"/> Short gut <input type="checkbox"/> Chronic diarrhea <input type="checkbox"/> Fat malabsorption due to GI or liver disease
PM 60/40 powder <input type="checkbox"/>	<input type="checkbox"/> Renal Condition <input type="checkbox"/> Heart Condition <input type="checkbox"/> Other: _____	
Boost Kids Essentials RTU <input type="checkbox"/>	<input type="checkbox"/> Tube fed <input type="checkbox"/> Oral Motor Feeding Disorder	
Nutren Junior 1.0 <input type="checkbox"/>	<input type="checkbox"/> Medical condition that increases calorie needs (specify): _____	
Nutren Junior 1.0 with Fiber <input type="checkbox"/>	<input type="checkbox"/> FTT supported by anthropometrics *See WIC criteria regarding FTT	

D) Food Restrictions

Infants 6-12 months: No infant food package (>6 months old) No fresh fruit/vegetables (>9 months old)

Children: No milk No eggs No peanut butter No fruits/vegetables
 No cheese No juice No beans No grains

Reason for restriction: Prematurity Developmental delay Food allergy Oral Motor Feeding Disorder Tube fed

Special requests/comments:

Give infant foods to child Give soy formula for child 1-2 years old Give whole milk >2 years (*See instructions/criteria*)

E) Provider Information

Provider's Name (print): _____ Title: MD DO PA APRN

Provider's Phone Number: _____ Ext. _____

Provider's Signature: _____ Date: _____

F) WIC USE ONLY BELOW THIS LINE

Formula History/Reactions; Additional Information: Most recent growth percentiles: Wt for Age: _____ Wt for Len/Ht _____ BMI for Age%: _____ Weeks Gestation: _____	Renewal? Yes <input type="checkbox"/> No <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved <input type="checkbox"/> Approving Dietitian: _____ Amount to Issue: _____ Begin Date: _____ Exp Date: _____ CPA Name: _____ Clinic: _____ Date: _____
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Instructions & Definitions

This form or a prescription must be completed by an MD, DO, PA with prescriptive authority, or APRN with prescriptive authority. A WIC Registered Dietitian will review requests in accordance with federal regulations and AR WIC policies.

No Prescription is Required for Infants receiving:
Gerber Good Start Gentle Gerber Good Start Soothe-Pro Gerber Gentle Good Start Gentle Soy

SECTION A)

- Indicate number of ounces per day. "Max" is acceptable.
- Indicate number of months formula is being requested. **Most prescriptions may be approved for up to 3 months.**
- Optional information in this section can be provided to assist the approval process.

Formulas may be approved for 6 months for patients with documented:

Tube feeding	Confirmed Cow's Milk Allergy	Short Bowel Syndrome
Galactosemia	Specified Malabsorption	Palliative Care
PKU	Conditions requiring Similac PM 60/40	Fatty Acid Oxidation Disorders
Cystic Fibrosis	Preterm infants discharged on a preterm transitional formula	

SECTION B)

- Check or circle formula requested. All special formulas provided by Arkansas WIC are listed on this form.
- WIC offers powdered formula as a default, *unless* powdered is not available.
- Additional documentation may be required when requesting liquid concentrate or RTU.
- Conditions which qualify an infant for liquid concentrate or RTU include: unsanitary or restricted water supply, caretaker with difficulty diluting powderformula, allergy to ingredient in powdered form, improved compliance in consuming the prescribed formula.

SECTION C)

- Indicate diagnosis. The diagnoses in Section C are allowable for formulas ***in the corresponding row*** of Section B.

SECTION D)

- Check and/or write in any special requests.
- Children on special formula may receive infant fruits and vegetables if requested, with a supporting diagnosis.
- Whole Milk: Children receiving special formula with diagnosed, *verified* FTT *and* a prescription for Boost, Nutren Jr, or Nutren Jr with Fiber may receive whole milk if requested.

Definitions

CMPA = Cow's Milk Protein Allergy

OMFD = Oral Motor Feeding Disorder

FTT = Failure to Thrive*

RTU = Ready to Use; Ready to Feed formula requiring no dilution

FTT supported by anthropometric data (without an underlying medical condition) must be verified with *at least one* of the following:

- Weight consistently below the 3rd percentile for age
- Weight less than 80% of ideal weight for height/age
- Progressive fall-off in weight to below the 3rd percentile
- A decrease in expected rate of growth along the child's previously defined growth curve, irrespective of its relationship to the 3rd percentile

Nutritional supplements cannot be prescribed for "picky eating" or "poor weight gain" without an underlying medical condition or diagnosis of FTT.