Pennsylvania WIC Program Formula Authorization Form

Hamilton Health Center WIC Program
110 S. 17th Street, Harrisburg, PA 17104
Ph: 717-230-3979 Fax: 717-230-3977

Client's First & Last Name________________________________**Birth Date**______________________________

Parent/Caregiver's First & Last Name____

1. **Formula requested:** ____

*WIC is offering a wider variety of hypoallergenic and amino-acid based formulas in response to the supply shortages. Please **only** check alternatives that are **NOT** appropriate for this client. Products not checked indicate provider authorization for WIC to issue a comparable product to the type requested, if needed.*

Hypoallergenic: □ Alimentum □ Gerber Extensive HA □ Nutramigen □ Pregestimil
□ Parent's Choice Hypoallergenic □ Tippy Toes Hypoallergenic □ Signature Care Hypoallergenic
Amino-Acid Based: □ EleCare □ Alfamino Infant □ Neocate Infant □ Neocate Syneo Infant □ Puramino

2. Amount requested: ___ oz/day (if formula) ___ Tbsp/day (if modular formula)

3. Length of use: □ 1 month □ 3 months □ 6 months □ through this date__________ (max 6 months)
Monthly renewal required for pre-discharge premature formulas. WIC encourages re-challenge with primary infant formula after solids have been introduced, generally at 6 months of age, with physician approval.

Via tube feeding? □ Yes □ No

Special instructions for preparation and use (if necessary): ____

____

4. **Qualifying Medical Condition(s):** ____________________________ICD-10 Code: ________________________
(Justifies the prescription of above formula).

5. Are there any WIC food restrictions? □ Yes □ No

If yes, please check the foods below that your client should not receive from WIC as well as length of restriction:

Infants (6-11 months): □ infant cereal □ infant vegetable or fruit □ infant meat

Children & Women: □ tofu □ soy beverage □ milk □ yogurt □ cheese
□ juice □ breakfast cereal □ whole wheat bread or other whole grains
□ eggs □ vegetables & fruits □ fish (tuna/salmon/sardines)
□ legumes □ peanut butter (available after age 2 only)

Length of restriction: □ 1 month □ 3 months □ 6 months □ other:__________________________

Reasons/Instructions/Comments: ____

____

6. Please select a dairy alternative to what WIC automatically authorizes, if indicated:

a. whole fat milk and yogurt for children 12-23 months. Check box below if other than whole milk is indicated:

milk: □ 2% □ 1% □skim □ soy beverage □ tofu: 1-4 lbs: ____ > 4 lbs:____ □ yogurt: low fat/non fat

b. 1% or skim milk or lowfat/nonfat yogurt for women and children age 2 and over.
Check box below if other than 1% or skim milk is indicated:
milk: □ whole* □ 2% □ soy beverage □ tofu: 1-4 lbs:____ > 4 lbs:____ □ yogurt: whole fat

* Whole milk may be provided for women and children age 2 and over, only if a special formula is prescribed.

Signature: ____ **Date:** ______________
Physician, Certified Registered Nurse Practitioner, Certified Nurse Midwife, Physician Assistant

Printed Name: ____
Medical Office/ Clinic: ____**Telephone:** _____________
Address: ____**Fax:** _____________

PA WIC is funded by the USDA.
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